

Physician-Focused Payment Model Technical Advisory Committee

Potential Questions for Previous Submitter and Subject Matter Expert (SME) Listening Session Presenters June 7, 2022

There will be three listening sessions as part of the June public meeting on population-based total cost of care models. The first session on Tuesday, June 7 will include three SMEs and one previous submitter (American College of Physicians). The second session on Tuesday, June 7 will include four SMEs. Each listening session presentation will be 8-9 minutes. Following the presentations, the Committee members will have the opportunity to pose questions to the presenters.

To facilitate the Committee's discussion with the listening session participants, we have provided some "General Questions" that could potentially be asked of all of the listening session participants. We have also provided some potential questions that may be relevant for each presenter, based on information included in their slide presentations. Committee members can choose to use these questions if desired.

General Questions:

- What are best practices for providing patient-centered care for various types of patients in population-based models – including beneficiaries that rarely need to see specialists; beneficiaries with chronic conditions that require transitions both between specialty care and primary care (including high-cost beneficiaries whose care may be managed by a specialist)?
- What care delivery model innovations and design features have the most significant impact on driving reductions in total cost of care (TCOC) models?
- What model design features are most important for supporting providers' and organizations' success in being able to take on financial risk?
- What are best practices for providing screening and referral for addressing health-related social needs and social determinants of health (SDOH) in these models? Should this kind of screening be provided broadly, or targeted to higher-risk patients?
- What are best practices for managing some of the trade-offs involved in designing care delivery models?
- What are best practices for monitoring the performance of model participants, and measuring the overall success of population-based TCOC models?

First Listening Session on Tuesday, June 7, 2022

Questions for Debbie Zimmerman, MD, Corporate Chief Medical Officer, Lumeris

- What are best practices that can encourage and support physicians in assuming financial risk and higher financial incentives in a patient-focused model? What are lessons learned from your model of organizing physicians into pods that take on value-based contracts? What are the

challenges with this model versus an Accountable Care Organization (ACO) model where organizations assume risk?

- How do MA plans encourage specialists to engage in value-based care (including financial arrangements)? How do MA plans improve coordination between primary and specialty care? Do MA plans provide capitated payments to primary care and/or specialty care providers?
- Your findings show a move away from specialty care toward primary care. Are there situations where specialists are best suited to be the primary provider? If so, are there times when care coordination responsibilities (and related measures) are the responsibility of a specialist, as opposed to a PCP? Does your model address patients that may have periods of time when their main source of care is not a PCP?
- What are the pros and cons of various options for coordinating episode-based and condition-specific models with broader population-based models (such as nesting, carve-outs)?
- What are some TCOC-related lessons learned from Essence Healthcare that are transferable to or relevant for Medicare fee-for-service (FFS)?
- What data-driven best practices have emerged from Lumeris to inform other population-based health services platforms or arrangements?
- You described a comprehensive information technology system. How timely is the data your physicians receive? What are some common data-related challenges for physicians trying to engage in population health management, and how has Lumeris helped to overcome those challenges?

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

- What are practical options for sharing data to facilitate the implementation of population-based TCOC models? How can we overcome the challenges of lack of interoperability and proprietary data systems to facilitate effective and timely data sharing?
- How can we improve timely data sharing across model participants? How can timely data sharing improve coordination of care?
- How can model participants overcome the challenge of lack of consistent funding for data collection and sharing?
- How can improved access to patient data improve care delivery and potentially reduce costs?
- What data are needed to adequately measure the quality and outcomes of population-based TCOC models?
- What kind of information and evaluation will be needed for real-time insights?

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

- What factors do actuaries typically consider when designing population-based models that would result in the desired effect of reducing costs and improving quality of care?
- What care delivery model design features are most important for driving reductions in TCOC?
- How can population health models be designed while factoring in the heterogeneity and unpredictability of the covered population?
- How can population-based TCOC models provide additional services and improve health equity from an actuarial perspective? What are best practices for addressing SDOH in population-based TCOC models? What is the estimated return on investment (ROI) for providing screening and referral for SDOH?

- How can limited treatment resources be allocated more efficiently at both the high-risk and low-risk ends of the patient spectrum, while ensuring patient-centered care is provided to all patients? What are some approaches that providers can implement to determine the specific needs or gaps in care for (potentially) high-cost or high-risk patients?
- How can financial benchmarks be established ensuring that continual improvement incentives are in place for historically high performers?
- Given the imperfect correlation between historical utilization and future health care costs and needs, do you have any suggestions on how actuarial projections can eliminate bias that can result for some beneficiaries based on their historical utilization and spending relative to their needs?
- What are some best actuarial or cost projection practices or principles that should be used in the health care area to assess and identify health (care) disparities?

Questions for Shari M. Erickson, MPH, American College of Physicians; The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM) (Revised Version) proposal

- How can accountable entities prepare and incentivize physician participation in population-based TCO models?
- How can accountable entities encourage coordination between primary care and specialty care providers?
- How can specialty services be integrated into population-based models?
- What information is needed in order to measure and evaluate provider performance in these models?
- You mentioned voluntary patient attribution for physicians and their clinical care teams in your presentation. Does this pose challenges for patient attribution for high-risk patients?
- You mentioned fixed benchmarks across all participants in your presentation. Does this create a level playing field for participants treating patient with multiple conditions or high-risk conditions?
- What are some of the best practices for engaging specialists in care delivery models? How is accountability for care coordination spread across primary care providers, specialists and their clinical care teams?
- Operationally, how do you think clinicians can be incentivized to address health and social drivers of health for their patients?

Second Listening Session on Tuesday, June 7, 2022

Questions for David C. Grossman, MD, MPH, Kaiser Permanente

- How does your organization's care delivery model support the provision of patient-centered care for beneficiaries that rarely need to see specialists, as well as high-cost beneficiaries with multiple chronic conditions?
- What are some best practices for incentivizing coordination and alignment between primary care and specialty providers?
- What are some incremental improvements that can be included in population-based TCO models to support broader care delivery transformation?

- Can participation in population-based TCOC models improve health equity? What are some of the strategies used by integrated delivery systems to address SDOH? Have these strategies resulted in better patient outcomes and reductions in TCOC?
- What care delivery model design features are most important for driving reductions in TCOC?
- What have been the key factors that affected successful implementation of Kaiser's Social Health Framework? How is success measured?
- From a design perspective, how are the care delivery model teams held accountable for implementation of the Social Health Framework?
- What are some of the unique advantages/disadvantages that Kaiser faces as an integrated health care delivery system in implementation of social health framework?
- In areas with a high social deprivation index, how does Kaiser connect patients with resources for meeting their social needs? For example, if patients face housing issues in the Bay Area due to a shortage of housing options, how does Kaiser connect patients with community resources for housing?

Questions for Ali Khan, MD, MPP, Oak Street Health

- How can primary care providers and specialists coordinate to provide patient-focused care to a patient population with multiple chronic conditions? Given the multiple providers involved in providing care to these patients, what are best practices for assigning accountability to the providers and facilitating coordination of care?
- What kinds of care delivery model features are most important for driving improvements in quality and outcomes and reductions in TCOC for this patient population?
- How can we reduce overall health care costs if care delivery models have incentives to retain savings due to reduced health care utilization?
- Given the strong correlation between the number of health-related social needs and health outcomes, what are some of the best practices adopted by care delivery models, such as Oak Street Health, to address and refer health care social needs?
- What are some of the options for integrating specialty care in primary care focused models, such as Oak Street Health? Given the focus on patients with multiple chronic conditions, what are some of the strategies used by primary care focused models to engage specialists?
- How does Oak Street Health address the health care needs of the patient when the patient needs more specialty care (e.g., oncology care)? In such a situation, does the accountability shift from primary care to specialty care (in this case to the oncologist)?
- What will be some of the challenges faced by models like Oak Street Health when they expand from Medicare eligible patients to Medicaid and commercial patient population?
- How do primary care focused models like OSH, assess and stratify patients and determine the care plan? Is the payment received by OSH from Medicare aligned with the patient stratification?
- How do primary care focused models, such as OSH, get buy-in from Medicare beneficiaries transitioning from traditional FFS with respect to provider choice, especially specialists?
- For physicians who are not currently in a value-based arrangement, what advice would you give them to help them to begin participating in these arrangements?

Questions for Dana Gelb Safran, ScD, National Quality Forum

- What performance metrics are most important for driving improvement in quality and outcomes, and reductions in TCOC?
- Are the current performance metrics that are being used in APMs sufficient for incentivizing the provision of high-value patient-focused care? What, if any additional kinds of performance metrics may be needed?
- Should there be a minimum level of quality required for participation in value-based arrangements?
- What role can timely performance measurement and evaluation play in supporting providers who are transitioning to participating in value-based models and taking on financial risk? What, if any, are the unintended consequences of moving more care delivery to in value-based arrangements?
- How can we strike a balance between reducing the burden of reporting by model participants and arriving at a “meaningful” standardized selection of performance metrics for population-based TCOC models that is easily understood by providers, payers and most importantly beneficiaries?
- Are there opportunities for improving multi-payer alignment related to reporting of performance metrics?
- How does the wide range of atomistic performance measures reported by Alternative Payment Models (APMs) affect the flexibility for the care delivery models to innovate? How can care delivery models be compared with each other in terms of providing “better care” if they each measure a different set of atomistic performance measures?
- Despite a strong association between process measures (atomistic performance measures) and outcome measures (“big dots”), how should performance evaluation incorporate risk adjustment to create a level playing field?
- Should risk adjustment for outcome measures also account for health equity? If so, how can we create patient specific composite measures without “medicalizing” health-related social needs?
- Would up-front payments for investing in health equity lead to higher enrollment for patient with health equity needs and disenrollment later?

Questions for Adam Weinstein, MD, DaVita

- Should providers in condition-specific models or episodic models have primary responsibility for coordinating care for patients with major conditions, such as renal failure or cancer? Who should be responsible for coordinating aspects of the patient’s care that are unrelated to the specific condition that the model focuses on?
- What are some potential unintended consequences of nesting specialty care within population-based models?
- In the context of kidney disease, how can population-based TCOC models ensure a seamless transition from primary to specialty care? How can models incentivize continued coordination between primary care providers and nephrologists, particularly in the high-risk time you identified between chronic kidney disease (CKD) stages 3 and 4?

- You stated that nephrologists should take over as the “quarterback” for care once a patient reaches CKD Stage 3. Should providers in condition-specific models or episodic models have primary responsibility for coordinating care overall for patients with major conditions, such as renal failure or cancer? If so, should this be for all patients or patients that receive care from a specialist as their “main” source of care? How should this shift for models where patients may go back and forth between having their main source of care be a PCP vs. a specialist?
- What are some best practices related to population health management for managing the care of kidney disease patients along the entire continuum of care (i.e., all phases of the disease)? How can data be made available in a timely manner to provide patient-focused care and improve coordination of care?
- Can you provide examples of promising or successful population health management models or arrangements that are being used to support the renal patient population across the full continuum of care?
- As nephrology practices increasingly move toward population health management, what are some EHR-based investments and strategies that can improve nephrology-related workflows and care coordination, and consequently patient outcomes?