Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

March 4, 2025
9:01 a.m. – 2:16 p.m. EST
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attendance

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

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

PTAC Members in Partial Attendance

Lauran Hardin, MSN, FAAN (Chief Integration Officer, HC^2 Strategies)

Department of Health and Human Services (HHS) Guest Speaker

Abe Sutton, JD (Director, Center for Medicare and Medicaid Innovation [CMMI], and Deputy Administrator, Centers for Medicare & Medicaid Services [CMS])

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

Audrey McDowell, PTAC Designated Federal Officer
Steven Sheingold, PhD

Via Zoom

List of Speakers and Handouts

1. **Panel Discussion: Enhancing the Ability of PB-TCOC Models to Be Competitive**

   J. Michael McWilliams, MD, PhD, Warren Alpert Foundation Professor of Health Care Policy and Professor of Medicine, Department of Health Care Policy, Harvard Medical School*
   Stephen M. Shortell, PhD, MPH, Blue Cross of California Distinguished Professor of Health Policy and Management Emeritus, Dean Emeritus, and Professor of the Graduate School at the School of Public Health and Haas School of Business, University of California-Berkeley*
   Jose Peña, MD, FACP, Chairman of the Board and Chief Medical Director, Rio Grande Valley (RGV) ACO Health Providers, LLC*
   Tim Layton, PhD, Associate Professor of Public Policy and Economics, Frank Batten School of Leadership and Public Policy, University of Virginia*

   Handouts
   - Panel Discussion Day 2 Panelists' Biographies
   - Panel Discussion Day 2 Introduction Slides
   - Panel Discussion Day 2 Discussion Guide

2. **Listening Session 3: How to Maximize Participation of Beneficiaries in Accountable Care and Improve the Sustainability of Effective PB-TCOC Models**

   David Muhlestein, PhD, JD, Chief Executive Officer, Simple Healthcare*
   Sanjay K. Shetty, MD, MBA, President, CenterWell, Humana
   Sean Cavanaugh, MPH, Chief Policy Officer, Aledade
   Karl Koenig, MD, MS, Executive Director of the Musculoskeletal Institute, Division Chief of Orthopaedic Surgery, and Associate Professor of Surgery and Perioperative Care, Dell Medical School, The University of Texas at Austin*

   Handouts
   - Listening Session 3 Day 2 Presenters' Biographies
   - Listening Session 3 Day 2 Presentation Slides
   - Listening Session 3 Day 2 Facilitation Questions

3. **Public Commenters**

   Florence Fee (No Health without Mental Health)

Via Zoom

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

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

Welcome and Co-Chair Overview

Soujanya Pulluru, PTAC Co-Chair, welcomed the Committee and members of the public to the second day of the March public meeting. She introduced Mr. Abe Sutton, the Director of the Center for

Medicare and Medicaid Innovation (CMMI or the Innovation Center) and the Deputy Administrator of the Centers for Medicare & Medicaid Services (CMS), who provided the opening remarks.

Mr. Sutton stated that he has been aware of PTAC since his prior role as the advisor to the Department of Health and Human Services (HHS) Secretary Alex Azar II. He discussed CMMI's work of designing models that will improve quality of care while reducing costs, and noted that this commitment is aligned with the vision of HHS Secretary Robert F. Kennedy Jr. and the future CMS Administrator, emphasizing the Secretary's vision to Make America Healthy Again. Mr. Sutton also discussed CMMI's commitment to ensure that resources are used efficiently to reform the health care delivery system and improve the quality of care. Additionally, Mr. Sutton noted that there is a great model portfolio at CMMI, and much of its work will build on the past successes at the Innovation Center. He indicated that CMMI's metric of success will be designing models to be certifiable. He also described CMMI's vision, which emphasizes the prevention and management of chronic disease and the use of data to empower people to meet their health goals. Mr. Sutton also stated that CMMI would like to understand how to promote choice and competition in health care markets.

Co-Chair Pulluru reviewed the agenda for the second day of the public meeting, which focused on reducing barriers to participation in population-based total cost of care (PB-TCOC) models and supporting primary and specialty care transformation. She noted that the meeting would include one panel discussion and one listening session bringing together experts with various perspectives. Co-Chair Pulluru indicated that a public comment period would be held in the afternoon. Participants must register to provide an oral public comment, and public comments are limited to three minutes. She stated that the meeting would conclude with a Committee member discussion of comments for inclusion in the report to the Secretary (RTS).

Co-Chair Pulluru then invited Committee members to introduce themselves and describe their experience reducing barriers to participation in PB-TCOC models and supporting primary and specialty care transformation.

Panel Discussion: Enhancing the Ability of PB-TCOC Models to Be Competitive

Subject Matter Experts (SMEs)

- J. Michael McWilliams, MD, PhD, Warren Alpert Foundation Professor of Health Care Policy and Professor of Medicine, Department of Health Care Policy, Harvard Medical School
- Stephen M. Shortell, PhD, MPH, Blue Cross of California Distinguished Professor of Health Policy and Management Emeritus, Dean Emeritus, and Professor of the Graduate School at the School of Public Health and Haas School of Business, University of California-Berkeley
- Jose Peña, MD, FACP, Chairman of the Board and Chief Medical Director, Rio Grande Valley (RGV) ACO Health Providers, LLC*
- Tim Layton, PhD, Associate Professor of Public Policy and Economics, Frank Batten School of Leadership and Public Policy, University of Virginia

Co-Chair Pulluru moderated the panel discussion with four SMEs offering their perspectives on enhancing the ability of PB-TCOC models to be competitive. For additional details, please see the transcript and meeting recording (00:14:57-01:42:04).

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

- J. Michael McWilliams discussed his role as the Senior Advisor to CMMI and indicated that his comments do not represent the views of CMMI or CMS. Dr. McWilliams stated that the goal is not necessarily competitiveness but success, which can be considered more value at a lower cost. He suggested that competitiveness is important to success, but competitiveness must be clearly defined. He emphasized the importance of fixing design issues in total cost of care (TCOC) contracts, including making models more financially attractive to providers and addressing barriers to participation (e.g., the rachet effect, benchmarking methods). Dr. McWilliams also described the competitiveness between TCOC models and Medicare Advantage (MA). He suggested that payment policy favors MA over traditional Medicare. Dr. McWilliams stated that Accountable Care Organizations (ACOs) cannot compete with MA because MA is heavily subsidized, and subsidies translate to better coverage for beneficiaries. He described policy considerations to even the playing field between traditional Medicare and MA and determine the extent to which traditional Medicare should discipline the MA market. Dr. McWilliams proposed two considerations for the role of ACOs and TCOC contracts in the interaction between traditional Medicare and MA. First, strengthening incentives in ACO models can help lower the cost of leveraging traditional Medicare to discipline the MA market. Second, developing ways for ACOs to share savings directly with patients, as MA plans do, could foster demand for efficiency in traditional Medicare, strengthen ACO incentives, and pressure MA plans to elevate their standards. Dr. McWilliams discussed the value of making population-based provider payments more competitive and discussed the trade-off between cost containment and quality. For additional details on Dr. McWilliams' background and organization, see the panelist introduction slides (slides 2-5).
- Stephen Shortell introduced himself as a health policy researcher and described three ongoing workgroups relevant to the panel discussion topic. He discussed how vertical integration is associated with increased negotiating leverage with insurers and increased prices. Dr. Shortell suggested that these issues can be attenuated in ACOs due to incentives to share the savings from reducing the TCOC while maintaining or improving quality. He also explained that hospital-affiliated ACOs tend to have higher overall spending compared with independent physician-affiliated ACO groups due to higher inpatient use and specialty services. He noted that independent physician-affiliated ACO groups tend to perform better on some metrics, but there is no evidence showing a difference in quality of care. Dr. Shortell described the challenge of designing payment models to take advantage of the resources and infrastructure that hospitals and health systems can provide to medical groups and reduce the incentive to increase spending. He listed different considerations related to this challenge, including all-payer models; risk-adjusted prospective payment; global budgets; standardized measures; attribution methods; benchmarking methods; and primary care. For additional details on Dr. Shortell's background and organization, see the panelist introduction slides (slides 6-9).
- Jose Peña described his ACO located in south Texas. Dr. Peña noted several challenges with PB-TCOC models, including the growth of MA plans. He noted that MA plans have advantages, including financial predictability and stability, over the Medicare Shared Savings Program (MSSP) and the ACO Realizing Equity, Access, and Community Health (ACO REACH) Model. He explained that physicians lack financial resources and administrative expertise to be competitive in PB-TCOC models. He also noted data access and utilization challenges. Dr. Peña recommended increasing financial and policy stability and predictability. He also recommended reducing regulatory burdens by streamlining waivers and improving ACOs' abilities to recruit beneficiaries. He recommended reducing the percentage of TCOC required for financial guarantees and

improving data sharing practices. Additionally, Dr. Peña recommended increasing up-front funding to enable infrastructure development through access to advanced payments. He also recommended expanding community-based organization (CBO) services. Dr. Peña suggested reducing the burden of the V28 Hierarchical Condition Category (HCC) model and incorporating social risk factors. For additional details on Dr. Peña's background and organization, see the panelist introduction slides (slides 10-15).

- Tim Layton introduced himself as an economist. Dr. Layton emphasized two goals of TCOC models: 1) lower spending; and 2) improve the allocation of a fixed amount of money. He stated that spending can be lowered without TCOC models. He explained that the purpose of TCOC models is to improve the allocation of a fixed amount of money. Dr. Layton suggested that it is difficult to set every payment for every service in fee-for-service (FFS) correctly. He noted that TCOC models provide an opportunity to allow organizations to experiment with different allocations until they find the allocations that deliver the most value to patients. Dr. Layton explained that achieving both goals using a single payment policy often results in doing a poor job at achieving either goal. He suggested that the key problem is the drive to diminish shared savings via payment rules. Dr. Layton stated that any savings that ACOs must share with the government will decrease the incentive for organizations to participate. He suggested that breaking the two goals apart could lead to a different payment policy where all models (e.g., FFS, ACOs, MA) are paid the same amount for the same person and therefore are on an even playing field. He stated that ACOs should be able to use savings on the services patients want. He explained that leveling the playing field—where FFS, ACOs, and MA are paid the same amount for the same person—is difficult but solvable through survey-based risk adjustment, randomization of defaults, or simple fixes to the current risk adjustment system. To achieve an optimal, global outcome, he recommended pushing for more active choice and engaging in more competition policy. For additional details on Dr. Layton's background and organization, see the panelist introduction slides (slides 16-20).

Dr. Peña discussed his thoughts and recommendations about social risk scores.

- He stated that the Health Care Payment Learning & Action Network (HCPLAN) has been working on a social risk score.
- He also noted that there are additional incentives in the ACO REACH Model to treat the top 10 percent highest poverty patients, but this component could be enhanced. There are Z codes in the billing system to let CMS know which patients have poor access to transportation, housing insecurity, and food insecurity. He stated that his ACO receives additional payments to address these gaps but in a limited way. He also indicated that it remains unclear what is permitted versus not permitted.

Panelists discussed whether the unlevel playing field between models is nearly 26 percent worse for the MSSP and other CMMI value-based programs compared with MA.

- One presenter confirmed that the 26 percent difference seemed correct. The ratchet effect and benchmarking methods diminish the savings produced. However, ACOs participate because the benchmarks are set based on average spending in a region; there are built-in subsidies for providers in the program so that providers are awarded for historical levels of efficiency.
- Although the increases in payments to MA have been unintended and appropriated by insurers, they have translated into additional benefits. Panelists suggested that MA has been a backdoor financing mechanism for the Medicare program to expand coverage in a way that society wants. They also stated that it is a substantial challenge to determine how to be fiscally responsible and improve risk adjustment without losing benefits.

- Panelists indicated that the playing field is unlevel in two ways: 1) what is paid; and 2) what can be done with the money. MA plans can use money to provide the services people want. ACOs do not know what they can spend money on. This contributes to the unlevel playing field.

Panelists discussed potential steps to make the MSSP and ACO REACH Model more competitive and attractive to patients.

- They suggested considering being clearer and more permissive about what ACOs can do with the savings that they produce. Simultaneously, consider shifting more of the savings to ACOs. Traditional Medicare is already at a disadvantage to MA, and ACOs are further disadvantaged within traditional Medicare.
- They stated that the 4 percent discount from the top is a problem.
- They suggested that ACOs need more flexibility to be attractive to patients. For example, MA plans provide patients with $100 credit cards each month. Many ACO patients would be interested in this benefit, but the ACO cannot provide this type of money. ACOs would like to provide more benefits to patients.
- They also suggested that one way to share savings with beneficiaries could include Part B or Part D premium reductions. These reductions would allow the more efficient ACOs to be more attractive to beneficiaries, which would help strengthen the incentive to save and apply more pressure on MA plans to perform better. However, even if ACO models are better designed with more savings and flexibility, ACOs are still stuck with having to finance with savings the additional benefits for beneficiaries, whereas MA plans can finance beneficiaries with savings and subsidies. The MA program will be favored for as long as those subsidies are in place. It should be considered whether traditional Medicare should remain to supply competitive pressure on MA to discipline the market, which would be difficult to do through a regulatory structure. If traditional Medicare remains, then the playing field needs to be leveled in terms of the subsidies.
- Additionally, they stated that approximately 20 percent of Americans receive care that does not help them. This costs between $100 to $300 billion per year. There are approximately seven procedures that account for a large proportion of the low-value care, and this issue should be addressed. About eight or nine states have set spending targets to make care more affordable. In addition to spending targets, some states develop participation targets to move to value-based payment models. For example, California has set targets so that by 2032, the value-based payment should be a percentage of revenue or percentage of enrollees ranging from 65 percent to 90 percent. One way to achieve the spending target is to eliminate low-value care. This problem cuts across all payment models.

Panelists discussed the competitive management opportunity between FFS and MA and how providers advise Medicare patients to move between FFS and MA.

- They stated that some MA plans offer a better value for patients than other MA plans. For example, some MA plans have more social workers and community health workers (CHWs), use quality metrics, and provide feedback on blood sugar control. Other MA plans are difficult to communicate with. In addition, some MA plans provide sufficient capitation payments that have allowed the integration of behavioral health. The extra income received from some MA plans has allowed one ACO to increase access by having a nurse practitioner go to patients' houses. The landscape in south Texas has changed due to the ACOs and MA plans.
- They also stated that it is critical that patients have the information they need to make good decisions. If patients are not making good decisions, letting the market decide does not work.

- Panelists noted that unlike MA plans, ACOs are not permitted to advertise or compare plan options with patients. The ACO is unable to compete with the MA plan.
- They suggested that the playing field can be leveled with the information patients receive about the options available to them. Leveling the playing field could be done by allowing ACOs to advertise, allowing doctors to talk to their patients about the trade-offs between ACOs and MA plans, and/or empowering brokers who help people enroll in MA plans. Choices are following the value for patients, not the value for society.

Panelists discussed whether the system is designed to push patients to traditional Medicare or to MA, where risk is borne by someone else.

- They stated that the system is working in the way it was designed. For MA to work, there needs to be competition. There are a variety of policy strategies to help guide patients to high-value options and strengthen competition within MA. If people are not making good decisions in their own self-interest, insurers will not be rewarded for their offerings, and there will be fewer insurers. Additionally, there is a need to reform the risk adjustment system. There are a variety of regulatory and market design needs to improve the MA program and competition for enrollees.
- They suggested that the role of traditional Medicare should be considered. There is competition within MA and competition between the programs. It should be considered how much traditional Medicare is needed and how strong of a role traditional Medicare needs to play to exert competition on MA, especially if competition cannot be generated within MA for the program to succeed for all beneficiaries. Currently, traditional Medicare is needed. The playing field needs to be even to encourage people to move to traditional Medicare if their needs are not met in MA.
- They noted that patients are provided limited information when choosing a health plan; they might see the benefit structure and the name of the plan. Patients should be provided basic metrics on the quality of care (e.g., diabetic patients' scores on blood sugar control); hospitals included in the plan network; and publicly reported safety grades for the hospitals.
- They also stated that when people make an active choice, they tend to do well. The problem is that people do not make active choices; they choose a plan once and usually stay with the plan. Information on patient satisfaction with plans could be provided to patients. The key to making this market work is encouraging more active choice, not necessarily providing more information. Plans must design themselves with the entire patient population in mind rather than those patients 65 years of age or older. Plans are designed for elasticity. If only 65-year-old patients respond to changes in plan design, elasticity will be low. If many people respond because people have been helped to make active choices, then the insurers' elasticities will increase.

Panelists discussed considerations for Medigap policies to promote active choice. They also discussed the extent to which subsidies going to MA are returned as increased coverage.

- They stated that approximately 50 cents on the dollar are returned. The plans retain much of the additional payments as surplus profits. However, some money is used to cover out-of-pocket costs inclusive of premiums, making these costs lower in MA versus traditional Medicare. The rate of money returning to the beneficiary as increased coverage is higher in competitive markets. This underscores how critical competition is to the performance of the MA program. The markets are not competitive right now. Approximately 90 percent of MA enrollees live in counties that exceed the new threshold of the Herfindahl-Hirschman Index (HHI) of being highly concentrated.

- They stated that there are inefficiencies in the Medigap market and reasons to reform it. However, reforming the Medigap market would be difficult to do without adjusting the traditional Medicare benefit. Rising premiums allow people to flow more freely between the program and make the traditional Medicare plus Medigap option less attractive for lower-cost beneficiaries. Human nature is a major source of inertia. The government should consider reminding beneficiaries that there may be better options available, potentially through a publicly financed broker system.
- They noted that of those 50 cents that do not go to the patient, it is unknown how much goes to the insurer versus the providers. Occasionally, MA plans give providers good capitation deals.
- They also stated that the traditional Medicare structure incentivizes people to join Medicare upon eligibility to avoid adverse selection versus Medigap, which people generally wait to purchase until they are sick. This is why people are risk-rated when returning to traditional Medicare from MA. One fix could include not fully risk-rating people when they come from MA but continuing to fully risk-rate people when they go from traditional Medicare without Medigap to buying Medigap. Incremental changes could help address the issue; however, the main reason for the lack of active choice is that people do not pay attention when choosing insurance.

Panelists discussed their perspectives on provider competitiveness as opposed to plan competitiveness. They also discussed how to design the plans to benefit the beneficiary as opposed to increase the margins for integrated delivery systems (IDSs).

- They noted that there has been horizontal consolidation of integrated health systems. They stated Federal Trade Commission (FTC) is not solving this issue although there are steps it could take to address the horizontal consolidation. About nine or 10 states have spending targets. For example, in California, providers are financially penalized if they do not meet the spending target. This approach has encouraged providers to reconsider their spending. A combination of the FTC choosing to address horizontal consolidation and setting spending targets may be needed to incentivize providers and plans to change behavior.
- They suggested considering determining how to have smaller practices move into value-based payment. Although CMS could consider accelerating its efforts, some steps have included the Making Care Primary (MCP) initiative and providing up-front investment funds for team development and technology.
- They suggested considering how to encourage urban-rural alliances and partnerships. These alliances may not be through consolidation or ownership models. Instead, models could allow arrangements between urban health systems and rural health systems to provide capabilities and resources, including telehealth. In Cooperstown, New York, Bassett Healthcare Network is working on arrangements with academic medical centers to provide resources for value-based care in rural areas.
- They noted that the commercial market is critical. It is difficult to preserve or improve competition in provider markets without price regulation (e.g., regulating FFS prices, a cap, regulating TCOC targets).
- They suggested that models should be designed so they do not entrench the market power that has been amassed by providers under FFS. The models and accompanying pay-for-performance (P4P) programs have created a level of complexity and cost of participation that is beyond what smaller organizations can afford. Simplifying the burden and complexity of the models would allow providers to have a better opportunity to be competitive. Organizations of any type should have the ability to compete. For example, a small primary care organization may not be able to compete in FFS because the revenue will not be high. However, in a TCOC model, there are

stronger incentives to generate savings, which would allow the small practice to compete. There are different levers to be pulled in the different markets.

- They suggested that while there is horizontal and vertical consolidation, there can also be consolidation between payers and providers. The FTC is considering how to regulate this consolidation. This type of consolidation allows efficiencies. For example, consolidating a payer and provider automatically creates a TCOC model. However, this type of consolidation has also allowed integrated entities to prevent people from other integrated entities from seeing their providers. Consider decreasing all other barriers to entry that can be controlled, including reducing complexity and the regulatory environment that makes it difficult to enter these spaces. Reducing these barriers would provide different organizations a chance to compete against the large integrated systems that continue to be formed.

Listening Session 3: How to Maximize Participation of Beneficiaries in Accountable Care and Improve the Sustainability of Effective PB-TCOC Models

SMEs

- David Muhlestein, PhD, JD, Chief Executive Officer, Simple Healthcare
- Sanjay K. Shetty, MD, MBA, President, CenterWell, Humana
- Sean Cavanaugh, MPH, Chief Policy Officer, Aledade
- Karl Koenig, MD, MS, Executive Director of the Musculoskeletal Institute, Division Chief of Orthopaedic Surgery, and Associate Professor of Surgery and Perioperative Care, Dell Medical School, The University of Texas at Austin

Krishna Ramachandran moderated the listening session with four SMEs on maximizing beneficiary participation in accountable care and improving the sustainability of effective PB-TCOC models. Full biographies and presentations are available.

David Muhlestein presented on reducing barriers to participation in PB-TCOC models and supporting primary and specialty care transformation.

- There is a trend of physicians moving from smaller groups to larger group practices, which often positions them better for participating in new models. Primary care providers (PCPs) are transitioning to larger groups at a faster rate than specialists.
    - The shift to larger groups is not primarily due to changes in practice patterns or preferences but rather a result of generational turnover in the workforce. Younger physicians, especially recent medical school graduates, are more likely to join larger practices, while older physicians, many of whom have been in practice for decades, tend to remain in smaller, independent practices.
    - Physician groups have significant untapped potential to participate in ACOs. While over a third of hospital systems capable of becoming an ACO have already joined, less than 10 percent of eligible physician groups have done so.
- The growth of ACO participation slowed down around 2018-2019 and has since remained relatively stagnant. However, this stagnation is not due to a lack of interest, but rather the fact that for every new organization joining an ACO, another drops out.
- The number of physicians qualifying to participate in Advanced Alternative Payment Models (AAPMs) has been growing consistently, increasing from just 8 percent in 2017 to 29 percent in 2023.

- The adoption of AAPMs among non-physicians is much lower than that of physicians. Non-physician providers are growing in number and need to be considered more proactively in value-based care models as they are taking on an increasing share of the care.
- PCPs are adopting AAPMs at a much higher rate than specialists, largely due to the lack of suitable AAPMs for certain specialties. There is a need for specialty-specific models to increase participation from specialties with low engagement in AAPMs, such as dermatologists and psychiatrists.
- The percentage of providers participating in value-based care models varies widely by state, ranging from below 10 percent to over 50 percent. Participation seems to be driven by local market dynamics, where once one part of the market begins adopting value-based care, others follow suit. A regional approach to stimulate the adoption of value-based care is needed.
- The majority of providers are not participating in any AAPMs. While there are many AAPM options available, most participants are concentrated in a few key programs, including the MSSP and ACO REACH. There could be improvements in how models are ranked to reduce confusion for providers participating in multiple models.

For additional details on Dr. Muhlestein's presentation, see the presentation slides (pages 2-15), transcript, and meeting recording (00:00:00-00:12:28).

Sanjay Shetty presented on maximizing participation in accountable care and improving the sustainability of effective PB-TCOC models.

- Dr. Shetty is the President of CenterWell, a health system that provides senior primary care, home health, and pharmacy services. CenterWell's value-based care model is designed specifically for seniors, with purpose-built clinics, integrated care teams, and extended appointment times. A study published in *Health Affairs* highlighted that CenterWell's senior-focused model outperforms others in improving access to care, health outcomes, and reducing health disparities.
- It is important for practices to have access to a broad set of value-based programs across different payers. MA, which offers the highest percentage of higher-level TCOC models, is a crucial component of CenterWell's value-based care model.
- He stated that success in value-based care requires providers to have access to essential tools such as population health management; effective electronic health records (EHRs); and sufficient staffing to manage patient panels. Providers must also facilitate patient engagement, including effective communication and outreach to patients both inside and outside the office. Collaboration and data sharing are key to enhancing patient care and coordination.
- It is important for value-based care models to offer practices financial stability and predictability that allow them to plan for future growth, including workforce investments and expansion of services. Successful value-based providers invest in clinical operations, including care coordination, emergency room diversion plans, and post-hospital discharge follow-ups, to avoid unnecessary costs and improve patient outcomes.
- Providers need robust internal quality and financial reporting systems to track performance and manage their value-based care contracts effectively.
- Providers should also invest in their care teams, utilizing social workers, behavioral health specialists, and pharmacists alongside PCPs.
- Providers need stability and predictability in programs such as the MSSP and ACO REACH to drive participation in PB-TCOC models, including stability in benchmarks, quality measures, and financial returns.

- Payment models should focus on outcomes, not solely processes. Tying payment to outcomes incentivizes providers to invest in meaningful improvements rather than merely completing tasks.

For additional details on Dr. Shetty's presentation, see the presentation slides (pages 16-24), transcript, and meeting recording (00:12:28-00:22:11).

Sean Cavanaugh presented on how to maximize participation of beneficiaries in accountable care and improve the sustainability of effective PB-TCOC models.

- Mr. Cavanaugh is the Chief Policy Officer of Aledade, the largest independent primary care network in the country focused exclusively on value-based care. Aledade supports primary care practices with transitioning to value-based care by providing technology, workflows, data analytics, and regulatory and compliance expertise. Aledade primarily focuses on having practices in the MSSP but aims to have as much of the patient panel as possible in any value-based care arrangement.
- The growth in Medicare value-based programs has slowed in recent years, particularly as the early adopters have already engaged. The challenge now is determining how to engage the mainstream market of providers. The factors that attracted early adopters to value-based care differ significantly from what will attract the mainstream market.
- Despite strong participation from PCPs, many remain outside of value-based care programs. The evidence supporting the success of primary care in the MSSP is strong. Primary care should be the initial focus to drive broader adoption, even though specialists remain important.
- He suggested that CMS should consider taking a more active marketing role, engaging practices directly and emphasizing the benefits of value-based care, as data show that it is beneficial for both practices and beneficiaries.
    - He also suggested that there should be a clear message that FFS models are detrimental to both practices and patients, similar to how "paper kills" was used to promote the adoption of EHRs.
    - Additionally, he suggested that the financial incentives for transitioning to value-based care should also be emphasized. For example, ACOs, particularly physician-led ACOs, typically receive significant shared savings.
- Moreover, Mr. Cavanaugh suggested that emphasis should be placed on the MSSP as the main value-based care program. It is a statutorily mandated program with proven evidence. It should be the central focus of efforts to transition providers to value-based care.
- He stated that the mainstream market wants a stable and predictable model with minimal technical implementation burden; it is not interested in being an "innovator." The MSSP has undergone changes over the years, but these dynamic shifts (e.g., changes in benchmarking formulas) create uncertainty. He suggested that the program needs to be more consistent and predictable before the broader market can fully embrace it.
- He also noted that simplifiers, such as Aledade, play a crucial role in helping practices engage in value-based care.

For additional details on Mr. Cavanaugh's presentation, see the presentation slides (pages 25-35), transcript, and meeting recording (00:22:11-00:32:21).

Karl Koenig presented on considerations for implementing PB-TCOC models.

- Many specialists, including orthopedic surgeons, are supportive of value-based care models and have already participated in voluntary models as they have emerged.
- He stated that the current system does not enable specialists and ACOs to collaborate on musculoskeletal care, as PCPs in ACOs cannot effectively identify high-value specialists for referrals. Specialists are largely still operating within FFS, creating challenges for PCPs who are working within value-based care models. A new payment model is needed to incentivize collaboration and high-value care across primary care and specialty care.
- He suggested that the specialist should manage the full episode of care for certain conditions, allowing them to share in the risk and savings while also helping PCPs with aspects outside their expertise. This approach would use condition-based bundled payments. For acute conditions such as an ankle fracture, a single payment covers the full cycle of care. For chronic conditions such as osteoarthritis, a bundled payment would cover care over a defined period (e.g., up to a year), including various surgical and non-surgical treatments.
- Dr. Koenig provided an example of a knee osteoarthritis bundle where the care team is responsible for the overall outcomes, regardless of the treatment approach. The model allows for flexible care paths, whether the patient undergoes surgery, tries physical therapy, or follows other treatment routes. Patient-reported outcome measures (PROMs) are collected at various stages (initial visit, six months, 12 months) to assess improvements.
    - Dr. Koenig shared data highlighting that outcomes for patients treated with surgery were almost the same as for those treated without surgery, suggesting that the care team was skilled in determining who truly needs surgery and who can benefit from non-operative treatments.
- Dr. Koenig proposed a voluntary model with an episode price for musculoskeletal conditions, which included all relevant services (e.g., surgical fees), treatment for conditions such as osteoarthritis, and other necessary care. The price would be adjusted based on the population's characteristics and historical treatment patterns. Under such a model, providers would be incentivized to develop specialized care teams and conduct high-value care, such as spending more time at the first visit, encouraging patients to follow treatment plans such as physical therapy, and addressing lifestyle factors such as weight loss, when applicable.

For additional details on Dr. Koenig's presentation, see the presentation slides (pages 36-48), transcript, and meeting recording (00:32:21-00:45:02).

Following the presentations, Committee members asked questions of the presenters. For more details on this discussion, see the transcript and meeting recording (00:45:02-01:28:37).

Presenters discussed outcome measures for PB-TCOC models.

- The foundation of measurement for PB-TCOC models begins with focusing on TCOC. Payment structures should encourage preventative care, such as avoiding readmissions, rather than solely paying for specific processes (e.g., post-acute office visits). Prioritizing TCOC and meaningful health outcomes is key.
- The panelists stated MA Star Ratings measures focus too much on process metrics (e.g., medication adherence, transitions of care) instead of the outcomes that truly matter, such as emergency department (ED) admission rates or readmission rates. They suggested that these process-focused metrics are unnecessary when the goal is to impact health outcomes. Additionally, they stated that the Merit-based Incentive Payment System (MIPS) includes numerous subcategories of spending metrics even though TCOC should already cover those

metrics. They suggested that many of these process and spending measures should be reduced. However, they noted that eliminating them has been challenging.

Presenters discussed the use of specialty-focused nesting models in the context of primary care-focused PB-TCOC.

- They stated that while starting with one condition in value-based care can make the transition less daunting, a sub-capitated model for all musculoskeletal care could work well. Musculoskeletal practices are often multidisciplinary. These specialists tend to order fewer unnecessary tests and non-value-added care, which makes them well-suited for managing a sub-capitated model. However, there are certain conditions, such as musculoskeletal tumors, that could not fit into a sub-capitation model due to their complexity and lack of homogeneity. Additionally, musculoskeletal specialists already measure outcomes that matter to patients, particularly using PROMs, which would work well in a value-based care model.
- To integrate value-based care, CenterWell employs its own cardiologists and identifies high-value specialists outside its network, guiding PCPs to make more efficient referrals. Access to data is critical for assessing the effectiveness of these referrals. CenterWell also considers partnerships with value-based care companies focused on specialty care. The presenter noted challenges in determining which services (e.g., hospital services, imaging, drug spending) and conditions to include in a value-based care arrangement. CenterWell is still on a learning journey, aiming to develop financially sustainable partnerships that improve patient experience, quality, and outcomes.
- Similar to CenterWell, Aledade experiments with various approaches. However, there are important technical issues with pricing based on small numbers. Despite using larger populations, CMMI has difficulty with accurate pricing based on historical data and projections. When dealing with smaller populations, such as Aledade with only 20,000 lives, the margin of error increases, making it even more difficult to ensure stability and fairness in pricing.
- There are challenges in determining what should be included or excluded in condition-specific models, particularly when considering comorbidities. Full risk adjustment, such as the risk scoring used in MA, can help adjust the expected costs for models. In this approach, even if a patient is assigned based on their principal diagnosis (e.g., a psychiatric condition), their risk score will increase due to other comorbidities (e.g., heart conditions). Additionally, stop-loss arrangements should be considered, where costs above a certain threshold (e.g., the 99th percentile) are not included in TCOC, as in the MSSP.
- Engaging specialists in value-based care is challenging. Risk adjustment is crucial to incentivize specialists to care for more complex patients. One presenter expressed concern that PCPs may ration care under TCOC models, referring patients to orthopedic surgeons only as a last resort. This could harm patients who would benefit from early orthopedic interventions that significantly improve their quality of life.

Dr. Muhlestein discussed the influence of health system dominance on the adoption of Alternative Payment Models (APMs).

- The influence of market dominance on the adoption of value-based care is bimodal. When a dominant player in a market shifts to value-based care, others typically follow suit. Conversely, if no dominant entity has taken the first step toward value-based care, APM adoption is much lower.

Presenters discussed the potential benefits and drawbacks of incorporating specialty condition-based bundled payments in primary care-based PB-TCOC models.

- They stated that rather than a one-size-fits-all approach, flexibility is critical in value-based care models to accommodate varying market dynamics across different regions. Groups should have the option to choose models that fit their local context, such as sub-capitation for orthopedic services, without mandating it nationwide.
- While successful ACOs focus on primary care strategies such as wellness and prevention, the transition to value-based care in Medicare must eventually include specialty care. However, the limited availability of specialists in some communities poses significant challenges. In areas with fewer specialists, PCPs often lack choice in referrals, which alters the financial relationships between them and specialists. They suggested that value-based care approaches will need to be tailored to local markets, as cultural and financial factors make it difficult to apply a one-size-fits-all model. Although the transition is challenging, it is essential for the future of Medicare.

Presenters discussed motivations for physician engagement in value-based care.

- Motivations for joining value-based care models vary. Initially, early adopters were eager to try new models, viewing them as an exciting opportunity. Others join due to financial strain and overwork, seeking a new revenue model because the current one is not sustainable. Despite the financial uncertainty caused by cash flow issues and delayed payments when first adopting, most practices stay because they recognize that value-based care models offer a better way to practice medicine. However, they noted that small practices face challenges with erratic payments when CMS changes its financial models, although CMS is working to smooth these fluctuations. Physicians employed by community health centers typically prefer to treat all patients equally. Gaining their engagement involves integrating Medicaid, Medicare, and commercial contracts into one inclusive approach for all patients.
- The traditional FFS model is not suitable for primary care. Value-based care offers a solution by encouraging a team-based approach, allowing physicians to focus on what they are trained to do. It offers financial incentives, as well as a better working environment and care model. Keeping providers informed of their performance, such as tracking missed screenings, also serves as a strong motivator.
- The value-based care model allows specialists to practice medicine as they envisioned in medical school, focusing on patient care rather than just performing procedures. For example, after performing hip replacements, one presenter calls patients the next day to check on their well-being. It is important to provide specialists with the opportunity to practice medicine in this more personalized and holistic way.

Mr. Cavanaugh discussed the use of subscription-based and hybrid models for managing patients with chronic diseases.

- Aledade has not yet used subscription-based or hybrid payment models. Instead, it has experimented with “care contracts” in several markets, where PCPs engage local specialists to discuss collaboration under the ACO model. These conversations focus on what specialists need to do to continue receiving referrals. Aledade has had mixed results with this approach, and it has not yet been scaled to the payment side. One key challenge is that specialists are often unwilling to wait 18 months for uncertain payments, making participation less appealing.

Presenters discussed how to incentivize PCPs and larger health systems to adopt value-based care models.

- Physician-led models typically outperform hospital-led ACOs, although hospital-based ACOs have improved over time and are now generating savings. ACO participation increased partly because MIPS became less appealing. However, MIPS has increasingly blended into the ACO model, and clearer distinctions between the two are needed. There is also a need for more meaningful quality measures and reduced administrative burden for physicians. Additionally, the ACO financial model should be made more stable by addressing issues such as rebasing and ratchet effects. Resolving these challenges would increase physician engagement and ACO participation.
- The key is graduate medical education. By training medical students in value-based care, coordinated care, and collaboration between specialists and PCPs, future doctors would develop an expectation of how medicine should operate. This shift in mindset would encourage them to seek opportunities for value-based care and apply these principles in their careers. This approach would have a better long-term impact than trying to change the practices of established doctors nearing the end of their careers.

Presenters discussed payment and incentive structures to improve the efficiency of home health services.

- Dr. Shetty stated that while traditional home health services typically cater to a small population with specific needs, CenterWell is expanding its focus to include those with social determinants of health (SDOH) or post-acute needs. To enable this, CenterWell has developed internal payment models using a value-based approach. He suggested that generally, home health reimbursement should shift to a value-based model, as the current FFS system is too restrictive and process-focused. The internal, value-based payment model for home health services at CenterWell has fostered more collaboration between home health staff and PCPs, leading to better outcomes.
- Panelists stated that integrating home health providers into specialty condition models offers significant value. When surgeries do not go well, patients often end up in skilled nursing facilities (SNFs) for extended periods, which is not ideal for recovery. Specialists with strong partnerships with home health providers through value-based contracts can trust the providers to support patients in recovering at home, which leads to better outcomes.

Public Comment Period

Co-Chair Mills opened the floor for public comments. The following individual made comments:

- Florence Fee (No Health without Mental Health)

Committee Discussion

Jay Feldstein opened the floor to Committee members to reflect on the day's presentations and discussions. The Committee members discussed the topics noted below. For additional details, please see the transcript and meeting recording (00:07:07-00:43:37).

- Consider addressing barriers to making APMs a viable option as a choice for Medicare, Medicaid, and commercial beneficiaries. The goal is success.
- To scale and integrate specialty care, consider simplicity and avoid complexity. Alternatively, consider embracing complexity as a requisite to engage specialists. These trade-offs should remain front and center in future conversations about specialty integration, multi-payer alignment, and scaling up either within or across payers and purchasers.

- One Committee member questioned who should bear financial risk: providers (e.g., the MSSP), insurance companies (e.g., MA), or both.
- If everyone is going to participate in models, models cannot be complex.
- More work is needed to nest specialists into TCOC models, as well as to implement evaluation and management (E/M) services for chronic disease performed by specialists in TCOC models.
- Consider refining how competition is defined (e.g., competition between traditional Medicare and MA, competition between physicians and hospitals).
- One Committee member noted interest in promoting value-based care in graduate medical education.
- Consider lowering the financial hurdle for smaller ACOs.
- The MSSP is the chassis on which value-based care should be driven.
- Consider simplifying the MSSP. However, the MSSP is blurred with MIPS. Additionally, consider making MIPS less palatable and the MSSP more palatable.
- The MSSP was compared with MA. Both programs have flaws that could be addressed with policy changes. For MA, consider addressing issues with Stars bonuses and risk adjustment. For the MSSP, consider addressing issues with the ratchet effect, regression to the mean, the 4 percent clawback, and allow practices in a MSSP ACO to drive savings to make themselves more competitive with MA (e.g., reduced deductibles, added benefits).
- Consider not paying for low-value care.
- The early innovators and the early adopters are participating. Now, consider changing the messaging and incentives to entice the mainstream market of providers.
- Data democratization and transparency enable more active choices to allow a functioning free-market health system.
- One Committee member emphasized interest in the example provided on nesting a specialty, condition-based model within a TCOC model.
- Individuals in graduate medical education training are the next best population to move to value-based care.
- There is an unfair playing field between MA and traditional Medicare. Because of its achieved savings and subsidies, MA can do more than traditional Medicare can, even under PB-TCOC models.
- Humana's care model developed through CenterWell supports the payment model. It is important to have a strong, underlying care model to succeed in PB-TCOC models. High-access clinics, home health services, and the pharmacy provide the type of care needed to succeed in PB-TCOC payment models.
- An episode compare, or bundles compare, could engage specialists in value-based care. Referring physicians could see the value of care that the specialists in their areas provide.
- The people transforming the health care system are focused on portfolio management of payer sources in order to stay in business.
- Patients need choices. The MSSP is the ACO for the FFS population, and MA is the ACO for the non-FFS population. The products for accountable care, value-based care, and PB-TCOC will be both MSSP and MA because they enable choice.
- There is a geographic disparity in participation and penetration of ACOs. Regarding cost and quality and the value proposition, consider the geographic disparities in penetration of participation, which may lead to low- versus high-value care.

- Physicians are willing to change their clinical care model because it is more gratifying to practice medicine in this way. Younger physicians and non-physician providers are more satisfied with health care delivery because they are working in a different care model.
- Policy recommendations for the Secretary must consider integrating behavioral health.
- Patient goal attainment should be a quality measure that is shared between all payers.
- Regarding the diffusion of innovation, the early adopters have all adopted. Instead of developing standalone models outside of the MSSP, focus on building within the MSSP to allow the continuation of programs. There may be a decreasing number of people who are interested in separate payment models outside of the MSSP. Accountable care models can be tested in the MSSP. This approach could provide stability and certainty regarding planning for the future. This approach could also help attract providers who are not looking for innovation but rather the new normal. Additionally, this approach could address concerns about complexity by narrowing rather than expanding.
- Quality measures should continue to move away from process measures, even in the MSSP, as there is more downside risk. This will reduce burden and decrease barriers for later adopters who want to participate.
- PB-TCOC models have different functions, and some models may be better for certain needs compared with other models. There is a trade-off between access, quality, and cost. This is apparent in the FFS versus MA markets. Competitiveness can be considered in a broader sense, not within a certain segment. PB-TCOC models represent an intermediate point between FFS and MA. Traditional Medicare is an open network with a uniform benefit structure, whereas MA supplemental benefits have restrictions. There is a continuum, and PB-TCOC models serve as the bridge. Consider the usefulness of an intermediate offering. The intermediate offering would need to have the right goal and the right value, and it would need to be competitive without ratcheting down and rebasing.
- MIPS is used for too many functions (e.g., rate adjustments for everyone in the fee schedule, non-advanced APMs), and the technical pieces of MIPS could be adjusted. However, consider a health care system with FFS, MIPS FFS, APMs built on the chassis of the MSSP, complex but narrowly focused specialty integration models, and MA. This approach should avoid overfitting PB-TCOC models for some segments (e.g., rural), which is not a defect in the system but a feature.
- The MSSP and traditional Medicare are not competitive with MA. The goal is to create patient choice. Consider what is paid for and what it is spent on, reflected in a financial model and an operational model. MA wins in both the financial and operational models because it allows creativity, such as reinventing care design. Traditional Medicare does not allow this type of creativity.
- Low-value care has a high cost, possibly $100 to $300 billion. Although there are efforts to find pennies in the margins for high-acuity patients, there is still a lot of money spent on low-value care.
- Consider regional flexibility when integrating specialists using the chassis that exists. Specialty care is regionally mediated in competition.
- There should be a financial value in the delivery system that is assigned to access, such as time to first appointment, same day appointment, time of return appointment, and time to specialty appointment.
- There is a desire for a middle model between FFS to MA that is viable and strong to enable better outcomes. Consider changing the fee structure on the FFS chassis to increase the amount

of money that goes to primary care for middle models (e.g., ACO REACH, MSSP). This approach could increase participation.

- Conveners have a role in participation for the middle market (i.e., the next addressable market). There was 2 percent to 3 percent participation in accountable care early on, and participation grew to 30 percent through the use of conveners. If conveners work with both MA and the middle products, they will have flexibility to repurpose the money they receive. This could improve the fee schedule, increase engagement with PCPs, and allow metrics to be more structured around outcomes (e.g., utilization outcomes). Increasing adoption through conveners could allow payments to be structured to incentivize the right behaviors and create competitiveness while achieving desirable outcomes and increasing primary care investment and uptake.

Closing Remarks

Co-Chair Mills adjourned the meeting.

The public meeting adjourned at 2:16 p.m. EST.

Approved and certified by:

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

4/18/2025
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Date

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