PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

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PUBLIC MEETING

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The Great Hall
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

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Tuesday, March 4, 2025

PTAC MEMBERS PRESENT

TERRY L. MILLS JR., MD, MMM, Co-Chair
SOUJANYA R. PULLURU, MD, Co-Chair
HENISH BHANSALI, MD, FACP
LINDSAY K. BOTSFORD, MD, MBA*
JAY S. FELDSTEIN, DO
LAWRENCE R. KOSINSKI, MD, MBA
JOSHUA M. LIAO, MD, MSc*
WALTER LIN, MD, MBA
KRISHNA RAMACHANDRAN, MBA, MS
JAMES WALTON, DO, MBA

PTAC MEMBER IN PARTIAL ATTENDANCE

LAURAN HARDIN, MSN, FAAN

STAFF PRESENT

AUDREY MCDOWELL, Designated Federal Officer (DFO), Office of the Assistant Secretary for Planning and Evaluation (ASPE)
STEVE SHEINGOLD, PhD, ASPE

*Present via Zoom

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P-R-O-C-E-E-D-I-N-G-S

9:02 a.m.

* CO-CHAIR PULLURU: Good morning. And welcome to day two of this public meeting of the Physician-Focused Payment Model Technical Advisory Committee, known as PTAC. My name is Dr. Chinni Pulluru, and I'm one of the Co-Chairs of PTAC, along with Dr. Lee Mills.

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

Today, we begin our day with opening remarks from Mr. Abe Sutton, the Director of Center for Medicare and Medicaid Innovation and Deputy Administrator for the Centers for Medicare & Medicaid Services. We are very honored to have him with us here today.

Mr. Sutton previously served as a Principal at Rubicon Founders, where he cofounded two health insurance -- health service companies: Honest Health, which focuses on enabling primary care physicians; and Evergreen Nephrology, which focuses on enabling nephrologists in kidney care.

From 2017 to 2019, he also served at

the National Economic Council, Domestic Policy Council, and Department of Health and Human Services. In these roles, he coordinated health policy across the federal government with a focus on value-based care, increasing choice and competition in health care markets, and updating the federal government's approach to kidney care. Thank you, Abe, for being here.

MR. SUTTON: Thank you for those kind introductory remarks. Good morning to you, the members of the Physician-Focused Model Technical Advisory Committee, and the public in the audience and listening in today. I'm so appreciative of the invitation to give some brief remarks today as the new director of the Innovation Center.

To begin, I should say that I've been aware of the work of this Committee in my prior role as an advisor to Secretary Azar focused on value-based transformation in the first Trump Administration. And I'm also aware of the transition the Committee has made to focusing on theme-based discussions in each session as a way to get critical input on value-based care to the Innovation Center.

In particular, the last meeting's

focus on discussing strategic priorities for the Innovation Center is a critical input for us to have at this time, and I'm grateful for the focus of this Committee in those recent discussions. We welcome this public discussion from leading physician voices in value-based payment and appreciate your focus and attention.

I know you're taking time away from other activities that you could be doing and are appreciative of you doing so. I'm overjoyed to be the new Director of the CMS[1] Innovation Center. I believe deeply in our work as a Center and the mandate we have from Congress, to design models that will improve the quality of care and reduce the cost of care.

This commitment is aligned to the vision of Secretary Kennedy and our CMS Administrator nominee, Dr. Oz. I see it as a commitment to the taxpayers supporting our system and the beneficiaries that we care for to make sure we're efficiently stewarding the resources entrusted to us and delivering the delivery system reform that will make us efficient and improve the quality of care.

We have a great model portfolio at the

1 Centers for Medicare & Medicaid Services

Innovation Center. And much of our work will be building on the past successes of the Center. But I also want to make clear that my focus as Director and the focus of the great team at the Center, will be on designing models to be certifiable. That is our metric for success. Over the coming months, you will hear from me and my team about how this vision will come into focus in the future.

We're currently conducting a review of our portfolio and will have more to share on that in the future. As we go forward, I expect our vision will emphasize prevention and management of chronic disease and using data to empower people to meet their health goals.

We also, aligned with the focus of today's discussion, want to understand how to promote choice and competition in health care markets, as we know if there's competition in the marketplace, we'll be able to provide better care, and patients will win. I look forward to sharing more at a future meeting, but I will emphasize that all our work is aligned to the Secretary's vision for how we can Make America Healthy Again.

To close, I want to thank the members

of the PTAC for their commitment to creating this forum for a robust discussion where we hear from those in the field directly convening their ideas and concerns on how we can deliver high-value care for Medicare beneficiaries.

This independent expert Committee is a critical resource as we develop the way forward to achieve Secretary Kennedy's vision and accomplish our goals as a Center. Thank you.

*** Welcome and Co-Chair Overview - Reducing Barriers to Participation in PB-TCOC Models and Supporting Primary and Specialty Care Transformation Day 2**

CO-CHAIR PULLURU: Thank you for sharing those remarks, Abe. We appreciate your continued support and engagement, and we look forward to continuing to collaborate with the Innovation Center.

Yesterday, we had several expert panelists and presenters share their perspectives on reducing barriers to participation in population-based total cost of care models and supporting primary and specialty care transformation. Thank you.

Today we have a great lineup of

experts for one panel discussion and one listening session. We have worked hard to include a variety of perspectives throughout this two-day public meeting, including the viewpoints of previous PTAC proposal submitters who address relevant issues in their proposed model.

Later this afternoon you will have -- we will have a public comment period and welcome participants either in person or via telephone to share a comment. As a reminder, public comments will be limited to three minutes each. If you have not registered to give an oral public comment but would like to, please email ptacregistration@norc.org prior to the 1:20 p.m. public comment period today, that's Eastern Standard Time, again, that's ptacregistration@norc.org.

Then the Committee will discuss our comments and recommendations for the report to the Secretary of HHS[2].

*** PTAC Member Introductions**

Because we might have some new folks online who weren't able to join yesterday, I'd like the Committee members to please introduce themselves. Share your name and your

2 Health and Human Services

organization if you would like. You can tell us about your experience with our topic.

I will queue each of you. I'll start. Hi, I'm Chinni Pulluru. I'm a family physician by trade with 20 years of experience implementing value-based care models both at a multispecialty provider group, as well as Walmart Health and Wellness.

Most recently, I am fractional Chief Medical Officer of Stellar Health, a technology-based, value-based care enablement company, as well as consult across the landscape with large and small payer and provider groups, as well as hospitals in the last mile of transformation and value-based care. With that, I will turn it over to Lee.

CO-CHAIR MILLS: Good morning. I'm Lee Mills. I'm a family physician as well. I am Chief Medical Officer at Aetna Better Health of Oklahoma, one of the state Medicaid plans. Before that I was Chief Medical Officer of a payer -- sorry, of a provider-owned private health plan operating Medicare Advantage in commercial space.

Before that, I was in a medical group and health -- integrated health system leadership

in several states. And I've had the privilege and pleasure to help implement and operate and lead six or seven different CMMI[3] pilots over my 25 years in operations. Thank you.

CO-CHAIR PULLURU: Next, let's go around the table. Henish?

DR. BHANSALI: Hi. Good morning, everyone. My name's Henish Bhansali. I'm a primary care doctor and internal medicine doctor by training. I serve as the Chief Medical Officer for Medical Home Network. We work with community health centers across the country to help transform them and move them into value-based care.

Prior to that, I was at Duly or DuPage Medical Group for two years as their Senior Vice President for Medicare Advantage. Prior to that, I was at Oak Street Health as their VP and National Medical Director for Care Navigation. Prior to that, I was in academics caring for undocumented and Medicaid patients. Thank you.

CO-CHAIR PULLURU: Jay?

DR. FELDSTEIN: Good morning, everyone. My name's Jay Feldstein. I'm currently the President and CEO of Philadelphia

3 Center for Medicare and Medicaid Innovation

College of Osteopathic Medicine. I'm an emergency medicine physician by training. And prior to this role, I spent 15 years in the health insurance industry, both as a Chief Medical Officer and in running plans themselves in both governmental and commercial plans.

MR. RAMACHANDRAN: Good morning, all. Krishna Ramachandran, Senior Vice President of Health Transformation of Blue Shield of California. I've spent the past 15 years of my life furthering value-based care from technology provider and payer perspectives. Spent time in a large multi-specialty group prior to the payer's side and then worked for about eight years at Epic before that. Thanks. Larry?

DR. KOSINSKI: I'm Larry Kosinski. I'm a retired gastroenterologist. I've spent the last 10 years of my life in value-based care, which actually started as a proposal presented to this Committee, Project Sonar, which became the foundation for a company, SonarMD, which I founded.

I have been involved in building value-based care in the specialty space and have been on this Committee for three years.

DR. LIN: Good morning. I'm Walter

Lin, Founder of Generation Clinical Partners. GCP is a small independent medical practice based in St. Louis and Southern Illinois focused on caring for the frail elderly in senior living organizations. We've been involved in a number of different value-based care programs, including institutional assessment and needs plans, MSSP ACOs[4], funneled payments, PACE[5] programs.

And most recently, I took the position as the Clinical Strategy Officer of LTC ACO.

MS. HARDIN: Good morning. I'm Lauran Hardin. I'm a nurse by training and Chief Integration Officer for HC[2] Strategies, where we focus on building connected communities of care for high-cost, high-needs, and complex populations in partnership with states, communities, multistate health systems, and payers.

I've spent the better part of the last 20 years focused on high-needs populations, originally designing models with hospice, palliative care, and one of the first children's hospice and palliative care programs and then moved into the area of complex care.

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4 Medicare Shared Savings Program Accountable Care Organizations
5 Program for All-Inclusive Care for the Elderly

I was part of the team at Camden that developed the National Center for Complex Health and Social Needs and spent eight years traveling around the country in more than 30 states starting up models to meet those population needs.

DR. WALTON: Good morning, Jim Walton. I'm a part-time health care consultant now, retired internal medicine physician, and started my practice in Ellis County, Texas, and then transitioned to Dallas, Texas, where I practiced internal medicine and led a large health care systems community medicine strategy, as well as serving as their Chief Health Equity Officer and then transitioned to lead a large IPA[6] in Dallas and North Texas in their efforts to build out accountable care strategies for primary care physicians in Medicaid, Medicare, MSSP contracts, and commercial Medicare Advantage contracts. And I've served on PTAC for the last two and a half years.

CO-CHAIR PULLURU: Let's go now to our PTAC members joining us on Zoom, starting with Lindsay.

DR. BOTSFORD: Okay, good morning

6 Independent Physician Association

everyone. I'm Lindsay Botsford. I'm a family physician in Houston, Texas, where I continue to see patients as a PCP[7] and serve as the Regional Medical Director for the Midwest and Texas with One Medical.

In that capacity, I serve as the Chair of the governing body of our ACO REACH[8] entity, which -- of which we've been a participant since the inception of the program. Again, I continue to see patients as a PCP in Houston. And prior to that, worked both in academics and large health systems. Thanks.

CO-CHAIR PULLURU: Next, we have Josh. Please go ahead.

DR. LIAO: Hi, everybody, Josh Liao, an internal medicine physician and Professor of the University of Texas Southwestern Medical Center. I spent the last decade on a combination of activities that are relevant to this Committee's work, studying kind of the technical aspects of the evaluation of payment and care delivery innovations, as well as leading the strategic design, evaluation, and consideration and organizational strategy for payment and

7 Primary care physician
8 Realizing Equity, Access, and Community Health

delivery innovations for integrated delivery systems, as well as working with population health and other care delivery teams to actually implement these things in clinics and hospitals.

CO-CHAIR PULLURU: Thank you all. For today's agenda, we will explore a range of topics on reducing barriers to participation and population-based total cost of care models and supporting primary and specialty care transformation that include a panel discussion on enhancing the ability of population-based total cost of care models to be competitive.

And our third listening session, which will look on how to maximize participation of beneficiaries in accountable care and improve the sustainability of effective population-based total cost of care models. The background materials for this public meeting, including an environmental scan, are posted online on the ASPE PTAC website meetings page.

The discussions, materials, and public comments from the March PTAC public meeting will all inform a report to the Secretary of HHS on reducing barriers to participation in population-based total cost of care models and supporting primary and specialty care transformation.

Lastly, I'll note, as always, the Committee is ready to receive proposals on possible innovative approaches and solutions related to care delivery, payment, or other policy issues from the public on a rolling basis. We offer two proposal submission tracks for submitters, allowing flexibility depending on the level of detail of their payment methodology. You can find information about submitting a proposal on the ASPE PTAC website. And now, I'm excited to welcome our roundtable panel discussion.

At this time, I ask our panelists to go ahead and turn on video if you haven't done so already. In this session, we've invited four esteemed experts to discuss their perspectives on enhancing the ability of population-based total cost of care models to be competitive.

After each panelist offers a brief overview of their work, I will facilitate the discussion in asking each panelist questions on the topic. The full biographies of our panelists can be found online, along with other materials for today's meeting. I will briefly introduce each of our guests and give them a few minutes each to introduce themselves.

After all four introductions, we will

have plenty of time to ask questions and engage in what we hope will be a robust discussion. First, we have Dr. J. Michael McWilliams, the Warren Alpert Foundation Professor of Health Care Policy and Professor of Medicine in the Department of Health Care Policy at Harvard Medical School. Michael, welcome.

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

DR. MCWILLIAMS: Thank you very much. It's really a pleasure to be with you all this morning. Thanks for the invitation. So I should say first of all by way of sort of a disclosure or disclaimer that I serve as a senior advisor to the Innovation Center, but I am here this morning as me, as a professor of health care policy, as a researcher, so my comments should not be construed as representing the views of the Innovation Center or CMS.

If you could just go to the next slide, great. So I joined the session in September at the last PTAC meeting, and the theme of that session was participation. And so the first bullet of my first slide was the same here, which is that the goal -- the goal is not

participation.

And so I inserted the word competitiveness, which is a theme today because the goal is not competitiveness either, per se. It's success. And so we can talk about what it means to be -- what success means. I think most people would say some version of savings without any harm or more value at a lower cost.

But -- and competitiveness may be very important to success, but I think it's important that we define what is -- what we mean by competitiveness. For example, I don't think we want competitiveness for the sake of competitiveness if it means letting ACOs sort of game the system and increase spending by 20 percent just so they're at the same level with MA[9] insurers.

So I have some thoughts here on what we mean by competitiveness of total cost of care models with fee-for-service in MA. And when we talk about it with respect to fee-for-service, I think what we really mean, what we're really talking about, at least what we should be talking about is ACO contract design, sort of the model design.

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9 Medicare Advantage

Providers are the ones who decide whether to be in an ACO. So for total cost of care models to succeed, then we have to give providers an incentive to be efficient. We have to let them keep some of the savings as they limit intensity and volume. The main problem here is the various ratchet effects, whereby Medicare claws back the savings as they are produced, such that there is very little incentive for providers to ever save in the first place, or so that only some providers can ever sort of win the game.

Basically, if success begets failure, we shouldn't ever expect success. And there is this sort of implicit pervading notion in the benchmarking that benchmarks should be equal to claims expenditures, but of course, paying at the level of claim expenditures is called fee-for-service. So this would be my main point for this morning.

I can't underscore it enough, the importance of fixing the design problems in the total cost of care contracts, because in reality the ACO models really haven't moved that far from fee-for-service. So you can say ACOs are quite competitive with fee-for-service, but obviously

not in the way that we want.

In terms of competitiveness of total cost of care models with MA, Medicare Advantage, this is really more about payment policy favoring Medicare Advantage over traditional Medicare, because even if we can fix the core and center problems in ACO contracts, ACOs can never compete with MA because MA is so heavily subsidized. Those subsidies translate into better coverage for beneficiaries.

And being in MA is really a beneficiary decision. It's an enrollment decision. So we should absolutely consider various improvements and additional features to ACO models, but there’s really no amount of ACO contract redesign that can make ACOs compete with MA when out-of-pocket costs are thousands of dollars lower in MA.

So before we even think about ACOs, I think there are some broader, structural questions about whether we want a more even playing field between the programs and Medicare, how much do we need to rely on traditional Medicare to discipline the MA market, and by that, I mean, pressure plans into sharing more of their profits with enrollees as additional

benefits, trying to curb more overly restrictive practices.

And that, in turn, depends on a bunch of questions, like how much can we depend on competition within MA to get what we want out of the program? If insurer competition is limited or unproductive, and there's certainly evidence of it being far from perfect, how well can we regulate the program directly without relying on traditional Medicare to exert pressure in sort of more indirect ways?

And if we do want to level the playing field, at what level of payment? One way to level the field is to cut Medicare Advantage by the 15 or 20 percent or whatever it takes to even the field, but then enrollees may lose benefits, and we may want seniors to keep some of the coverage gains achieved by Medicare Advantage.

So if we're talking about competitiveness in Medicare, this is sort of the stuff that we need to talk about. Can we fix the risk adjustment system to get the rents out and put an end to competition to code but without cutting benefits too much?

Can we help beneficiaries shop for high-value plans to drive more competition. Can

we regulate prior auth without undermining the ability of MA to save money? How much of that is better accomplished by having a traditional Medicare program that doesn't cost $8,000 or $9,000 out-of-pocket a year?

And then finally, I'll just hit two points about the role of ACOs or total cost of care contracts in the interaction between the two programs. One is if incentives in ACO models can be strengthened, that can lower the cost of leveraging traditional Medicare to discipline the MA market.

Basically, if we need traditional Medicare around and generous enough to do that, we don't want it to be horribly inefficient, thus, ACOs. And second, if we can develop ways for ACOs to share savings more directly with patients like MA plans do, that could foster demand for efficiency in traditional Medicare too, help strengthen ACO incentives, but also help pressure MA plans to sort of elevate their game.

If you could just go to the next slide. I think I'm probably over my allotted three minutes by now, so I'll just try to mention these points very quickly.

Another vein in which, you know, folks talk about competitiveness is sometimes we just mean better. We want something to be better. We want total cost of care models to work better. And that, of course, begs the question, why? What do we get out of making these models better? Why do we think that they have some added value?

And I think, you know, obviously, they could help save the system money, but I think the real conceptual advantage of population-based payment is it can help navigate a really core trade-off in payment policy between cost containment and access for quality.

Basically, these models can help us get more value out of the spending in various ways. And I've listed some of the ways that they can do that. If you think about fee reductions as an alternative cost control measure, we worry about access problems as fees are reduced for too much for too long, but if providers can gain from efficiency, then that could help preserve access as spending is reduced.

They can provide an alternative way to finance services that are really hard to price and therefore, prone to overuse or underuse in fee-for-service when mispriced. As care delivery

gets more complex, it just gets harder and harder to separate everything out into little parts and price everything correctly.

And so total cost of care models allow a way to sort of not have to pay separately for everything if things reduce cost. So if there's an incentive to reduce cost, those things should diffuse anyway, and to provide a stream of no strings attached revenue that can be used more flexibly but with a limit.

Another way is they sort of minimize incentives that get in the way of providers doing what they think is in the patient's best interest. So, for example, physicians don't have to do 30 office visits a day just to keep the lights on. And also, when providers are bearing the risk, to enlist providers who are more informed and who deliver the care in maybe more clinically nuanced utilization management.

And then the final point I think we would get to later in terms of multi-payer alignment. So I will stop there and greatly look forward to the discussion. Thank you.

CO-CHAIR PULLURU: Thank you, Michael. Next, we have Dr. Stephen Shortell, the Blue Cross of California Distinguished Professor of

Health Policy and Management Emeritus, Dean Emeritus, and Professor of the Graduate School of Public Health and Haas School of Business at the University of California-Berkeley. Steve, please go ahead.

DR. SHORTELL: Thank you. I'm happy to be here and engage with the discussion and all the great work that people are doing. And let me just say something a little about my background. I just listed out there a few items relevant, I think, to our discussion today.

I'm now a researcher -- I had been a researcher, now an Emeritus at Berkeley and continue to do -- work on health policy research, ACOs, and so on. The Better Healthcare Policy Group, there's eight of us from different facets of the health care field that have been working on some of the issues that, you know, are on the agenda today.

So I just want to highlight that. And that we have three ongoing work groups that some people may want to know about or join from time to time. One working group is working on really the relationship between the three major stakeholders around the issues we're discussing today, health plans, providers, and then in the

commercial market, employers.

How do we get employers in this country to purchase more wisely in terms of better care? And we have a work group working on that. We have another one on transparency in terms of patient safety and quality involving a lot of the safety experts in the country, LeapFrog, Epic, and so on.

I've also been on the Office of Health Care Affordability Advisory Committee here in California around spending targets. Other states are doing that. We may want to talk about that today as well.

If we go to the next slide, what I want to do is I've been asked to talk about really vertical integration. Simply put, like, the relationship between medical groups, physician practice, hospice, and health systems, where there's some ownership or very strong affiliation of relationship, what's the evidence that this promotes better care or just increases prices, et cetera, what are the implications for value-based payment? And I'll try to hit some of the highlights of that and then welcome, you know, the discussion we're going to have.

First of all, let's look at the

evidence that vertical integration is associated with increasing negotiation leverage on the part of hospice and health systems when they integrate with physician organizations, and it's associated with increased prices.

There's little doubt about that. There's pretty much overwhelming evidence that indeed that does occur. One thing that's been new on the scene is private equity. Some of these arrangements are private equity-owned, and there's some emerging evidence that their prices are 1.5 to 3 times that of other ownership models.

So this is an issue, cutting to the quick, thinking, you know, what might be done about that from an anti-trust perspective? Some people have talked about the idea of contingent approval of these relationships beyond a certain monetary amount, in which you contingently approve the vertical integration purchaser relationship contingent on, for example, after a year or two evidence on reducing, for example, preventable hospital admissions, ambulatory care sensitive admissions.

For example, a diabetes patient shouldn't end up in the hospital and so on. Or

you make a contingent on reducing readmissions or on hospital infections, for example. And so you can begin to think of tying these relationships to performance indicators before giving full approval. That's just one example, and we can come back to that.

If you're participating in an ACO around these vertically integrated relationships, then the above issues that I've talked about may be attenuated to some extent, right? You have the incentive to share in savings that Michael has indicated and some of the evidence on that regarding total cost of care.

The national evidence, and Michael and his colleagues at Harvard do some of this, as well as others. They're probably ACOs, you know, reduce cost savings around 1 percent, 1.5 percent on average, while maintaining or maybe even improving the quality-of-care metrics.

Here in California, for years we've had the delegated care model, many of which are ACOs in which there's data from the Integrated Healthcare Association that our medical groups that are under full risk have significantly lower total cost of care and higher quality of care on various clinical metrics than those that are a

partial risk, partial risk models here, are for outpatient only and don't include hospital. And they, in turn, perform better than the fee-for-service. So California has some pretty consistent data over about 10 years now on some of these kinds of models.

The research suggests that hospital-affiliated ACOs tend to have higher overall spending than the independent physician-affiliated ACO groups due to higher inpatient use in specialty services. There's also the issue of hospitals needing to spread their overhead. There's also the issue that's being partially addressed, the facility fees being higher if it's hospital outpatient than other.

Independent practices, they tend to reduce the inpatient care that is used and also specialty services. Hospitals, you can argue, might have a natural incentive to fill the beds when in doubt. And so this is pretty consistent that the independent physician-affiliated ACO groups tend to perform better on some of those kinds of metrics.

No consistent differences in regard to quality of care. Some evidence that the independent physician groups, in terms of patient

communication or patient satisfaction of communication, a bit higher on the independent side, but no consistent differences in regard to other metrics. Let me wind up with the challenge here.

And that is in my mind, and we begin to discuss on this with some of Michael's comments, how do we design these payment models to take advantage of the resources and infrastructure that hospitals and health systems can provide to medical groups that also reduce the incentive though to increase spending?

So moving towards the all-payer -- and the multi-payer is really key here -- risk-adjusted prospective payment moving towards global budgets, Maryland, and so on. What are some of the things to push this along with all the challenges that are involved?

And I think some of them -- and we'll get to them -- the need to standardize these measures that are an administrative burden when they aren't standardized with different payers and so on. Progress is being made, and some states on that.

Attribution issues, the setting of the targets, of the benchmarking that's been alluded

to. And not only in terms of the ratcheting down, but also how do you get the smaller practices under the umbrella here in terms of making some rewards for improvements?

So maybe you don't hit the target, but you get something for improving from year to year, for example. And then up-front investment in capabilities for smaller and rural practices. CMS is doing, I think, a reasonably good job of that, some of the states also, but more could be done in that area as well. And then the primary care is another big focus of this.

So we can get into this in some of the conversation, but I think the need to move more quickly and accelerate the movement towards value-based payment is very sorely needed. Delighted to hear Dr. Sutton talk about CMS interests in moving that along. So, let me just leave it at that for now in terms of time. Thank you.

CO-CHAIR PULLURU: Thank you, Steve. Next, we have Dr. Jose Peña, the Chairman and --of the Board and Chief Medical Director at Rio Grande Valley ACO Health Providers. Jose, welcome.

DR. PEÑA: Hi, good morning and thank

you for the invitation. We are a small ACO located in South Texas. We started in 2012 taking down some risk from the very beginning. And so, the Track 2 ACO, the enhanced track, and now ACO Innovation, for the last couple of years.

We want to thank and applaud CMS and CMMI for all the value-based model created in the last 12 -- 13 years actually. And we are a testament in South Texas that we are a little better now versus our time that we were in fee-for-service, you know, in the -- before 2011 actually.

Next, so we are very focused around the patients, how to improve basic primary care. We have about 45 percent of patients with diabetes in our area. So we focus a lot on that. And we are quite outcomes oriented, right, in the case of admission, readmissions, and basically the emergency room. We have some clinics in San Antonio, and we have had some clinics at -- and we currently have some clinics in New Jersey.

Currently, we have about 5,500 ACO REACH, and the rest is commercial. And basically we are a standard ACO REACH and global option with specific capitation. Next, just to

highlight a few ideas, and we can expand later on with this question, but I think some of the challenge on the population-based total cost of care model is ACO and ACO REACH.

As it was mentioned before, we have a lot of competition, quote/unquote, with the MA plans because the Medicare, traditional Medicare, have decreased in our market. MA penetration is right around 65 to 70 percent, and that make it harder for the primary cares to keep the minimum of 5,000 patients around these programs.

Also, the financial predictability, as we know, MA have more tools. When we are in capitation, some of the MA plans is more predictable for the PCPs and less risky, but I say there are many patients that don't want to be in the MA plan, and the ACO REACH is a great opportunity to enhance care and provide service that we're not able to in traditional fee-for-service.

The cost is high to run this program efficiently. We think that it's about $1.5 million to $2 million usually for small ACOs to be able to hire enough IT[10] management and, you know, personnel infrastructure, usually we don't

10 Information technology

have the regular PCP practice.

Same lines about that access utilization, we then take more -- a lot of the claims base information from CMS but usually two to three months later. So we have some lags on action, and that put us in a more difficult position to deliver a better quality of service and to have more data for predictors and analytics that are fresh. Next, please.

We think -- and we can talk about that later, but we are having CMS can enhance the current financial environment in the ACO REACH model. One other big one is in the discount from the total cost of care budget that have increased from 3, 3.5 percent and now 4 percent from the top.

So that gives us a really a significant amount of money. We have a $100 million budget, and, you know, 4 percent is taken. So when we get to what we're saving, and we save 10 percent, it's maybe 40 percent of that is gone. And I can discuss that model a little later.

We think that the waivers can be improved and with less regulation so we can have better use. The same thing with the financial

guarantee that this is a big burden for us. We have increased to 4 percent. So in the previous example, we have to have $4 million of financial guarantee.

So many of us have to put, you know, our personal asset and cleanings as a collateral with the banks just to have the line of credit. And that's a big burden, and having, you know, again, money for the doctors to be frozen in the bank just to have the financial guarantee into the programs, so that's a big burden.

As I mentioned, CMS essentially should be able to provide data that could, that we can have, you know, that we can use more handily. So, next. And I think increasing up from funding, we are in capitation, but I think for the organization to have more funding will make more likely the PCPs to participate in this kind of program.

And there is other things, like they expand our ability to work together with the CBOs[11] will be good. The V28 HCC[12] model is making an extra impact on MAs and ACO REACH. And I mention already the discount that is taken out of

11 Community-based organizations
12 Hierarchical Condition Category

the benchmark that is probably the single biggest financial burden for us. Next. Thank you.

CO-CHAIR PULLURU: Thank you, Jose. Our final panelist is Dr. Tim Layton, Associate Professor of Public Policy and Economics at the Frank Batten School of Leadership and Public Policy at the University of Virginia. Welcome, Tim.

DR. LAYTON: Thanks. I'm excited to be here and chat with you all. I have to lead with a caveat that everything I need to know about these types of models I learned from a good friend and former colleague. You may have heard of him. His name is Michael McWilliams.

And so you're going to hear some like parallels which actually have gone through all of the panelist discussions so far. If you could go through the next slide, that'd be great. So I'm an economist, so I'm going to take the economist role and take the 10,000-foot view here.

And what I want to emphasize in these few minutes is that I think that we kind of have two goals that we want to accomplish. And I think that there's sometimes confusion that mixes these goals up rather than treating them separately. So the first goal is that we want

lower spending.

And the second goal is that we want to improve the allocation of a fixed amount of money. We want to get more bang for the buck from a fixed amount of money that we give to these provider groups in one form or another.

I think that we need to recognize that we don't actually need these models to do one, to lower spending, right? We can lower spending without the models. We can just cut payments across the board. It's not that hard to lower spending.

And because, you know, it's quite easy to just lower spending without the models. I think the real purpose of the models is two, right, it is to improve the allocation of a fixed amount of money the way that all three of the other panelists alluded to.

And the reason we want to do this is because it's really hard to set every payment for every service in fee-for-service correctly, especially when there's complements and substitutes, with various services and high fixed costs or a high variable cost, et cetera.

And what these models do is they provide us with an opportunity to take a step

back and let organizations experiment with different allocations until they find ones that deliver the most value to consumers, right, to allow them to invest in prevention, which may be really hard under a fee-for-service model.

And I think our key problem is that we're trying to do both one and two with a single instrument. And when we do that, we end up doing a poor job of both. You can go to the next slide. So the amount of points I want to emphasize today is that I think that what has come out of this as the key problem is this drive to claw back the shared savings via payment rules.

And Dr. Peña was alluding to this earlier, and Michael did as well, and so did Steve, but the key point is that any savings that the ACOs have to share back to the government will decrease the incentive for the organization to reduce spending, okay? I think that's an uncontroversial statement that you're taking money from them.

And so they're going to be less likely to participate. And I think this whole shared savings idea is partially driven by this kind of weird, misguided and, yeah, dare I say, actuarial

-- it's not going to get in me into trouble -- idea that payments should equal costs. Okay?

And what this does though in practice is it actually leads to payment policies that financially disadvantage the models, right, in order to capture the savings. Basically, we're making Goal 2 less likely to be achieved by focusing payment policy primarily on Goal 1.

I think breaking the two goals apart leads to a different type of payment policy that Michael alluded to, where we want all models to kind of be on the same level playing field.

We want all the models to be paid the same amount for the same person. We can choose that amount to be whatever we want it to be based on what we think the right level of spending is, and maybe we pick a level of spending under which some models survive and other models die, and that's okay, right?

That tells us that, you know, some of these models work at the level of spending we're willing to pay and others don't, and that's fine. But all the models should get the same amount, and then we can let the market decide. You brought an economist here, so you're going to hear that line at least once.

But ultimately, what we want the ACOs to be able to do is take the savings and use it on things that people want. We don't need to force this, right? Competition among the ACOs and competition with fee-for-service in MA, which is pretty strong, should do that if the ACO can take some of that money and get loads of people to want it. Then it's delivering more value for that same amount of money, and we should be okay with them doing that.

Now, we may need to improve the active choice in competition policy to achieve this, but kind of as my kids' favorite Star Wars show, The Mandalorian, says, this is the way. So remember that, though, that the purpose of the ACOs is getting the allocation right, not the level.

When we confuse those two, we're thinking purely like actuaries and not like the way that -- like policy makers. Okay, last slide, and I'll wrap up quickly. Okay. Now, the big question here is, how do you actually do that? How do you provide the level playing field?

We've been trying to do this with MA and TM[13] for years, and we failed miserably, but

13 Traditional Medicare

like ultimately, this is a hard classic causal inference problem. We don't know the counterfactual traditional Medicare spending for people in ACOs and in MA.

So how do we set payments to be equal across these different segments? You know, we try to solve this with risk adjustment systems. Those have had major issues in the past, but I think they get kind of a bad rap, because I think that these issues are solvable.

If there's a will to solve them, we can use survey-based risk adjustment, we can randomize defaults to people to figure out how much different types cost in different programs, or we can just use the systems we have right now, but fix them, right? And we know simple fixes that can help improve these systems.

But I think at the end, like I do want to make the major caveat that all of this leveling the playing quality field, letting kind of the market decide, really only works well if the demand follows value. So I think ultimately the main thing we should focus on, aside from leveling the playing field, is improving choice architecture, pushing for more active choice, and engaging in competition policy if we really want

to achieve a kind of optimal global outcome here. Thank you.

CO-CHAIR PULLURU: Wonderful. Thank you all for the great introductions. Now, let's move to some questions. In the interest of ensuring balance across different perspectives and questions, we encourage panelists to keep each response to a few minutes. First, I'd like to ask the Committee if there's any questions from the Committee initially. Lauran?

MS. HARDIN: Dr. Peña, I'm very intrigued by the social risk score that you spoke about. You didn't have an opportunity to talk more about that. I would love to hear what you're seeing and what your recommendations might be for that.

DR. PEÑA: Yeah, I mean, we live, again, in South Texas, it's a high poverty area with a significant amount of who are eligible patients and, you know, illiterate people. Like just make it a lot more difficult, you know, to take care of them. Some of our patients don't, you know, don't speak English, have difficult time -- even in Spanish, you know, to read instructions on medication, believe it or not.

So HCP-LAN[14], the Learning Action Network, has been working on these, you know, like social risk score. As a matter of fact, the ACO REACH has a component giving some weight to the newer labels and also that are used in this University of Madison map. I call the poverty map in short. So there is, you know, some incentive around the ACO REACH affects the payment for the 10 percent of highest poverty, but we think that could be enhanced, right?

And some elements probably should be added on the program also, not only on those two factors, but access, you know, there are some ZIP codes around the billing city when you can kind of let CMS know patients that have difficult access to transportation, to housing, food insecurity, and others, right?

So if we get, like, extra payment, we can show that we can use it to -- in those gaps, right, to provide transportation. We are doing so now, but doing it in a very limited way. And we are, like very afraid of what this -- this regulation. Can we do it, can we not, et cetera? So we are, like, working with a local food bank.

And so we give donation and they can

14 Health Care Payment Learning & Action Network

able, you know, deliver more food. But we are like very afraid from CMS in whatever we do because of the regulation, and this is, you know, and so many, again, burdens that we just don't know what we can do and what we cannot. And sometimes we don't have the money to ask the authorities for everything that we want to do, right.

But, again, the HCP-LAN line is working on some recommendation in the social risk score that should be a kind of percentage of the whole V28 model and that kind of thing.

MS. HARDIN: That's very helpful. Thank you. It looks like a couple of you may have wanted to add comment. Please jump in if you did, otherwise, I'll pass it to Walter.

CO-CHAIR PULLURU: Do any of the other panel members want to add on any comments to that? Okay. Walter?

DR. LIN: Thank you for a really rich and informative discussion this morning to all our panelists. You know, we've heard a lot about how unlevel the playing field is between MA and MSSP and other, you know, CMS CMMI value-based programs. And the number that I think is published in the literature that Michael referred

to earlier was roughly around 22 percent higher payments to MA because of various coding strategies and that kind of thing.

But the kind of insight that Dr. Peña provided to me today was this unlevel playing field could be even worse than I had thought because of the CMS haircut in terms of clawing back shared savings, right?

So if CMS takes back 4 percent, and then the MA's already 22 percent ahead, in essence, is it fair to say that the unlevel playing field is 20 percent worse? It's like 26 percent rather than 22, 23 percent. Is that kind of the right thinking about this?

DR. MCWILLIAMS: I'd be happy to field that initially. That sounds right to me that the fact that these ratchet effects of the benchmark sort of claw back the savings as they're produced means that if the ACOs and providers are spending money in order to lower spend -- lower that level of spending then they're not recovering the cost of lowering spending.

And so they're -- they can be even worse off in total cost of care models than they would be in fee-for-service. Now, that would mean that no one would participate. A reason

they participate is that the benchmarks are, in part, set based on average spending in a region.

And so there are some built-in subsidies for providers that are in the program, and sort of they get rewarded for their historical levels of efficiency. And so maybe they're not as worse off as if they were trying to save and losing the money invested in trying to save. But I think that's basically correct.

And on the MA side, it's hard, because although the increases in payments to MA have been unintended, and they've been appropriated by insurers through, you know, various rent seeking behaviors, they have nevertheless translated into additional benefits to some extent.

And so MA's been this sort of backdoor financing mechanism for the Medicare program to expand coverage in ways that, you know, society may implicitly want. Like, we may want better coverage than what's bare bones traditional Medicare offers.

And so that now, I think as other panelists have described, in particular Tim's comments, puts us in this challenging position of sort of trying to figure out how to be fiscally responsible, how to improve risk adjustment

strength and competition, et cetera, without losing benefits below what we want for seniors.

DR. LAYTON: Can I make a second point here too, that something that occurred to me while preparing for this as well as listening to the other panelists is that the playing field is not level in two ways. One is in terms of what we pay, but also in terms of what they can do with the money, right?

So like the MA plans can use it to provide things people want and get them to join the MA plans, but the ACOs, as Dr. Peña was alluding to, one, they don't even know half the time what they can spend it on, it sounds like, which is bad, but there are a bunch of things that they know they can't spend it on, but the MA plans they can spend it on, and that also puts the ACOs at an important disadvantage and takes away from this kind of level playing field that we'd be looking for.

CO-CHAIR PULLURU: Does anybody else want to weigh in? Henish, next question?

DR. BHANSALI: So to your point, there are so many different components that Medicare Advantage has, which allow it to be more competitive at least to the consumer in the

marketplace. What would be the next incremental change that could happen on the fee-for-service side, MSSP, ACO REACH, et cetera, that could bring it somewhat closer to being a competitor product that patients would be attracted to?

And because part, I guess some of the changes are coming is around the planned benefit design as well is that CMS is having a little bit more scrutiny around what sort of benefits are being offered so that they're not just bells and whistles to get patients in, but really improving patient outcomes are aligned to those sort of things.

And so as we're thinking about that scrutiny coming on the Medicare Advantage side, but also maintaining the competitiveness of the fee-for-service side, I'm just curious to know what that increment on the next action would be.

CO-CHAIR PULLURU: Who's going to jump in on this one? How about Tim?

DR. LAYTON: I'll try. Yeah, this is more of like a policy than a regulatory question. It's like what's the kind of easiest next step, which is not like my particular area of expertise, but I would think the easiest thing is -- the easiest things would be to be clearer and

more permissive about what the ACOs can do with the savings that they produce.

I don't, like I said, I'm not an expert on how the policy making process works, so I don't know how easy that is, but I would do that and simultaneously, like to the extent possible, shift more of the savings to the ACOs. I mean, like was alluded to, like we -- TM is already at a huge disadvantage to MA, and we are in a way like disadvantaging ACOs within TM even more.

And so I would, you know, I would work to shift some of the savings back to the ACOs. Those would be the two things that I would push.

DR. MCWILLIAMS: Yeah, I agree with -- oh, go ahead, Dr. --

DR. PEÑA: If I could have, like I mention before, I mean, a clear prong is this 4 percent discount from the top. That's huge, one. Number two, again, to give more flexibility to the ACOs, to share some, to make it more attractive for the patients. Right? Similar to the MAs.

Some of the MA plans are doing, you know, like a little credit card with $100, 75, 125 per month. That's huge. I mean, a lot of

our patients, they would, you know, will move for that $100 a month. Can we do that? I mean, in the fee-for-service, the traditional ACO, we cannot give one penny. Right?

So to allow us to compete and to, you know, to be more attractive for the patient to stay. One of the thing that if CMS allows that 4 percent that they are taking from the top for us to develop a dental plan, or a vision plan, that would be huge. Right?

So that would make us closer to give, to provide more benefits, you know, to our patients, similar to the MA. So there is a lot of, and again, to the rigid regulations, the burden of the overseeing of every details. That sometime there is some waivers, and I can talk about that later, that we initially apply, and then we need to drop it.

Because there is, you know, the scrutiny of every cent that, you know, a patient pay a copayment on the Part B waiver for copayments that we start, if we don't know if that person in the front, doesn't know if that patient is an ACO or not. And share the patient being an ACO, or do not share if the copayment, you know, based on that -- it's fee-for-service,

not an ACO, that already is, you know, it's a red flags, and our compliance officer, at some point, say just stop, because we are at risk of finality. Then we can get closed. Right? So that paralysis for this out of fear, you know, it's something that CMS need to work at.

DR. MCWILLIAMS: And I would just echo everything Dr. Peña and Tim just said. And just one concrete version of, sort of, sharing savings with beneficiaries might take the form of a Part B or Part D premium reduction. So then the more efficient ACOs look more attractive to beneficiaries. That help strengthens the incentives to save, helps apply more pressure on MA plans to do even better.

That being said, ACOs, even if the models are better designed, and ACOs can keep more savings, and have more flexibility, they're still stuck with having to finance the additional benefits for beneficiaries with savings, whereas MA plans can finance them with savings and subsidies.

And so, as long as those subsidies are in place, we are basically, from a policy perspective, favoring the MA program. That may not be a bad thing. If we think the MA program,

sort of, basically, for all of Medicare, is a good policy choice and we can make it work as sort of a, you know, a single dominant program for Medicare beneficiaries, then that may not be a bad thing.

I think that the big policy question in my mind, that I mentioned in my introductory comments is, do we know that? How do we figure that out? What is the role of traditional Medicare? Do we need to keep it around to supply some competitive pressure on MA to discipline the market in various ways that could be very hard to do through a regulatory structure?

And if so, if we want to keep it around, then we have to think about evening the playing field, in terms of the substance.

CO-CHAIR PULLURU: Dr. Shortell, any comments to add?

DR. SHORTELL: No, I would just support what we've been, what others have said. And I think, just to introduce perhaps something we haven't talked about yet, in terms of competitiveness in the payment models and so forth, is to remind us that we're paying whatever the models for a lot of poor care in our country currently. It's almost become normalized that

Americans, we talk about the beneficiaries accepting the kind of care they're currently getting.

And yet, there's various estimates of low-value care, for example, that about 20 percent of Americans receive care that doesn't help them, and in some cases harms them. And it's estimated it's costing us $100 billion a year, some estimates 300 billion a year, but at least 100 billion a year. There's been research done on this. All the specialty societies have weighed in on this, and it's probably about seven procedures, actually, that account for a lot of the low-value care.

So whether it's MA or the shared savings model, CMS, et cetera, you know, how do we begin to address that particular issue? And I'll give you just an example of where some progress might be made, but it's for people to think about. As you know, about eight or nine states now are setting spending targets to make care more affordable in our country.

And in those states, some of them are developing targets, not just around the spending target of no more than 3 percent or 3.5 percent increase year over year, tied to median wages in

the state, or GDP[15] in the state. But also building in targets for moving to value-based payment models like we're talking about.

So one example is California. Depending on the product line, Medicare, Medicaid, commercial, et cetera, have set targets that, by 2032, the value-based payment should be percent of revenue, or percent of enrollees, ranging from 65 to 90 percent. Now one way in which these spending targets can be made, of course, is to look at, eliminate, the low-value care. You know, providers, of course understandably, our hospitals, you know, are resisting a lot of this. They need to be paid for, you know, wage increases and technologies. And no question about it.

But there is some relatively low-hanging fruit there. But the American public does not realize a lot of this, and low back pain imaging, the opioids, et cetera. Routine lab tests that are done for pre-surgery, that doesn't give any more information that's going to enable the physician to act on it.

So I just want to introduce that maybe into the conversation. A little bit different

15 Gross Domestic Product

than what the main focus is today, but it cuts across all the payment models.

CO-CHAIR PULLURU: Thank you. Jim?

DR. WALTON: Thank you. Thank you for your time today. I'm struck with a couple of ideas that are, kind of, floating around in my head that a little bit hard to put together, so bear with me. Dr. Peña, I appreciate your comments, being a fellow Texan and knowing something about rural health care.

I wanted to start with this idea that the -- dealing with this idea of choice, being Medicare Advantage and traditional Medicare, or kind of in the field, to be available for physicians to choose to be part of both an ACO, MSSP, or Medicare Advantage. And in my experience, both are very desirable for physicians for various reasons, and clearly that's true for your ACO, as well.

And I'm curious about this kind of competitive pressure, or maybe competitive management opportunity between the two, which we're talking about this kind of unequal playing field between the two. But what I've noticed is that a lot of the patients choose fee-for-service Medicare because of the freedom of choice within

it.

As opposed to Medicare Advantage, which restricts choice at times because of prior authorizations and some of the regulatory aspects, but it's creating more financial predictability for you, which I find just really interesting. Right?

As far as how do doctors in the field advise patients in Medicare to, you know, moving them toward from one to the other because of the features of it are beneficial for the patient, even though maybe sometimes it's restrictive in their choices. And I'm just curious if you would kind of comment on that, as in your own experience.

And then from the economist at the table, reflect on that proposition of choice. The population having the choice but making that decision. But the lack of transparency in the value proposition each are being provided. Like is that clear for the patients, being in a Medicare Advantage program that a physician might prefer the patient to be in and might be really beneficial for the patient, but it's low-value care.

You know, at the end of the day, the

historical trend of that particular plan is lower-value than, let's say, a more traditional Medicare. So if you wouldn't mind kind of taking on that idea, and kind of providing comments, I'd appreciate it.

DR. PEÑA: Sure. Thank you for the, for the comments and question. It is like you said. I mean, we live in both worlds, not only our patients, but ourselves. So we work with several MA plans here in south Texas. Some of them offer a better value than others, because some of them have more social workers, community health workers.

They engage with all the -- they take really seriously the quality metrics. And they go, they give us feedback, you know, for blood sugar control, blood pressure, immunizations, and all of that. So some of the MA plan are quite good here. Right? There is some others that we don't know anything, and we get a very hard time to communicate with them when there is a, you know, they need a social worker, or DMEs[16], or extra. Right?

So they are not the same. But on that regard, and that is regarding the benefit for the

16 Durable medical equipment

patients. Regarding benefits of payment for the infrastructure and for the physician, this same idea goes. Some of the MAs provide very decent capitation payments that allow us to have the set integrated behavioral health.

Some of them have chosen to have a therapist in house. Because the, you know, difficult to access the psychiatrists, and psychologists, and so on. Between you know, the extra income that we get from some of the MA plans, and the ACO, we have been able to get nurse practitioners that go to the patient's house, for those that are bed-bound, wheelchair-bound.

So this is increasing access and, you know, making easier for the patient. So it incentive for use in the right way. And there are, you know, enough to deliver better care, but also to have more staff and to increase the salary for our employees. I think that's the best of both worlds, right?

For us, the competition has been also in the minimum of 5,000 live. As the MA penetration increased, you know, has been more difficult to us to keep those 5,000 live. So that way, you know, we struggle almost every year

to survive, on that regard. But there is the good and the bad on both, in the MA side and the ACO, right?

So we kind of survive, and we live on both. But definitely, the landscape of south Texas has changed, due to the ACO, and the four ACOs in the market, and two big MA plan. You remember they article one, the articles 2010, revisit on 2015. The difference is major, and we have some clinical practice.

We don't get the same number like before. The amputations, stroke, acute demise on the emergency room, and so on. Because we are just practicing better medicine. Better primary care, better primary prevention, and the cost of care, you know, have been stable or decrease in the last 10 years on south Texas, that was one of the highest in the country. We were, before, number one on amputations and below, you know, like below knee amputation in the country per 100,000 patients, and that's not the case anymore. So I say that the value-based medicine different colors has been a great, great thing for, you know, many communities in the country, particularly ours.

DR. LAYTON: To your question about

like, you know, are the patients making good decisions here? Do they have the information that they need to make decisions here? I think that's exactly the right question to ask, and I think it's a really, really critical one. Because obviously if they're not, then, like, letting the market decide does not work. Right? Yes.

DR. PEÑA: To be just one line on that, patients get bombarded from information from MA plans, we are not allowed to make any PR[17], whatsoever. Period. So there is a huge discrepancy there, right? And they take decision based on the paperwork that they get from the MA plan.

And so that sometime is not necessarily the decision, but that's an area that we don't even compete. I mean, we had a voluntary alignment, but what we get is for defaults, based on the might travel out of the area minimum. Everybody else is getting the MA plan. We don't have that room to tell the patients, leave the MA plan and come to the ACO. Prohibited, period. We get killed if we do that.

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DR. LAYTON: Right. And so I think, like, again, like in terms of leveling the playing field, this is another place that we need to make sure that the playing field is level, in terms of the information that the patients have about the options available to them.

Whether that involves, you know, ACOs being allowed to advertise, or just letting doctors, like, talk to their patients about, like, where they would be better off in the trade-offs. Or it involves, you know, empowering brokers, who are very active in this space, at least getting people into MA plans, but they don't face the same rewards for getting somebody into, you know, a TM and an ACO. Right?

And so there are a lot of places where this playing field is not particularly level. I think, you know, in this day and age though, like whenever anybody with my in-laws and my parents ask me what to do, I'd say join MAs, for sure.

The government's giving them 20 percent more, but they're going to pay for you in this other program, you're going to get, like a lot of, not all of it, but you're going to get a chunk of that. Right?

And so it just makes it really quite -

- I think yes, consumers making good choices is critical to this market functioning. Right now, the discrepancy is so big that, like, I think the consumers are generally seeing that. We see that in MA penetration numbers going up, up, up.

And so I'm not super worried that they're not making good choices, it's just that the whole market is structured in such a way, such that it's not a fair game, and yes, those choices are following the value for them, but not necessarily the value for society. And that's the trouble that we're in.

CO-CHAIR PULLURU: Thank you. Larry?

DR. KOSINSKI: I hope I'm not being repetitive here, and I don't even know if this is going to come out as a question. But I'm confused. I ask myself, what does -- this is a policy issue. What does CMS want? What do they want? Do they want traditional Medicare? Do they want Medicare Advantage?

Because the decision is obvious, you know, to a consumer. I can pay more for this and get less, or I can pay less for this and get more of what I think I might need. But I'm not educated enough to know what I'm being restricted on beyond that. And we haven't really educated

the public as to what the true decisions they have to make for a decision between TM and MA.

It comes out in Medicare Part D, as well. When someone -- I'm on Medicare and when you go to choose a Part D plan, you're immediately pushed towards the plan that gives you the lowest monthly payment, it covers your current meds. But if you wind up going on chemotherapy halfway through the year, it might not cover that.

But the public is not sophisticated enough to load into that program potential medicines that they might have to go on, and use that to judge how to pick which plan to choose.

So I think every system is designed to produce the outcome it produces, and I keep coming back to the thought in my mind that this is designed to push everybody into -- this is Pontius Pilate, washing hands of risk, and pushing patients into risk borne by somebody else. I don't know if I asked a question or made a statement.

DR. MCWILLIAMS: Well, I'll just say I love hearing Deming quoted. So that will be my first comment. Because I think that's absolutely right, and we're getting exactly what the system

is designed to do. It may be helpful to sort of think about this because I think to Tim's point, and some of Dr. Peña's comments and Steve's, that, you know, clearly for this to work, and by this I loosely mean Medicare Advantage, but also the notion of managed competition, there needs to be competition.

So there needs to be choices, the choice is completely overwhelming, there are a variety of policy strategies to try to help beneficiaries sort through those options, help guide them to the high-value options.

And we should all be thinking about what can be done in that space, because it's sort of they're two sides of the same coin. Right? If people aren't making wise decisions in their own self-interest, then insurers aren't going to be rewarded for offering more stuff.

And then you have fewer insurers, or they're not offering as much as they should. And so that's certainly one way that we can strengthen competition within MA, but it may also require other competition policies. It probably requires reform of the risk adjustment system, because now there's, sort of, rather than just competing on generating efficiencies and

converting them into extra benefits, there's sort of competition to code the best.

And then the winner of that game out-competes their rivals. So there's a variety of needs, from a sort of regulatory and market design perspective, to make the MA program work better and make competition work better for enrollees. So that's sort of one suite of thoughts and policy strategies.

Because it isn't -- so then the big question is, okay, what's the role of traditional Medicare? And then you get into, not just competition within MA, but competition between the programs. And how much do you need traditional Medicare around?

And how robust, or strong, or generous does it need to play a role of exerting competitive pressures on MA if we can't generate that competition within MA that we need for that program to succeed for all beneficiaries? And to me, that's sort of the crux of the question.

Clearly in its current state, it seems like we really need traditional Medicare around, and the playing field probably needs more to be more even, to give people a place to vote with their feet, if they're not liking what they see

in MA, for whatever reason. But we don't have that, really, right now.

And the markets in MA are highly concentrated, and we haven't figured out risk adjustment reform, and we haven't figured out how to help beneficiaries choose better. So there's just a ton of work to be done.

DR. SHORTELL: So I would just like to add to that a little bit, as well, in terms of information that consumers, whether or not it be traditional, or MA, or in ACOs, how many of us here today, and in the room there, when you choose a health plan, have any information at all besides the benefit structure, and what the plans are, the names of the plans, et cetera?

What I would like to see is okay, in terms of my needs, I may not be able to predict them, you know, very well. Maybe I can. Do you have, for example, the provider network in Texas, Dr. Peña's group, do you have available to you the diabetes patients? Where do they score on blood pressure and control of their sugar levels and control? Just a couple figures on that.

And if I might need to be hospitalized, what are the hospitals that my plan uses in my area? And just give me a couple of

figures. For example, 3,000 U.S. hospitals now subscribe to Leapfrog. Publicly reported safety grades on a bunch of measures, in particular, hospital acquired infections.

Just tell me whether the hospital's A, B, C, D, or F. They grade the hospitals. Is it a hospital that’s A grade or not? Tells me something about, am I going to get a hospital infection if I do have to be hospitalized? Or sepsis, et cetera. Just a few metrics like that.

We don't have that in the United States. We don't have that. We have the benefits. Okay, looks better in MA. I pay less. I get more of these benefits. But nothing approaching just some basic metrics of the quality of care that I might receive.

DR. LAYTON: I'm going to take a bit of an optimistic turn here, and just say that I, yes. I think people do make a lot of mistakes, and there's not sufficient information out there. And it's a problem. I want to emphasize, though, that like when people make an active choice, they tend to do okay. The number one problem here is that people don't make active choices, but they choose a plan once and they stay with it, basically, forever.

But when they make choices, they do okay. We could help them to do better. I think the main way to help them to do better would be to provide them with information about, like, not a billion different things, but instead, just, like, people like me, what's their satisfaction, right? And that's about it.

But the key to making this market work is more active choice. Not necessarily more information. The key is more active choice. And that's not just so that, like, I'm reoptimizing from year to year. It's so that the plans have to design themselves with everyone in mind instead of just the people who are turning 65 and entering this year. Right?

Like when, as economists, we think a lot about what determines how plans design themselves. Elasticities, right? So if I lower my price by a dollar, how many more people do I get? If I increase my network breadth by an additional hospital, how many more people do I get, right?

And if only the 65-year-olds respond to changes in my plan design, then those elasticities are super low. And so I'm not going to respond in my plan design. But if many, many

more people respond because we help people to make active choices, not tell them what to choose, but just help them to make a choice every year, then the insurer's elasticities go way up.

And at that point, they'll respond in terms of premiums. They'll respond in terms of network breadth. But the key is we need more active choice, and we need to figure out how to get that.

CO-CHAIR PULLURU: Walter?

DR. LIN: Just a quick follow-up on what Timothy just said about active choices. So it seems like one impediment to active choice is seeing the selection of MA is often a one-way street, because of how Medigap policies work, right? Once you choose MA, it's hard to go back to traditional Medicare.

The question is, is there any policy considerations that you guys are aware of underway where that might be changing? Where maybe to promote active choice, we might kind of reconsider our Medigap policies regarding risk adjustment, number one.

Number two, real quick question, circling around to what Michael said around Medicare Advantage being a backdoor financing

option to increase coverage for beneficiaries. How much of the subsidies going to MA is actually returning back, in terms of increased coverage? So, two questions.

DR. MCWILLIAMS: Two very good questions. So to take your second question first, and maybe Tim can help me because I don't have the literature top of mind, but the estimates range -- there's a wide range of estimates. I kind of keep in my head something on the order of 50 cents on the dollar, about.

And so plans are clearly retaining much of the additional payments as surpluses, profits, but some does make it through, and there are definitely clear studies that show that out-of-pocket costs, inclusive of premiums, are way lower in MA than in traditional Medicare.

And so that's just sort of a fact that's hard to explain if it weren't for you know, a good chunk of the subsidies making it through. The other thing to note about those studies is that that sort of rate of pass-through is much higher in competitive markets.

And so it's just sort of, like, really underscores how critical competition is to the performance of the MA program, but the markets

aren't super competitive right now. You know, something like 90 percent of MA enrollees live in counties that exceed the new threshold of HHI[18] for being highly concentrated. About, I think, 60 percent exceed the threshold under the old definition. I'm forgetting your first question now. It had to do with active choice, but maybe you could --

DR. LIN: Yes. Just reconsideration of Medigap policies so that it's easier to make traditional Medicare an active choice, if someone made a mistake selecting MA in the first place.

DR. MCWILLIAMS: Right. I mean that's certainly one friction, and the Medigap market has other inefficiencies. I mean, processing each claim twice is another inefficiency. The coverage is, arguably, too generous in some ways, with zero cost sharing for basically all of care.

And so there are a number of reasons why one might want to reform the Medigap market. That's hard to do without adjusting the traditional Medicare benefit. There are some states that have different regulations, like community rating, guaranteed issue.

The trade-off there is then the

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premiums rise. They become -- you know, it allows people to flow more freely between the program, but it makes sort of the traditional Medicare plus Medigap option less attractive for the lower-cost beneficiaries.

So I definitely think that that is something that we need to be thinking about, as well. However, you know, I think a major source of the inertia that Tim was describing is just sort of human nature, just we all do it. I mean, we all pass up opportunities to open high-yield savings accounts for years on end, even if we're completely, you know, on top of our game.

And so it does seem like the government, as an agent on behalf of the public, will need to step in somehow and sort of remind beneficiaries, in various ways, that there may be better options out there. You know, does that mean like a publicly financed broker system or something? You know, I think we should be thinking about how that could be accomplished.

DR. LAYTON: Yes, I'll make two points about this, as well. So one is that, you know, of those 50 cents that don't go to the patient in these studies, we don't know how much of the other 50 cents goes to the insurer versus the

providers. So as Dr. Peña was alluding to, sometimes they get, you know, pretty good capitation deals with, you know, the MA plans. That's because they're actually passing through part of that additional 50 cents, in that way.

So there's not great work on understanding that. So some of it is there, as well. I think, for the Medigap thing, like, this is tough. Because like the reason why, you know, people get risk rated when they go back is essentially because, within the traditional Medicare structure, you want to incentivize people to join right at the beginning.

Because otherwise you get this adverse selection problem where people don't buy Medigap until they get sick. But I think there's some fairly straightforward fixes here, right. Like, you know, not fully risk rating people when they come from MA, but still fully risk rating them when they go from TM without Medigap to buying Medigap. Like things like that, that would be pretty, you know, incremental changes that could help with this.

But yes. As Michael alluded to, I don't think that this is the biggest reason for a lack of active choice. It's one reason, but I

think the biggest reason is people just aren't paying attention.

CO-CHAIR PULLURU: Jay?

DR. FELDSTEIN: Thank you. Great discussion this morning. I just, a couple of questions before my head explodes. One would be the fact that no patient chooses an ACO. And they're not even aware when they're in an ACO. So that's a totally competitive disadvantage when you start looking at Medicare Advantage, traditional Medicare, or ACO.

So I don't know how we solve that issue. But we talk a lot about plan competitiveness, but I'd really like your perspective on provider competitiveness and what's happening in the marketplace. Because the plans don't operate in a vacuum.

And when you have all the consolidation of integrated delivery systems that are now offering their own plans, and their own ACOs, and they offer one hospital inpatient rate to their own plan and their own ACO, and they offer a different hospital inpatient rate to their competitors in the marketplace. It totally inflates and artificially affects the rate setting process for everyone.

So how do we work that into this policy discussion of making these plans competitive and more attractive and ultimately benefitting the beneficiary, as opposed to increasing margins for integrated delivery systems, whether it's on the insurance side, the ACO side, or as a provider?

DR. LAYTON: This one's for Steve, I think.

DR. SHORTELL: Yes. Well, let me start off, at least I think I alluded earlier around the vertical integration part of that. Of course, there's been a lot of horizontal consolidation over the years of all these integrated health systems.

So, you know, the FTC[19], there's certain things they can do. They, by and large, have not so far. And we'll see what happens with the current administration and so on. I mentioned earlier the idea of contingent, you know, approval of some of these arrangements. Contingent on, you know, the fact that prices do not rise in the ensuing year, and various quality metrics, low-value care and so on, are reduced.

Another element here is the fact that

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in some states, about nine or 10 now, they have these spending targets, okay? So what I'm familiar with on the advisory committee here in California, but I've also looked at Washington, Oregon.

Of course Massachusetts has a lot of experience in this, as well. And Michael, maybe Tim, can speak to that. And it has to do with the enforceability. In California, there's going to be real penalties on the providers, in terms of if they do not hit the spending target.

And it's not just performance improvement plans, but actually paying financial penalties and then setting certain targets for the following year. That is beginning to, you know, get them to think through some of what they're currently doing, in the way of spending, and how that spending can be changed.

And we'll see whether or not, what the impact of that is going to be. But that is one thing that's occurring in about nine or 10 states, to change provider behavior around -- well, just to take the case here in California, Northern California.

Over the years, Sutter used to say, well, you got to take all our hospitals. You've

got to take all of them. Same prices, right? You got to have all of them in the network. Well, that's no longer going to be the case in California.

And so I think a combination of the FTC, and actually sending these targets to create a pressure and incentives for the providers, and the plans that the providers are in, to change their behavior, is what's going to be needed.

Short of that, I think you're going to continue to see some of the consolidation, vertical integration, and, you know, I think the big challenge is going to be for Dr. Peña and others, the smaller practices. How do you get them into value-based payment?

And I think some of the things that CMS is doing should be, if anything, accelerated. So making primary care, or Making Care Primary is one initiative. Upfront investment funds for team development, and technology, EHRs[20], and so forth, capability investments will be needed for some of the smaller practices, going forward.

The other thing I will say, in terms of rural America, and some of the problems there, is what might be done to encourage urban rural

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alliances, and partnerships, in the way of it may not be consolidations as such ownership models, but models where urban health systems make up arrangements with rural health systems to provide the capabilities and resources needed. Telehealth is a part of that, of course, as well.

So there's some things going on in New York State that you may want to take a look at. Where Cooperstown, I think it's the Baseball Hall of Fame, but Bassett Memorial systems, the rural hospital in Cooperstown, is working out arrangements with some of the academic medical centers in New York, in order to get some resources around value-based care in rural America. And there's a few other examples of that as well.

DR. MCWILLIAMS: I'll just make a couple additional points. I think Steve is absolutely right. I think Steve was alluding to the commercial market in a lot of this, and that's really critical here. Like it just, it's going to be very hard to preserve or improve competition in provider markets without some sort of, essentially, price regulation.

Whether that takes the form of regulating fee-for-service price is the most

extreme, you know, maybe a cap, or regulating total cost of care targets in some way. But, you know, while I'm very supportive of antitrust law enforcement efforts, and those are quite critical, it just does seem like the point we're at now, it seems hard to unwind a lot of what's been wound.

And so, on the commercial side, it does seem like the, you know, the prices is really the key thing to focus on. But then getting back to sort of value-based payments or total cost of care models. I think there, where we, at least in the public payers, where we're not as worried as much about high prices from market power, we do need to be mindful to design these models in a way that doesn't entrench the market power that's been amassed by providers under fee-for-service.

And one way that they may unintentionally be doing that is that the models in a lot of the accompanying pay-for-performance programs has just created a level of complexity, and cost of just participation that is just well beyond some of what the smaller organizations can afford. I mean, just, you'd kind of have to like hire a bunch of consultants to deal with all of

this.

And so that burden, that complexity, if it can be simplified, then the models would have a better shot at supporting what Steve laid out at the outset, or said at the outset, which is that, in principle, they should be pro-competitive by giving organizations of any type an ability to compete.

So, you know, a smaller primary care-oriented organization may not be able to compete on fee-for-service. The revenue is just not going to be very high. But in a total cost of care model, they actually have stronger incentives to generate savings. And they may be able to compete on that basis, at least in a system like Medicare where the prices are set.

So it's sort of like there's different levers to be pulled in the different markets. But with respect to the total cost of care models, we do need to think about the complexity.

DR. LAYTON: And Jay, I like what you described, you know, about like this type of foreclosure scenario that you're describing, because I think it's something that's been largely overlooked. So there's different types of consolidation.

You know, there's horizontal, there's vertical, there's different types of vertical consolidation. And the one that I think is happening more and more and more, and that the FTC has a really hard time figuring out how to regulate, is consolidation between payers and providers. And when that happens, there are a lot of efficiencies that occur, that can occur. Right?

Because like if you have a payer provider that's consolidated, then they're automatically at a total cost of care model for everything they do. Right? And we don't even need the government to do it. They're automatically in it. And so there's -- I mean we think those are good, so there's efficiencies that can occur.

But at the same time, what it does is it makes it so that that integrated entity now wants to prevent people from other integrated entities from coming to their providers, so that that encourages the patients to join their integrated entity rather than the other.

So the classic example of this is UPMC[21] in Pennsylvania, where you know, they had a

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health plan, and they had University of Pittsburgh Hospital System, and what happened was they said okay, like, we're not going to accept Blue Cross anymore. And so Blue Cross bought up a bunch of hospitals and said okay, these hospitals are not going to take UPMC anymore.

And you get in this situation where if you want to be an insurer in western Pennsylvania, you have to own a hospital. Right? And at that point, the barriers to entry are much harder and higher than ever before. Right?

And so the problem is that this is a new kind of integration that the competition authorities have not exactly figured out how to deal with yet, because of these trade-offs of efficiencies versus, you know, these types of foreclosure activities. And so I'm not optimistic that there's going to be a lot of action from them.

And so, as Michael was alluding to, I think our best move is probably to just decrease all other barriers to entry in this space. Because we know there are going to be more and more coming from this foreclosure. And so there are other things we can control, like the complexity, the regulatory environment that makes

it hard to enter these spaces. Shrink those as much as possible so that, at least, you know, on the margin, like, the different organizations have a better chance against these behemoths that keep being formed.

CO-CHAIR PULLURU: I'd like to thank all four of you for joining this meeting. This helped us cover a lot of ground during this session, and you're welcome to stay and listen to as much of the meeting as you can.

At this time, we have a break until 10:55 a.m., Eastern Time. Please join us then, as we welcome a great lineup of experts for our listening session, which will explore how to maximize the participation of beneficiaries and accountable care and improve the sustainability of effective population-based total cost of care models. Thank you.

(Whereupon, the above-entitled matter went off the record at 10:44 a.m. and resumed at 10:56 a.m.)

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

MR. RAMACHANDRAN: Welcome back. I'm Krishna Ramachandran, one of the PTAC Committee members. At this time, I'm excited to welcome four amazing experts for our listening session who will share their perspectives on maximizing the participation of beneficiaries in accountable care and improving the sustainability of effective population-based total cost of care models.

You can find their full biographies and slides posted on the ASPE PTAC website. I see our presenters have turned on their video. Thank you. After all our experts have presented, our Committee members will have plenty of time to ask questions. The full biographies of our presenters can also be found there, as I mentioned, along with the materials for the meeting today, as well. So first up, we'll have Dr. David Muhlestein, who is the Chief Executive Officer of Simple Healthcare. David, go ahead.

DR. MUHLESTEIN: Thank you. It's great to be with you today and to talk a little bit about what opportunities I see in value-based care and population-based payment models. So I'm going to, primarily, share some data, and talk about some of the trends that are there and

opportunities that I view exist today.

So next slide. First, we'll start with looking at some general trends about groups. So this is looking from 2013 to 2019, and this trend has continued, though I haven't updated the numbers.

But you can see that the percent or proportion of physicians that are practicing in small groups, so on the left-hand side, that's the onesie, twosies, has decreased pretty significantly while those that are practicing in very large groups has grown.

So we see a broad trend that's moving towards larger group practices, which often enable people or put them in a better position to participate in models. Next slide. Subsequently, there is a difference, though, between the primary care physicians and the specialists, in terms of the rate that people are moving toward these.

So lots of movement, even faster movement with primary care, but slower with specialists. So while there's still a general trend moving from the smaller groups, the specialists are more inclined to stay in these smaller group practices.

Just given the dynamics of how their practices tend to function, and the ability that they have to stay in these smaller groups. Next slide. A lot of this, though, is not driven by changes in practice patterns.

So this is an important concept where it's not people that are saying, oh, I'm in a onesie, twosie practice, I'm going to go join a 500 group or doc group. It tends to be people that are leaving the practice of medicine and being replaced by people that have a different expectation of how they practice.

So this chart shows a static shot of what's happening. This was in 2018, but similar trends, you can see today, where you see that the old timers, the really old doctors that are still practicing, that graduated from medical school 60 years ago, over half of them are in onesie, twosie practices, and only 17 and a half percent were practicing in these larger groups.

If you go to the other extreme, the recent graduates for medical school, half of them were practicing in these larger practices, relative to very, very few that were hanging their own shingle.

And so this trend that we're seeing,

some of it is by people that are moving practices, but much of it is that an older generation of clinicians is retiring, and they're being replaced by a new generation that has different expectations about how they practice, primarily moving to these larger groups.

Next slide. There's also a trend about where there is opportunity, and yesterday there was a presentation that showed some data on how more ACOs are being led by physician groups. A lot of this is because there's, frankly, more physician groups that are capable of forming these ACOs, risk-based entities.

This is a study that we did a few years ago, but it found that over a third of all hospital systems that potentially could become an ACO, already were. While less than 10 percent of physician groups that could ultimately become an ACO had been there. So the groups are getting larger, and there's a significant number of them that have not yet joined an ACO, or another population-based model.

Next slide. So this is the trend looking at ACOs. So if you go back to the early twenty-teens, there was pretty significant growth, quick growth, that was happening. And

then about 2018, 2019, when enhanced risk provisions started to happen with Medicare Shared Savings Program, the growth started to plateau, and it's been relatively stagnant over time.

And this is not just because nobody is joining these programs, but it's because now, for every organization that joins a program, there's another ACO that drops out. And this is looking at commercial and government backed ones.

So Medicare, Medicaid, and commercial-based ACO programs. But this doesn't mean that there hasn't been a continuing growth of Advanced Alternative Payment Models.

Next slide. So this looks at the percent of physicians that are qualified participants in Advanced Alternative Payment Models. So in AAPMs[22]. This is people that have qualified under the regulations that came out of the macro legislation, and you can see that there has been very consistent growth. So only 8 percent of physicians were qualifying in 2017, a little bit more in 2018, back when we saw that plateau with ACOs.

And now it's up to 29 percent, at least in 2023. That's where this article that I

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published last December had data through '23. And we are seeing a pretty consistent year over year trend, where more and more physicians are starting to go to APMs[23].

Now there's two reasons that this happens. One is because current participants are expanding and getting larger, so some of them are adding additional 10s, or group practices, to their current models. And then there's also new models that people are starting to join.

So it's an expansion beyond -- what I thought about 10 years ago was that everybody that wanted to move to some sort of a population-based model would really be in an ACO or some variation of that. But we're seeing a lot of models that are formed that I really don't think of as ACOs, in the same way that the shared savings program manages a population.

Next slide. There is a difference, though, between physicians and non-physicians. So an important trend that is happening, and I didn't put the data here, but the number of physicians practicing in the country is basically flat. It's been flat since about 2017.

The growth of non-physicians, so nurse

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practitioners and physician assistants that are practicing in billing Medicare and taking care of patients is growing considerably.

So since 2017, in that same time frame where physicians have been flat, non-physicians have grown by 30 percent. But when you look at the adoption of these Alternative Payment Models, they are significantly below. Yes, they're growing, but they are significantly below physicians.

So non-physicians are just starting at a lower rate, and also growing at a slightly lower rate, in terms of absolute percentage increase year over year. Next slide. When you compare, just among the physicians, the trend has been much more pronounced among primary care docs, as opposed to specialists.

You look at these numbers and you see that nearly half of all primary care docs have moved to become a qualified participant in an APM, while it's only approaching a third of the specialists. And so I'll come with some recommendations of why I think that is in a few slides.

Next slide. This is the breakdown by specialty. So you look at the -- it's a pretty

stark difference. So family medicine, over 50 percent were qualified APM participants, and you look at ophthalmologists or dermatologists, when it's down around 19 percent. So fewer than one in five are participating.

And the reason for this, that I think is a major challenge for a number of specialties, is that there are not models that really make sense for how they practice medicine. So if you are a cardiologist, a lot of what you do actually involves primary care. You're managing a population.

They just happen to have heart disease, so they might have heart failure, but you're also managing their diabetes, and you're working with any other conditions that come up. They go see their cardiologist, and they're feeling sick, and they just ask them.

And so there are a number of specialties that do have a lot of that longitudinal care and management, similar to traditional family medicine, internal medicine type specialties. But if you look at other ones, they really do things very differently.

If you look at the psychiatrists, for example, the way they care for their patients is

dramatically different than the way that a family medicine doctor is going to care for their patients. So I think there's going to be an opportunity, and a need really, to create some models that are built around the needs of those specialties.

Next slide. It's also not consistent where growth is happening around the country. So this is looking at all doctors -- or excuse me, all providers. So physicians, plus the nurse practitioners, physician assistants, everybody that's billing Medicare, and the percent of them that are qualified participants, and this ranges from below 10 percent in some states, to well over 50 percent in other states.

And it doesn't follow a clean blue-state, red-state divide. It doesn't follow an urban rural divide. It doesn't follow coastal versus interior. There's no real rhyme or reason with how these markets are moving towards value-based care, other than when a market starts to move, all of the participants start to think about this. And they start to respond to where there might be opportunities to move towards value-based care.

Next slide. So this is by the

different government-backed APMs around the country. The majority of people that are participating in one of these models are participating in Medicare Shared Savings Program, but also, you see the ACO REACH has a fairly high number of participants. But a majority of people, 56 percent, still are participating in zero APMs right now.

And so there is a, while there are a bunch of models, it's really just a couple of programs that are bringing in the majority of people, in terms of participation. Next slide. So here are my recommendations. The first one is that, for primary care providers, there are sufficient numbers of AAPMS that exist for them.

If they are not participating, it's not because they're not aware of them, and it's not because they couldn't, it's because they made a choice not to. Now individuals, there might be reasons why not. Certain groups, there might be reasons why they can't join them. But by and large, primary care providers have a pathway forward.

This is different, though, for specialists. For certain specialists, I think there needs to be specialty-focused models that

are created, really around these low participation specialties, and say what do we need to do to get dermatologists into APMs? What do we need to do to get psychiatrists participating?

We also really need to think about these non-physicians. There is a significant number, and they are growing. And they will continue to grow, and the percent of care that they're providing to Medicare beneficiaries, and also non-Medicare beneficiaries, is going to continue to increase over time.

So we need to think about them more proactively than has happened in the past. I think there can be improvement with model hierarchy. There could be confusion when people are participating in different models. I think you could just do a rank ordered list, and say, if you're in a model that's higher, then that's the one where you get credit for that, and that's their participation. We can talk more about that during the question and answer.

But then finally, I think there needs to be regional focus. What do you do to seed the initial organizations that start moving to value-based care that will bring other people along?

Or how do you create a model, similar to what's happened, for example, in Vermont, where there is a Vermont-specific model, where you market based model that really drives adoption within those regions of the country? With that, I will pass the baton to whoever's next.

MR. RAMACHANDRAN: Thank you, David. Next we have Dr. Sanjay Shetty, who is the President at CenterWell, Humana. Sanjay, thanks for joining us in person. Go ahead.

DR. SHETTY: All right. Well thank you so much for having me. Really looking forward to the conversation. As was mentioned, I'm Dr. Sanjay Shetty, President of CenterWell at Humana. I'm a member of the management team at Humana.

I'm a radiologist by training, but I've been working in value-based care for a little bit longer than that, including running one of the Pioneer Next Gen ACOs, back in the mid-2010s. But happy to talk to you a little bit more about CenterWell.

We founded CenterWell basically with the aspiration that we could continue to drive forward value-based care by attempting to provide differentiated and integrated care that would

improve experience, quality, and outcomes. Our goal is really to help seniors, in particular, navigate what we believe to be a very fragmented health care system.

CenterWell's composed of three main parts. We have CenterWell Senior Primary Care, which includes over 340 primary care centers operating in 15 states, caring for just north of 400,000 patients. Importantly, all of our patients are either in some form of total risk contract, or on a path to some value-based paradigm.

That includes working with many different Medicare Advantage payers, as well as being a participant in ACO REACH. These clinics are really purpose built to provide value-based care with integrated care teams, longer appointment times, immediate access. Really not built at all around an old fee-for-service paradigm, but built if you were starting from scratch to serve value-based care patients, how would you build it?

Especially for a senior population. And that includes caring for them both inside the clinic, outside the clinic, community rooms where we provide activities, et cetera, to really care

for the whole person.

CenterWell also includes CenterWell Home Health, one of the leading home health agencies in the nation, with 350 branches across 37 states, providing over eight million visits a year. We have a number of specialized clinical programs that we've developed in order to serve the needs of our patients, including in areas like diabetes and congestive heart failure.

And finally, CenterWell includes CenterWell Pharmacy, which is inclusive of a large home delivery pharmacy, a small set of retail, a specialty pharmacy, and a hospice pharmacy, overall serving over 48 million prescriptions a year, 2.5 million patients.

You can tell by describing these things, I think in some of the materials that I received, this would qualify as a low-revenue ACO. Right? We're providing care in very distinct areas. So although we don't, sort of, own the dollar of spend, we believe we have a disproportionate influence on the spend.

And that is why we are so engaged in value-based care with these three particular assets, where we're really trying to surround the patient with care that allows us to achieve

better outcomes, better experience, better quality. And I did want to point out before I move on from this slide, some recent results that we were able to publish in *Health Affairs*, in association with Harvard.

In a study of over five million patients -- sorry, half a million patients, we looked at our results, as well as the results of other senior-focused primary care providers. And we were able to actually look specifically at this model, not just comparing us to, sort of, all others, but actually comparing us to other value-based providers, and say what happens differently, if you're able to focus, sort of, cater made to a particular population.

And what we found is that our model is actually helping to provide better access to care and improvement in health outcomes. In particular, we see better access, 17 percent more primary care visits for senior-focused primary care patients. We're able to see better outcomes.

Fewer ED[24] visits. Eleven percent. Fewer hospitalizations. Six percent. And 10 percent fewer 30-day inpatient readmissions.

24 Emergency department

Importantly, we were also able to see, in senior-focus primary care reduction and some of the health equity disparities that we see more broadly, even among a value-based care group, with black and low-income beneficiaries having 39 percent, 21 percent more primary care visits, respectively.

So really exciting work that is also pointing towards improvements in cancer screening, blood pressure control, medication adherence, and diabetes adherence. So really exciting. And what we're beginning to put together at CenterWell, we're excited to continue to develop our model over time.

One of the key points I wanted to make by moving to the next slide is that Medicare Advantage is a really important part of our overall model. My big worry about a focus on just one segment of the population is it's really hard, in reality, to run a clinic around a small subset of your population.

For us, we've been able to build a sustainable model because we are caring for patients under a variety of Medicare Advantage constructs, as well as the ACO REACH program. And in fact, Medicare Advantage has, in a lot of

ways, led the way. Right? Just sharing data that I'm sure you're all familiar with.

Knowing that patient -- that Medicare Advantage has broadened access to the higher-level total cost of care models. Category 3 and above. Sixty-four percent in Medicare Advantage, compared to only 42 percent in original Medicare. And so, having a broad subset of access to value-based programs across different pairs is really important for practices to succeed.

Skip over this slide, just to go to this one. Humana has spent a lot of time thinking about what it takes to be successful in value-based care. And actually, this diagram that I'm sharing on this slide is pulled directly from our value-based care report that was just published a few weeks ago.

As we look across our broad network and the broad base of value-based care providers that we have working with us at Humana, we see a couple of things that are really important predictors of success. The first is that patients have to have -- sorry.

Providers have to have access to strong infrastructure. That includes having population health management tools, sufficient

staffing, and actually to be able to actually manage a panel, not just the next visit, but a panel of patients. And effective electronic health records, and the ability to really mine that information for insights.

We also know that our practices need to have models of engagement. They need to be able to manage collaboration. They need to be able to think about metrics, at scale. They need to be able to communicate with their patients, at scale, and have mechanisms in which they're outreaching to patients.

Again, not just the ones who are in the office, but those that are outside the office. And a willingness and ability to share their data. Right? Both to ingest data from other sources, as well as to share it elsewhere.

For many of our practices, value-based care becomes a really important method of growth. It allows them to set up a growth strategy. It becomes an opportunity for them to think about how they will widen their opportunity for revenue and bottom line in the long run.

We also really believe it's important that growth is enabled by stability and predictability in these models. Having a program

or a set of programs that they can depend on year over year, over year, with financial returns that will be sustainable, is absolutely crucial for them to both plan for future growth, to make the investments in their workforce, but also to support all of the other mechanisms that you see here on the slide.

An effective value-based provider has invested heavily in clinical operations. That includes care coordination. It includes making sure that they have access for their primary care provider so that they're able to increase utilization of the primary care, relative to other points in the health care system.

They have to have an actual, functioning ER[25] diversion plan. Right? That may be as simple as after-hours call, but some way of getting a patient seen so that they can avoid expensive emergency room visits, and the likely downstream admissions that might follow, as well as the ability to engage with patients after discharge from the hospital.

And finally, performance requires that they're thinking carefully about documentation, as well as really robust internal quality and

25 Emergency room

financial reporting, so that they're really able to understand how they're performing, and manage against the various contracts and engagements that they have.

If I were to summarize, like a couple of other ones that didn't even apply in the slide, but which I think are also really important, and I'd feel remiss if I didn't mention, is the ability to invest in care teams. Our model depends on the fact that everybody is functioning at the top of their license.

And that we have put around our providers -- that would be our physicians or practitioners, entire teams of social workers, behavioral health specialists, pharmacists, in order to ensure that folks are functioning at the top of license, and that data transparency, data liquidity is absolutely crucial.

So for us, you know, some of the key messages. First, we really want to encourage that, in any consideration of how we continue to promote value-based care, that we think about the stability of Medicare Advantage in driving expanded participation in population-based, total cost of care models.

Also, we need stability in MSSP and

ACO REACH. Right? To the degree that those fluctuate year over year, that is where providers, that is where these clinics, that is where, in general, the strategy can't depend on this model. And that includes predictability in benchmarks, predictability in the quality measures, predictability in the financial returns.

And finally, you know, as a general rule, what we've seen is that payments based on just completion of process versus outcome is going to actually weaken incentives for providers to commit. We've seen alternatives, right?

So if you can tie the process to the outcome, and pay people, basically, the interim, that may work as long as they feel like they have skin in the game in the outcome, but paying on process, which just dilutes the effort against what we really want folks to be investing in. So with that, I will hand it off to Sean.

(Whereupon, the above-entitled matter went off the record at 11:17 a.m. and resumed at 11:18 a.m.)

MR. RAMACHANDRAN: Thank you, Sanjay.

Yeah. Next we have Sean Cavanaugh, who is the Chief Policy Officer at Aledade.

Welcome, Sean. Thanks for joining us in person as well.

MR. CAVANAUGH: Thank you very much, and thank you for having me here today.

Let's see. Great.

So I'm Sean Cavanaugh. I'm the Chief Policy Officer at Aledade. I'm going to try to bring two perspectives to this discussion. One is the perspective of my previous job. I worked at CMS for six years. I was part of the team that helped design the Pioneer Model that Sanjay referenced. It was the first total cost of care model out of -- coming out of the ACA[26], and I was at the Innovation Center for the launch of a lot of other models.

Subsequent to that, I ran the Center for Medicare, where I was responsible for all of the payment rules in Medicare A, B, C, and D, but importantly also designing and help trying to grow the Medicare Shared Savings Program where we often asked ourselves the question you're asking all of us today, which is, how do we make this thing bigger and better?

The second perspective I want to bring is my current job, which is I am the Chief Policy

26 Affordable Care Act

Officer at Aledade. I think it's great that I've been partnered here with Sanjay because we represent two very different but complementary models, CenterWell, our clinics that they have designed and built and staffed from the ground up, presumably, you know, from scratch, and purpose-built. So, you can accomplish a great deal, as I'm sure CenterWell has by doing that.

Ours is a very different model, which is we work with primary care as it exists. So we don't build, own, create primary care practices. We go to existing primary care practices, and we partner with them. And the partnership is we're going to help make you successful in value-based care as you partner.

We'll provide you the technology, the workflows, various support, data and analytics, importantly, regulatory and compliance expertise, so that you can be in the Medicare Shared Savings Program and be successful, but also continuing a theme that Sanjay mentioned. In our practices, we always start with the Medicare Shared Savings Program, but we try to get as much of their patient panel in value-based care as we can.

So the 2.9, almost three million, lives that are at risk in our practices, we have

traditional Medicare, Medicare Advantage, over a million commercially insured lives, and even some Medicaid risk lives. We could have more, but the Medicaid total cost of care models aren't as mature or sustainable as we would like.

So, let me see, the last couple of years we've been facing the same question. So David Muhlestein showed a slide that growth in the Medicare value-based programs has flattened over the last four or five years.

We've heard CMS officials asking the question that PTAC is now asking, and we have been asking ourselves. What is happening? Why are we not growing? How do we get more providers involved?

And what we came upon and believe is going on is very much very predictable, and it's the science of technology adoption. We have been very successful in engaging the early adopters. So these are the people who need change. They're not comfortable with the status quo. They are comfortable operating in areas of ambiguity, but they are also feeling some pain.

So we got the -- and this is in health care, largely primary care, right? Primary care has -- fee-for-service has failed primary care.

So a lot of the early adopters from primary care rushed into the program and have been very successful.

The problem is, we have plateaued, and now we need to extend beyond the early adopters into the mainstream market. And the most important message we take from the literature is the things that attracted the early adopters are very different from the things that will attract the mainstream market.

So hammering home on the same themes that got people in initially is not going to attract the mainstream market.

So what does the literature tell us? First, you really need to dominate and engage a niche market. And, again, we think, even though the numbers are very good for primary care engagement, there is a huge number of primary care physicians still not in the program.

The other thing is the data on primary care, in particularly MSSP, is the strongest. So the evidence base of them being able to participate and be successful is very strong.

What we've noticed is both in the last couple administrations, starting with myself, we have often talked in policy terms of trying to

get more spend, more Medicare spend, in value-based care models or trying to get more beneficiaries in primary care models.

But, of course, as we've heard in the earlier discussion, the way you get people in is by practices joining value-based care models. So CMS needs to do something that it's not built to do and not very comfortable doing, which is marketing. We need to be -- start talking to the practices about the importance of moving to value-based care.

And as I said, the CMS data alone shows that this is the right thing to do, and that it's good for beneficiaries and good for the practices.

So the other thing we take from the literature is defining the competition. My colleague, Farzad Mostashari, who founded Aledade, when he was at ONC[27], when they were trying to promote the adoption of electronic health records, they came up with the phrase "paper kills." And what they meant was, you know, to engage practices, "Hey, this stuff you're doing is really bad for you and bad for

27 Office of the National Coordinator for Health Information Technology

your patients." We need a similar approach that fee-for-service is bad for practices and bad for patients.

The good news is that -- so to put it in a financial context, last year Medicare physicians, through the fee schedule, across the board took a 1.24 -- 1.25 percent reduction in Medicare fees. At the same time, we paid out billions to ACOs, and physicians -- primary care physician-led ACOs got almost $300 per beneficiary in shared savings.

At Aledade, two of our most mature markets, our physicians make more on Medicare -- traditional Medicare and shared savings than they bill in fee-for-service. So there is a pathway here for them.

And then getting to the programmatic thing, the mainstream market doesn't want bells and whistles. They are not looking to be involved in innovation at all. In fact, when we talk to our doctors, that's a fairly scary term to them. They want to participate in what's the new normal. So we have to paint the program, the mainstream, and what we've been rallying around and talking to CMS about is, first of all, let's key in on the Medicare Shared Savings Program.

We participate in REACH. We think testing new things is wonderful, but make clear that MSSP is the total cost of care destination. It's the statutorily mandated program. It's where the evidence is.

If you need -- and, importantly, if you need to test new things, like primary care capitation, and things like that, test it in the context of MSSP, use MSSP as the chassis for innovation, so you're constantly driving people to the statutory program.

Assemble the whole product. And by this what we mean is the people who joined MSSP 10, 12 years ago, they've seen an evolution of the program. The benchmarking formula has changed, and I did it twice myself, very -- in various ways, I think generally for the better, but that level of change in dynamic life is not what the mainstream is looking for.

They want to know that you've figured out what the payment model is. And, frankly, we haven't in MSSP. We didn't have rebasing and ratchets that don't make this a long-term sustainable proposition.

CMS is -- has stated that. MedPAC[28]

28 Medicare Payment Advisory Commission

has stated that. Steps have been taken, but we've got a ways to go. So we really have to nail down the product that we're pushing before we can expect that the mainstream will accept it.

And the last thing I would say is the mainstream is not -- are not do-it-yourselfers. I think it was Dr. McWilliams on the previous panel who talked about the complexity of the program. They want -- the mainstream wants someone to figure this stuff out for them.

The early adopters, Sanjay, these folks went in and read 300-, 800-page regs. They figured out the nuances of the program. They came to conferences. The mainstream, that's the last thing they want to do. But the good news is there are simplifiers out there who will make their lives easier. It's not for everybody. Some people want to do it themselves.

But they're -- and Aledade is certainly not the only one, but we should make room in the market for the simplifiers, and I think CMS to date has sort of been ambivalent about the role of simplifiers. If not -- and I heard previous discussions here where people who came and testified said actually the simplifiers are a problem, they cost too much, but the

program -- the providers are voting with their feet.

So when the program started, it was 2 or 3 percent of the practices in the program were going through Aledade or some similar organization. And now it's nearly almost a third. So without these simplifiers, you wouldn't have the program you have today.

So, in summation, we need new strategies different from the ones that attracted the early adopters. We need to speak directly and market directly to the practices. Currently, Aledade, MHN[29] and others are the ones doing the marketing. CMS needs to get engaged in that.

We need to focus on the audience where we can make a real improvement, which is first primary care. That's not to say specialists aren't important. We're working every day to figure out the role of specialists in our ACOs, but we have to totally dominate the primary care market in order for this to spread more widely.

And then, we've got to make sure the program is ready, stable, and sustainable in the long term, if you're going to get the mainstream to engage.

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So thank you very much.

MR. RAMACHANDRAN: Thank you, Sean.

Last we have Dr. Karl Koenig, who is the Executive Director of the Musculoskeletal Institute, Division Chief of Orthopaedic Surgery, and Associate Professor of Surgery and Perioperative Care at the Dell Medical School, at The University of Texas at Austin.

Karl, welcome.

DR. KOENIG: Well, thank you very much, and I really appreciate the opportunity to speak to this esteemed panel and with this group. I -- you might be wondering why an orthopedic surgeon would be coming to talk to you today, but I definitely represent a group of forward-thinking specialists who want to try to help find ways to create appropriate specialist interactions with ACOs.

You know, many of us believe in value-based care models, and we've participated in voluntary models as they have come forward, and so I'm here representing the American Academy of Orthopedic Surgeons to talk about or at least suggest some ways that we start thinking about innovative payment models that are going to drive the kind of behavior change that we need to see.

Next slide, please.

So no relevant disclosures.

Next slide.

So I guess, you know, to put it into context, musculoskeletal disease affects one out of every two people over 18, and three out of every four people over the age of 65. It is a major part of the specialty care that our patients undertake, and we have an important role in keeping our patients healthy and active.

Also, with that amount of care, obviously, it is a big part of the spend that we have to responsibly utilize together and help our patients move forward. I think, you know, there are some studies that suggest that over half the time that a patient turns the door of a primary care doctor's office, it's to talk about a musculoskeletal complaint.

So the way we interact, together with our ACO colleagues, is going to be really, really important. And we think there are better ways to do it.

Next, please?

So I want to just kind of remind us all that, you know, value can be increased by either improving outcomes or decreasing costs,

and I think we get focused on that costs a lot, which is obviously important, but it's because we feel like we have a little bit easier way to move some of those levers.

But it is primarily accomplished by incentivizing the use of effective evidence-based treatments and allowing the patient and the physician to partner in producing better health.

So as we tried to change this conversation from sick care to better health, we have to have models that promote that type of behavior, and it -- and it doesn't mean just finding a way to bolt on, you know, a different payment model onto systems that already exist. I think the payment model can actually help drive the system that you want to see.

And so the mechanism for appropriate specialty and ACO interaction has really not been worked out, and so, you know, you have most of your specialists living in a fee-for-service world doing what we've always done, and so our -- I think it puts our primary care colleagues who are trying to set up these models, it puts them at a disadvantage.

So right now, since the ACOs are being held accountable for the musculoskeletal

outcomes, they don't really have a way to interact with those specialists, other than their referral patterns.

And then we've tried to, you know, come up with ways -- and I know you have -- of helping them figure out who the high-value specialists are, but so far those efforts have not been very successful, and so we're suggesting that it's actually the payment model that can incentivize that kind of collaborative, high-valued care, and it's going to be the best way forward.

Next slide.

So, you know, the primary care doctor leads the -- leads from the ACO, and the specialist would have an opportunity to manage the full episode of care for certain conditions, right? That really gives us skin in the game, allows us to share in the risk, and also allows us to share in the savings created with actually allowing our primary care doctors to get that portion of things that they really don't have much training in off their plate and allow the specialist to actually be a contributing partner.

And so that requires a different type of payment other than just referral patterns into

the same fee-for-service area. So I'm talking about condition-based bundled payments, and that is a bundled payment that covers the full cycle of care for something like an acute injury.

So, if you have an ankle fracture, there is one payment that goes to the specialist for taking care of that entire cycle of care from beginning to end. And if it's a chronic condition, like osteoarthritis of the knee, that it would likely be, you know, for a defined period of time, for up to a year, but that could include surgery, not surgery, all of the other evidence-based treatments that we would actually use in the care of that chronic condition.

Next slide.

And so, you know, why do I think these are the best -- you know, at least the best model for taking care of musculoskeletal conditions? So, you know, the ACOs have really matured at the primary care level, and many are, you know, improving this enhanced coordination, but they have challenges when they are trying to create transformation around specialty care.

They are kind of stuck in this world of, you know, do I hire my own specialists and try to manage them from within, and that kind of

thing, whereas I think a payment model can solve a lot of those problems. They can allow people to voluntarily participate, their right to specialists who want to be involved in a health-focused population health approach and allow them to interact with those primary care providers.

So there are multiple different types of stakeholders who can provide high-value musculoskeletal care, but I would really, you know, and I guess our profession would also suggest that unless you can provide the full spectrum of evidence-based treatments within the entity that is taking on a condition-based bundle that you're not really doing that job.

And so orthopedic surgeons are required to at least be part of these teams or lead these teams because we spend the most time in musculoskeletal training and are set up in a position to create models that we'll deliver for our set -- for this set of conditions in musculoskeletal care.

Next.

So just to give you a flavor of what I'm talking about -- I'm sorry, I thought I was going to have a pointer. But if you think about -- of a normal patient who is in one of our

models who is 68 years old and having pain in their knee, you know, where do they go?

They often go to their primary care doctor, which would be the appropriate place to start. Some go directly to an orthopedic surgeon. Some go directly to a physical therapist. And, as you know, they all bounce around this system where unfortunately there are a couple of major issues.

So one of them is that none of these people talk to each other. So there's no incentive for us to have that coordination. There are no mechanisms for us to really have that coordination. But what's most concerning about the current state of affairs is that the suite of treatments you're offered for this problem of, you know, knee pain in a 68-year-old is very dependent on where you decide to enter the system.

And so we do feel that, you know, having these types of payment models is going to allow the creation of patient-centered models of care for musculoskeletal disease, so -- such as the one that we've created in Austin, which I spent the last nine years of blood, sweat, and tears trying to create, is really a

musculoskeletal team that is set up to support the care of the primary care physician.

So our primary care colleagues are trying to take care of -- they're the captain of the health ship, and we can take this portion of the musculoskeletal care and deliver it in a high-value way in conjunction with them. And so it just requires a condition-based payment model to do it.

But by pushing that patient at the center, you can have the appropriate team for dealing with that musculoskeletal condition, and you can surround them with the appropriate services to make sure that we follow through and deliver on that care, and that's really what we're talking about.

Next slide.

And so, you know, just as a global look of how this would be, instead of just nesting a few condition models, such as, you know, surgery-focused bundles, we're suggesting that we back out to another layer and saying there are certain conditions that need to be moved over to a separate payment model, so that we can exist within current ACO structure.

Next. Thank you.

And this is just a very global look at what something like that might look like, as we have experimented with here in Austin, is, you know, like a knee osteoarthritis bundle.

And so the patient, once that diagnosis is established and they're referred into our team, the patient's treatment path is not dictated by whether they have surgery or don't have surgery, or whether they engage with physical therapy or not. Out team takes responsibility for the outcome of the patient and the resources that we utilize to achieve those outcomes, so that we can behave in an appropriate evidence-based and value -- high-value way.

And so, for example, the patient on the top line, you know, we're measuring patient-reported outcome measures at the first visit, and then again at six months and again at 12 months, and in between when we need to, but those reporting times are a way that we can say to the payer, "Hey, here's what we're doing for your population in terms or improving their functional outcomes and pain."

And then, whether they're on this path where they go into surgery, you know, whether they try physical therapy and then have surgery,

all of the follow-up is contained within this, and so that path is one segment.

But we're not disincentivized from doing the path at the bottom, which is to do appropriate imaging, actually surgery is not the best thing for this patient, but we still want to produce a good outcome for them, and so we're tracking that, and we're reporting it back to you.

And if you have a pathway like this, then the incentives actually fall on creating a better outcome for the patient no matter what treatment you use.

Flip to the next one?

And this is just a way -- this is a lot to throw at you in a short time, so if you just focus on the left side of the slide, so this is using a patient-reported outcome measure around hip pain. So this is the hip osteoarthritis outcome score. So zero is the worst pain imaginable, and 100 is the -- is a perfect hip.

And you can see that -- so on the far left at baseline, the population that came to see us within these two years had a pretty low score, in the 40s on average, and then at six months,

and then at 12 months, were able to report back to the payer, "Hey, we've improved the population on average this much and this much."

And if you look at the white and gray bars, we broke down into patients that were treated with surgery and patients that were treated without surgery. And when you look at this you would say, "My goodness, you almost got the same outcomes in patients treated non operatively as operatively." But that's not what that says, right?

What that really says is, "We're really, really good at figuring out who needs surgery to get better and who doesn't need surgery to get better." And that's the kind of behavior that you want to incentivize, and it takes a condition-based payment model to do this.

If you just leave us in a fee-for-service model, then of course we're -- you're only paying attention to the ones who need surgery. So this is just an example.

Next one, please?

And so just as a suggestion, we've got some templates for how we'd like to work with you on creating these type of condition-based models, but we're basically saying that, you know, an

episode price that includes the historical population treated by this entity and, you know, the relevant services that have to do with the treatment of musculoskeletal conditions would be the baseline of like, okay, we're going to set the target price for the year.

And when that patient comes into this practice, this is how we would pay, and that includes, you know, surgical professional fees and that type of thing, and we can adjust it for a patient population that traditionally was very high volume of surgery versus not. There is lots of ways to do that, but we try to include everything in that bundle.

And so all of the related care that needs to be provided and evidence-based treatments for osteoarthritis or, you know, you can talk about other conditions as well, and then appropriate, you know, withholds for reporting on patient-reported outcome measures.

So the success doesn't -- is not reported on, what are the volume of patients that you saw or what are the volume of visits that you did, but what are the outcomes that you're producing, and it allows the providers to behave in a -- in a high-value way.

We're going to spend longer with that patient at that first visit getting them on the treatment path. We're going to be incentivized in making sure they're doing their physical therapy. We're going to be incentivized in helping them lose weight if that's their treatment plan.

So it allows the creation of these condition-focused teams because the payment model incentivizes us to do so, just as some -- in the primary care side, some of our colleagues were sharing earlier.

And then, you know, we suggest that, you know, of course these would be voluntary models, and there are going to be entities who are going to be wanting to be very involved in these. And they're going to be the ones that step up, and then it becomes very easy for the ACOs to decide who they want to work with on the specialty side, because there are teams that are set up to deliver on these models.

Next.

So thank you for letting me kind of throw that at you, but I'm here to really talk about and discuss with you some paths forward to creating better interactions between specialists

and ACOs to allow both of us to behave in the way that we want to to create better health for the population.

Thank you.

MR. RAMACHANDRAN: Thanks, Karl.

Let's get some questions from the Committee members. Henish?

DR. BHANSALI: Thanks so much for that. A couple of questions. So, Sanjay, you mentioned outcomes versus process metrics. And when we take a look at Medicare Advantage versus ACO REACH versus MSSP, I think REACH is probably the closest to outcome measures. What are the sort of outcome measures you would want to see across Medicare products that would align more and more with population-based sort of cost of care improvements?

DR. SHETTY: I think fundamentally it starts with total cost of care, right? And ensuring that you've set that up appropriately, so you're not paying someone to, for example, do the post-acute visit in the office, but rather make sure they have the access to actually avoid the readmission, which is really what we're trying to do as opposed to just do the process step.

And so for me that's where it starts. I would say beyond that, I think we've started to dabble in what matters, right, which is the actual control of the blood pressure, not the adherence to the medication, et cetera.

So my first and foremost would go to total cost of care, and then beyond that.

MR. CAVANAUGH: If I could just supplement that. So take Medicare Advantage Stars for instance, they have both the medication adherence and the outcome, which is -- should be unnecessary.

Similarly, there is a lot of transition of care-type measures in MA Stars, where we'd rather see them judge us based on ED admission rates or inpatient or readmit rates. The outcome you are trying to affect through the transitions of care rather than the process of the transition.

DR. BHANSALI: So can I maybe just ask a follow-up around that? When we're taking a look at utilization rates, right, specifically, as you're -- as we think about creating metrics for utilization rates, I mean, that has always been a tricky thing to do, is that, how do you create a metric of a reward on that? And

shouldn't that already be covered in that total cost of care component of things?

And so both from you and from those on Zoom, would love thoughts on that or what other incremental outcomes-based metrics can be.

MR. CAVANAUGH: I think you raise a very fair point, and I takes MIPS[30], for example. MIPS has all of these subcategories of spend metrics that if you're capturing total cost of care, what's the point?

We would be willing to even forego some of those, you know, utilization metrics because total cost of care is in place. But, you know, we're having trouble getting rid of the process measures, so we're trying to go one step at a time.

CO-CHAIR PULLURU: Next we'll go to Lee for questions.

CO-CHAIR MILLS: Thanks so much. Great discussion. It's got my wheels turning for sure, so I'm really interested. I appreciate the, you know, first I think really granular elucidation of how a specialty condition type value-based model can work nested within a primary care population-focused model, and I'd

30 Merit-based Incentive Payment System

like to try to flesh that out a little bit more with the group.

So my questions about that are, you know, I appreciate your diagram on page 4. Are we considering this, you know, a specialty condition nested model, like your example, you know, related to knee pain? Or is it a one-step broader all musculoskeletal conditioned nested model, right? So it's knee pain now, and it might be back pain in six weeks. Is that same thing or two different -- two different episodes in your mind?

Secondly, does this only work in a population-based total cost of care model where essentially the risk owner ACO, for instance, is receiving full capitation, they're offering a sub-cap for a musculoskeletal model, or is there a way this can operate within MSSP somehow?

Then next would be how -- where do you draw the line? Meaning is this -- does this only work for the three most expensive -- the conditions affecting the three, you know, most expensive specialties in -- in the total cost of care population-based population? Or is there some other metric you'd think about where you'd draw that line to divide up the sub-caps?

Thank you.

DR. KOENIG: No. Thank you. Fantastic questions, and these are the ones that I -- I spend a lot of time thinking about.

I think the reason we have been most focused on something like one condition to get started has been that it seems very, very daunting to anyone that we talk to about, you know, changing the structure of the way we deliver this and, you know, sort of paying almost -- you know, paying on outcome rather than, you know, than paying for individual services.

So I think, you know, personally that it could very easily lead to a sub-capitated model for all musculoskeletal care. And actually, there are many orthopedic surgery practices. They tend to be the base, but they usually end up being multidisciplinary musculoskeletal practices if you really look at it.

There's primary care sports medicine physicians, there are, you know, rheumatologists, there are podiatrists, all working together in these practices. They are kind of based around orthopedic surgery practices, but I think any of them, and ourselves included, would be very

interested in a sub-capitation of musculoskeletal spend, because -- and not to denigrate any of our primary care colleagues, but, you know, we find that our rate of ordering advance imaging is lower because this is all we do, and we're very focused on it, and we know when it's going to affect the treatment decisions or not.

Our willingness to engage in certain, you know, non-value-added care prior to certain procedures is going to be less. So we -- we feel very comfortable managing that musculoskeletal spend, so you could go up to that sub-capitated level. It seems like the world wants to start with, you know, some conditions to kind of feel it out, but, no, I definitely think that's an important one.

I think in terms of, do we only do this for the three most expensive specialties or whatever? I think it's an interesting question. I think of course -- I think everyone wants to be involved, but there are even certain parts of our world which may never be able to fall into this, such as, you know, a musculoskeletal tumor, right?

It's -- those patients have no homogeneity. It may be nearly impossible to try

and do that, so that may also always need to live in some other model. But it's pretty narrow for us, so I think one metric to use is, does that specialty have a lot of things that can't fit? Or does it have just a couple things that can't fit?

So for musculoskeletal, almost everything can fit, other than things like tumor, maybe certain kinds of inflammatory conditions that -- you know, from birth or congenital conditions. But almost everything can fit, so that's when I would say this is a good place to start.

But also, the ability to measure outcomes that matter to patients, so using patient-reported outcome measures is something that we're very, very comfortable with, have been doing for a very long time, and we're actually comfortable measuring our results based on that.

And so we actually have a metric to put in that numerator of the value equation, which I think, you know, may be true for others and different ones for that.

So I don't know if I missed one of your questions. There was -- it was a very complex question, but that's how I would start.

CO-CHAIR PULLURU: Anybody else?

DR. SHETTY: Yeah. Maybe if I could add, I would say at CenterWell we are probably at multiple stages of our learning journey on exactly this point. We have the full range, so we have some cardiologists that are employed in part of the CenterWell practice because we found that the need for true value-based cardiology was important, and that we could embed it within the practice and improve access and also improve that alignment.

We also partner with -- we look at our entire specialty network and are very much thinking about, who are the high-value specialists out in the universe to whom we would promote referrals? Say, hey, we believe a referral to this doctor is the right place to go.

And so we work actively with our primary care providers on helping them understand the differences between the providers that may exist. Very hard to tell if you don't have access to that downstream data in order to understand that.

And we are contemplating partnerships with, you know, companies in the value-based care space that are focused on specialty care. I

think the considerations that we're bringing to the table are very much who is at risk for engagement in a particular model, right? Who is at risk for leakage if you -- if a patient decides or is referred outside of that particular partnership, and then something you referenced just now, which is, where do you draw the line, right? Is it Part B? Do you add hospital? Do you add imaging? Do you add drug spend?

And where does that line get drawn? And then around what conditions, such that you can create a meaningful arrangement, that you can have a partnership as opposed to a mechanism through with someone can try to essentially -- I wouldn't say it this way, but game the system, right?

It's amazing how you can control costs here, but it's a balloon squeezing. You're squeezing here and seeing it pop in other spots and just happened to not be responsible for it. And so we're very much on that learning journey of, how do we develop these relationships that we believe can be sustainable for both sides and deliver on that promise of improved experience, quality, and outcomes?

CO-CHAIR PULLURU: Sean?

MR. CAVANAUGH: Similar to CenterWell, we're experimenting with a lot of things, but I want to put my CMMI hat back on. And one of the things I would caution is, I mean, this is obviously -- what Dr. Koenig is describing is where we're all trying to get to.

There's a technical component to this that's very hard to overcome, which is small numbers. So even when CMMI ran these models and had much larger numbers, they struggled to price right, you know, based on historical data and projections, and so forth. When you get to a much smaller unit of service, like an Aledade ACO, which has only 20,000 lives to start with, the numbers get even smaller. The stability of the prices and the fairness starts, and the margin of error grows, and it's just technically difficult as well.

CO-CHAIR PULLURU: David, did you want to weigh in?

DR. MUHLESTEIN: I'll just mention that with the -- one of the challenges that I view with all of this is, I mean, it's this -- what has been brought up, what's in, what's out, and how do you say, if you're doing a condition-specific bundle or a conditional-specific model,

how do you decide if the total cost is related to that?

And I think that that can be addressed in two ways that could be considered. One of those is just doing full risk adjustment. So if you create a psychiatric model -- so if somebody is -- has the condition, you're going to manage them with psychiatric specialty, but they also have heart failure, you'd say, "Well, there is just a risk score," where we'd say, "The expected costs are higher."

This is the same risk scoring that happens in Medicare Advantage, and you could build that into that model. So you say, "Yes, you are being assigned based on this principal diagnosis. But because of your comorbid conditions, you're going to have a higher risk score, and that's going to adjust for it."

Another way that you do this is you just do either kind of a stop loss arrangement. This is what they already do at the MSSP where if you're above the 99th percentile for Medicare beneficiaries, those costs don't accrue to you, so you could figure out what that kind of stop loss might be or just say that if these are non-condition-specific those costs are excluded from

the total cost of care.

But I think there is -- it's a challenge to do that. I don't think it's impossible. People thought that it was impossible to come up with DRGs[31] and have a set of diagnoses for hospitals. But it's probably that level of effort to kind of do condition-specific carve-in and carve-outs. But I think it's doable.

DR. KOENIG: Yeah. And I would agree. I do not -- I do not underestimate the amount of effort that this would take, but I think, unfortunately, I mean, we're lacking a way to engage as specialists. And I -- I guess I'm speaking for other specialists who aren't here, but this is my whole interest, is trying to engage with ACOs and trying to create a better, healthier population.

I'm not the average orthopedic surgeon in that regard, but having a payment model that's just in fee-for-service is making -- doesn't make any sense. And I agree with you, the risk -- risk adjustment is absolutely key, right? We would love to get to a world where the most difficult patients are the patients you get paid

31 Diagnosis Related Groups

the most to take care of, right?

At the end of the day, then that takes away this disincentive we currently have to have people engaged with those. And, you know, working in an academic center, obviously, I see a lot of those patients.

But I do think that, you know, taking some piece of this and starting down the road, you're going to find a lot of engagement from, you know, the orthopedic surgeons, and I think many other musculoskeletal specialties, we recognize that, you know, we are getting into a very, very technical world where we're just doing small parts of this, and the only levers that our primary care doctors have is whether or not to refer patients to us.

And I am, truthfully, very worried about people being rationed, right? You're not going to get referred to the orthopedic surgeon until it's the last possible thing you can do. And if we didn't do so many interventions that improve patients' quality of life to such a degree, then I could understand that. But, you know, many, many patients are going to have a much healthier active lifestyle if we can get them treated appropriately.

So that's why, yeah, we're trying to build a bridge here. I agree.

CO-CHAIR PULLURU: Thank you.

I'm going to go next to Larry.

DR. KOSINSKI: Great set of presentations. The gears in my head are spinning.

I have just a technical question for David. On slide 11 where you showed the country and the states were all various colors, and I was struck by Wisconsin, which is dominated by health systems. And they were one of your reddest states.

I wonder if you overlaid health system dominance in an area on that map to see if that was driving some of the variation, because a lot of these physicians would gain access to those APMs by their participation in the hospital network.

DR. MUHLESTEIN: Yeah. So I can't talk specifically to Wisconsin, because I don't remember off the top of my head, but I can say generally we've looked at how dominance in a market does influence this, and it's kind of bimodal. It either makes it happen or not happen within markets.

And, generally, it's the gorilla in the market. If the gorilla starts to do something, everybody else responds to what they're doing. If the gorilla in the market says, "We are moving towards value-based care, we're going to move all of our patients -- or all of our physicians out of MIPS and into AAPMs," then everybody else in that market also creates their own strategy to do the same thing.

But, on the other side of the coin, if they say, "No, we're not -- we're good with fee-for-service," they're not the incentive. So they have that potential to do it.

I used an example of the two Rochesters. So Rochester, Minnesota, has over 90 percent AAPM participation, and it's not just Mayo. It's all of the systems that are there that have now moved towards this value-based model. Rochester, New York, is one of the lowest metropolitan areas, and those systems there, nobody has said, "We're going to take that first step." And if you don't have that kind of seeding event, you don't see the market level adoption.

CO-CHAIR PULLURU: Leave it to Larry to find one slide and one picture.

Walter?

DR. LIN: I also want to thank the panelists for a really great discussion, a lot of thoughts as well for myself.

I also want to thank the PCDT team and ASPE for convening kind of this particular panel in this way, because I feel like there is a great balance between both specialty engagement in total cost of care models as well as primary care-based models.

I'm going to ask my question first, and then I'm going to give the context for my question afterwards. So I'd love to get Sean and Sanjay's reaction to what Karl just presented, you know, like specialty nested condition-specific bundled payments essentially within population-based total cost of care models.

From a more philosophical perspective, I think, you know, earlier you guys spoke about some technical issues. Philosophically, how do primary care-based total cost of care models feel about something like what Karl presented, right? Because I could see it both ways. On the one hand, it is attractive to potentially carve out some risk and have the specialists take it. But on the other hand, I can also see how that might

make it harder for primary care-based total cost of care models to survive.

We just heard this prior presenter in the prior session, Dr. Peña, kind of just talk about how hard it is already for MSSP to compete against Medicare Advantage and all of the different bites that other organizations are taking from -- from his apple, you know, to make it harder to work.

You can have a primary care provider, for example, who is very well-versed in orthopedic musculoskeletal conditions who can provide more advanced primary care in that area, joint injections, for example, that might be dissuaded from -- from doing so if they had -- if they had this carve-out, whereas other PCPs may welcome this kind of carve-out.

So what's your take on this?

DR. SHETTY: Sure. I mean, I think you outlined the concern right off the bat, which is I think there is a huge amount of value in continuing to explore these models. I think the ideal state, at least from my perspective, would be to create optionality for groups that are participating, right?

So we are luckily -- lucky enough to

be large enough -- and I'll correct one thing Sean said. So we do have our own clinics. We also have an enablement arm that is -- that is doing other stuff. But given that scale, we have the opportunity to kind of think deeper and to sort of think through all of the complexities of what these arrangements would look like. That allows us to sort of have some optionality.

And, frankly, a lot of these strategies are not national strategies, right? They are -- we are going down into markets because the market dynamic in each of these areas is very different. And so, from my perspective, that -- that variance that happens across the country makes it really important to leave open the optionality, right?

So maybe there could be a role to say, "Here is what a model could look like. Here's how we can make it easier for smaller groups to say I want to approach -- I want to think about whether orthopedic makes sense as a sub-cap." But not to mandate it, right, and not to force it, especially to not force it on a national scale of, hey, that might be perfect for me in Florida, but terrible for me in Georgia, for whatever reason, because of a local market

dynamic.

And so I think optionality is great, but I think you're absolutely right. I think more and more we're trying to think creatively around, how can we solve these problems, and forcing this on a group would actually reduce the innovation that's possible.

MR. CAVANAUGH: Yeah. So this is an area that gets incredibly complex, so let me start with the simple part. You know, there is very -- there is a lot of commonality among ACOs that are successful, and it's usually a primary care strategy -- wellness, prevention, and access, transitions of care, some wraparound services.

But if this is truly going to be the future of Medicare, it has to get the specialty care right. The reason you haven't seen more of it is I think what Sanjay was touching on, which is our models scale -- you know, we're in Malvern, Arkansas; we're in Los Angeles; like we're in very different communities doing the same thing.

When you get to specialty referrals, specialty payment, you can't do the same thing in every community. The availability of specialists

varies, the relationship of our primary care doctors to the specialists, so in Malvern, Arkansas, we can't shop specialists. You know, we're dealing with the people who are there, and they're probably great. You know, there's not any disparagement.

But to the degree you don't have choice, then the discussion of how to have a financial relationship changes greatly, so that's what we're grappling with. And as Sanjay said, it will be slower, it's technically hard, but what you'll probably see is rather than one approach that catches fire, you'll see a variety of approaches growing up locally.

I do think what Dr. Koenig laid out is sort of the conceptual framework that a lot of us use in our heads, but you'll probably see it morphing locally. I mean, in some markets, we would be happy just if our primary care doctors just switched specialists, right? Like, hey, Dr. So-and-so, based on the data, is better care, lower cost.

And then once you realize there is a lot of local reasons -- cultural, financial, and other -- that make that more difficult than it sounds, and that's before you even get into and

we're going to pay you differently.

So the -- so the pessimistic answer is this is really hard. The optimistic answer is it absolutely has to happen.

CO-CHAIR PULLURU: Anyone else? Okay. Jim?

DR. WALTON: Thank you. Thank you all for coming.

David, I wanted to say a special thank you. We used your slides. I had the privilege of presenting a lot of your information, and I was glad to meet you here today, so thank you.

In light of what David has shared with us, and kind of formed the foundation of our discussion, you know, part of the journey of this Committee is to kind of represent physicians and advise them on some technical issues. And I'm curious about, as you all watched -- especially Sanjay and Sean, as you kind of watched that data that David presented, and saw where we're still about -- penetration in the physician community, participation is fairly flat, and there is still half of the PCPs in America are, like, hey, this isn't for me, and you've created different models. And I appreciate you coming and sharing with us.

I'm curious about what you've learned, what your organizations have learned, and how you might be able to represent what you've learned with regards to the changing motivation of physicians to actually do the best -- the next best thing to actually drive value, quality.

And I know you presented -- Sanjay, you were heavy on the quality, but you didn't share with us on the -- on the cost savings within, let's say, your ACO reach, like how -- how the performance was.

And so I know that there are a few levers. We heard before you all got here yesterday some discussion about sharing -- for example, one of the levers was the sharing of savings, right? We heard Dr. Peña just a little bit ago talk about the difficulties down in the Valley about earning savings, and then distributing those savings, which is what I --what I was challenged with when I was running an ACO in Dallas.

And so I'm curious about where -- what you think is kind of the magic motivators for physician participation, number one, and then engagement, to actually say, "I'm buying into what you want me to do. I'm in an employed

situation now. I'm not necessarily in private practice."

And, Sean, you have more of the private practice perspective, and so I think you all would do nice bookends here for us to kind of give us some insights.

MR. CAVANAUGH: Thank you for the question. So, yeah, we largely deal with private practice, but we also deal with a lot of community health centers in which the management does the deal with us, but the practitioners themselves are often in an employment situation.

So the motivations vary. As I mentioned, you know, the early motivation was early adopters who are like, this is a cool new thing, there's an opportunity here, I was the first on my block to get an electric car, I'm going to be the first to be in an ACO.

As you move along that adoption curve to people who are less or more risk averse, then you get to the more negative motivation, which is, I'm going broke. I can't -- I need a new revenue model. I've already done the part where I see more patients, and I'm running hours in the day. I need to make more money per patient.

But even for them, there is a leap of

faith that 18 months from now, after I do the work, I'm going to get paid, so there's a cashflow problem.

But the reason we lose very few practices once they join us, and if we lose them, they tend to go off on their own or go with another enabler, is professionalism. They realize this isn't just a payment model.

This is a better way to practice. Because what do we have them do? We have them reach out. We make them more intelligent about bringing in patients who they are responsible for who in the past they just waited to come in. Now they're reaching out to them, but with some knowledge. They were just in the ED. They just got discharged from the hospital. They need a wellness visit.

We make them smart about transitions, so there's a professionalism that kicks in that's important, even regardless of the financial incentives. But we do run into, as you say, like there is the weird financial model, which is our ACOs tend to ramp up and get more and more savings, then CMS rebases us and the finances change.

And so running a small practice on

erratic checks that come once a year is very difficult, and that's another part of, like, completing the model. And to CMS's credit, they are testing a bunch of -- the Flex model, making care primary of trying to smooth -- or advance shared savings of trying to smooth that out.

On the CHC[32] side, we do have to -- we're dealing with employed physicians. What we see more there is, if you only get engagement on Medicare fee-for-service patients that are, like, we're here, there's much more a mentality there of, I'm here for a mission, I'm here to treat everybody the same, don't give me a strategy on 15 percent of my patient panel.

So getting Medicaid commercial contracts, so it more becomes their complete way of practicing is how you get engagement and buy in.

DR. SHETTY: Yeah. Not much to add. I would say from our perspective, so, I mean, on the cost side, you know, I have referenced in the senior-focused primary care, right? The outcomes with respect to hospitalizations, the ER, et cetera. So it is I think an important part of both the quality as well as the total cost of

32 Community health center

care outcome.

But I would say what our aspiration really is is we want to be the type of practice that clinicians want to work at. And supporting them in their work of the day to day I think is really important.

I think, Sean, you said it before, right? Fee-for-service has let down primary care. It is not sustainable to, in most cases, run a primary care practice the way that any doctor would want to run it and just live off the back of fee-for-service.

What value-based care does is it creates an avenue to actually be sustainable and to practice in a way that most doctors would want to, which is I care for my patient whether they're in front of me or not. I have a team around me, so that I don't have to worry about all the tasks that I didn't go to medical school to do, but which someone can help me with.

I bring in other experts to care for all parts of a patient, the behavioral health, the pharmacist, everyone else, where they're actually better at it than I am, and that's okay because my job is to -- is to care for them in the ways that I was trained as a physician.

And so for us that itself has been an incredibly powerful motivator in terms of attracting people into our model of care, because we are sort of keeping the promise of, hey, their value-based care is not just the payment at the end of the year or the year after. It is -- it is investing in all of the work that has to happen along the way, and that is a better place to work.

But I agree with what Sean said, right? For the practices that we support, even within the clinics, right, there are -- we do create visibility for our providers, so they understand how they are performing. That itself is a very powerful motivator, right, for a lot of the docs, right? They were used to being A students, and they hate to see themselves on a list knowing that they missed a few screenings and they want to get them done.

And that is very helpful, and obviously financial incentives exist as well, both for the affiliate practices we work with as well as with our employed providers, just to help them really connect those dots in the day to day.

But for us, I think the most powerful thing has been the fact that the -- along with

the care model is -- sorry. Along with the payment model is a change in the care model and the practice model.

DR. KOENIG: And I want to add as well, Sanjay, because that is actually true on the specialist side as well. Like I get to work in this really unique place where we designed a model approaching population health, from that perspective, but I get to practice medicine the way I thought I was going to practice medicine when I went to medical school.

I take care of my patients. I call in help when I need it. We're not just there to do surgery. And, like today -- I just did a hip replacement on a guy yesterday. I called him this morning to -- not just because I'm worried about the ER. I called him because I want to see how he's doing, right?

And so it does allow you to do that, and I just would say that's why it's so -- even though it's going to be hard, it's so important that we do this together, because we have to get everybody behaving that way, and we have to allow the specialists a way to do so. So that's exactly why I'm here this morning. Thank you.

CO-CHAIR PULLURU: Larry?

DR. KOSINSKI: Well, Walter asked a question right after me and he got me thinking, so I'll give him credit for this. But I want to address it to Sean.

I wrote down a number of your statements because they -- they got me, you know? You need to dominate a niche market. CMS needs a marketing strategy. We need -- we need a statement that fee-for-service is bad for you. MSSP should be the chassis for VBC[33] innovation. You know, those stuck with me.

I'm a gastroenterologist, so everybody knows that GI[34] guys make all their money by doing colonoscopies. And it's a very low variation procedure, despite what the GIs would like you to believe. They shouldn't be paid more because they have a better, no. There's not much variation in there. It should be bundled.

But 50 percent of the variable cost of the entire GI space is coming from inflammatory bowel disease, a very expensive illness that only affects 1 percent of the population, but it's a major chunk of GI.

We've heard others in this meeting

33 Value-based care
34 Gastrointestinal

present -- and I love the term -- a subscription model for compensating providers. And we have also heard about a hybrid -- hybrid models where fee-for-service is combined with a low subscription model.

Have you experimented at all with compensating specialists for cognitive services for patients with chronic disease -- forget the colonoscopies -- but using any kind of a hybrid model or subscription model?

MR. CAVANAUGH: We haven't yet done that on the payment side. What we've done in several markets with very mixed results was more just what we called care compacts, where our primary care docs convened the local specialists and said, "Hey, I'm in an ACO now. This is the incentive I'm under, and I need -- you know, so I need to care about how you guys are treating my patients."

"So I'm going to be looking at data. And if you want me to continue referring, let's have a conversation about how you're going to care for the data, so that I can continue referring to you" as opposed to sending them to the other gastroenterologists.

But it has -- those conversations in

that model has had some sporadic success in certain markets, but hasn't replicated in other markets, and it hasn't grown to the payment side, though where it has worked payment has then come up, which is, hey, we're working together now.

Part of the problem is we're paid retrospectively. So, you know, the specialists -- not to generalize, but often the specialists are like, yeah, this notion of waiting 18 months and then taking a portion of an uncertain check is a difficult model. You know, I'm glad it works for you. Doesn't really work for me.

CO-CHAIR PULLURU: Anyone else have anything to add? Henish?

DR. BHANSALI: So this is to follow up a little bit on what Jim said. In thinking about the next addressable market, so we talk about it plateauing, and what is the innovator's, et cetera, the people who aren't the first electric car on their block, those are taken up.

Then I guess you have two options. One is fee-for-service just isn't working for me, and so I need something else. If you take a look at that group, right, I mean, primary care is able to flex quite a bit. It's that they're able to shift from the fee-for-service as a value-

based care structure much more easily.

Is that the next addressable market that's -- and then, how do we actually incent them to do that, other than creating a burning platform of "I have to do this"?

And I guess the second part of it is that the other systems that are there that have large, fixed costs, or, like, the infrastructure, I have the hospitals, I have the ASCs[35] that I've built, I have hired X number of specialists. I mean, they'd need to still be able to be sustained.

So how do we get -- how do we I guess think about models that would incent them, given the fact that they have fixed costs today?

MR. CAVANAUGH: I'm happy to go if no one else wants to go first. The fixed cost is a hard problem, but we -- I mean, I would -- the cause for optimism is when MSSP in its first couple years, all the shared -- all the true savings in the program came from physician-led models and net -- the hospital-led models or delivery ACOs were a net drain on the Treasury. That has changed.

The hospital-based ACOs, they're still

35 Ambulatory surgery centers

not performing the way physician-based ACOs have. But they are seemingly generating savings. So there is some cause for optimism.

We've seen multiple reasons for that. Some hospitals are full. So the notion of reducing admissions is consistent with their financial interest.

Some are -- would rather be full of commercial patients than Medicare patients which is we'll take the short-term win. But that's not a long-term solution. But going back to your original question which is really what we've spent most of our time thinking about. Where do we go next?

I still think it's -- I mean, you said Primary Care Flex -- but there's still a long runway in primary care. When I was at CMS and people were, like, oh, we could make MIPS really crappy and drive more people into the ACO models.

And I was, like, I hate to have any part of Medicare be crappy. So I was really reluctant to do that. Having said that, Congress did try to set up this dynamic where MIPS is not a lot of fun, or -- and I don't know they did this on purpose -- or very meaningful.

And that did drive some membership in

our ACOs. Unfortunately, and I've told CMS this directly, they've blurred those lines. A lot of MIPS requirements which ACOs were supposed to be exempt from have drifted into the ACO.

So you could reestablish that distinction that not only do we think this is good for you and you should do it, we're going to make it clearer through policy as well, less burden, more meaningful. The measures will be more meaningful. I can't tell you enough after time, like, our physicians want a couple -- time is a big thing they want.

But after that, that the work be meaningful. And they still -- we always sometimes disagree about what's meaningful. But on the ACO, they think the ACO quality measures have slowly eroded in meaning because, as I said, more and more of the MIPS type stuff is coming.

So make it more meaningful, more outcomes-focused. And I think you'll see -- and as I said, finish the model. Make the financial model clear and not unchanging but, like, established and get rid of the rebasing and the ratchet effects which I know your previous panel had Dr. McWilliams who has been one of the leading thinkers in this area.

CO-CHAIR PULLURU: Any --

DR. MUHLESTEIN: So --

CO-CHAIR PULLURU: Go ahead, David.

DR. MUHLESTEIN: -- an area where I think -- if you look at the next market where you could invest in models that would really impact the broader industry is in GME[36]. So when you look at graduate medical education, so academic medical centers where people are being trained, if they were being trained to practice in the value-based mindset, coordinated care, alignment among specialists and primary care doctors, all of these things that we've been talking about for decades, that sets their expectation of what medicine is and how it should operate going forward. They would then go out to work, and they would have an expectation.

And they would both seed ideas that are there. But they would also look for opportunities that are there. The slide I showed about how people that graduated from medical school in the '60s all had an expectation that they would hang their own shingle has played out for their entire career. People now say, we're going to go to a group. But if they said, we're

36 Graduate medical education

going to go to a group, we're going to practice value-based care, we're going to take care of populations, over time, I think that will make more of a difference than trying to get somebody that's got five years left in their career to switch.

CO-CHAIR PULLURU: Great insight. So let me end with just one more question and particularly directed toward Sanjay but everybody else as well. I'm going to switch to home health.

And given the position you're in with being able to put primary care with having a home health asset, as well as trying to coordinate that care, what payment parameters would be helpful in helping to further that in order to add sort of more efficiency in the care? And I'd love for everyone else to weigh in as well. And Karl, I know you guys use home health as well.

DR. SHETTY: Yeah. So for us, home health has been a really important part of how we begin to think about primary care differently. Our agency, the CenterWell Home Health, is a traditional skilled home health, right? So it really serves a subset of the population, maybe 10 percent, that really has a skilled need in the home.

We're broadening that focus to say there's a whole other group of folks that would benefit from some type of engagement in the home, whether it's addressing social determinants, whether it's a visit, whether it is post-acute engagement. And so broadening that has been very helpful. But we've had to innovate there on our own, right?

So we've created internal within CenterWell payment models in order to allow for that level of engagement in a way that is compliant and outside of the contours of traditional skilled episodes that are paid under the Medicare fee schedule. And so I think what would be useful in that setting would be to create alternatives or create other levels of service that could actually be useful for payers, ACOs, and others to engage with folks that are already out in the field, to provide the value-added services that allow us to achieve our goals on the total cost of care side. Right now, it feels like we've had to do it purely on the Medicare Advantage side where we have more of the levers of freedom to be innovative.

Have not been able to pursue that on the fee-for-service side because they're -- it's

so highly regulated. Frankly, this will be true more generally, right? If I were looking out into the future on what I really want to see is home health reimbursement should pivot to a value-based model, right?

It is still very mired in fee-for-service, very mired in regulations of minimum visits, et cetera, where, in fact, again, I don't want to pay for process. I want to pay for outcome. Keep them out of the hospital.

Don't worry about how many times you saw them in the home if you can replace home visits with other types of engagement that yield the same outcome. And so we're working on that in the short term, sort of within the sandbox that we have at CenterWell to sort of think differently. I will tell you the unlock has been amazing.

Having home health and primary care collaborating has turned into daily huddles where all patients on the home health service are being engaged with a primary care doctor daily. It is not just, sign my orders. See you in eight weeks. It is very much a different model of care.

And that's what's been most exciting

is to say it started with a payment model. It's turning into a care model and changing the way that our clinicians are engaging. And that's been particularly exciting.

CO-CHAIR PULLURU: Anybody else? Karl?

DR. KOENIG: I would just speak to it that it actually plays really well into a conditioned model as well because when we do surgery, we still want to do it in the most focused way. And certain things like unplanned surgery, like a hip fracture, for instance, in a patient with dementia, I think we've all seen our career that when that doesn't go well, right? You get the hip fracture fixed, and the patient ends up in a skilled nursing facility for a prolonged period of time. And that cycle just goes on and on.

And it's not even their fault. Like, that patient is better off recovering in their home. So you have a tight relationship with your home health providers and you can feel comfortable allowing them to go and recover in their home after certain surgeries, that's helpful. Or same thing for elective, like, joint replacement procedures, we've moved from 20 years

ago, half of those patients going to a skilled nursing facility to almost all of them now going home, some of them being supported by a home health service.

But when I have to make that decision, it is so much more helpful to have a partnered person that you're working with in a value-based contract. So I highly endorse trying to bring all of those folks into the fold. And it works well for us.

CO-CHAIR PULLURU: I'd like to thank all four of you for joining us this morning. You helped us cover a lot of ground, and it was an incredible session balancing each other out. You're welcome to stay and listen to the meeting as much as you can.

At this time, we have lunch break from now until 1:20 p.m. Eastern Time. Please join us then for the public comment period and Committee discussion. Thank you.

(Whereupon, the above-entitled matter went off the record at 12:24 p.m. and resumed at 1:31 p.m.)

*** Public Comment Period**

CO-CHAIR MILLS: Welcome back. At this time, we'll have our public comment period.

Currently, we have the pleasure of Ms. Florence Fee, Executive Director of NHMH[37], in person and present. If you'd like to go ahead and give your public comment.

MS. FEE: Hello, my name is Florence Fee. I'm executive director of NHMH which stands for No Health without Mental Health. Thank you for allowing me to make a brief statement.

So I represent the part of the public that encompasses mental health patients, families, caregivers, and mental health advocates, and we believe mental health policy makers as well. My main message to you this morning is that there's a critical need to reform our U.S. health care system to allow for the integration of behavioral health care as an essential, foundational component of high-quality accountable care relationships, including population-based total cost of care models.

If you have any doubt about this, just look at CMMI's record of the past seven, eight years where they've progressed from the CPC+[38] -- these are all primary care models -- from the CPC+ model to the Primary Care First model to the

37 No Health without Mental Health
38 Comprehensive Primary Care Plus

Making Care Primary to the IBH[39] model, all moving closer and closer to optional, then mandatory behavioral health integration. Currently, our health care system is living with a 40-year-old outdated anachronistic carve-out feature which separates mental health care from medical care in terms of care delivery, provider payment, and provider networks into completely separate independent systems. This may have made sense 40 years ago.

But today, in today's world with the prevalence of mental health care -- mental health needs as we have it -- is so high, 50 percent of the American -- U.S. adult population has a mental health condition. And half of them get no mental health care at all. So this carve-out system makes no sense.

It's hurting us terribly on an individual patient level and certainly at a population and societal level. It's resulting in poor medical and behavioral health outcomes for Americans, greatly increased total health care cost, and frustrated, burnt-out providers, as well as dissatisfied, sicker patients. And yet

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in its October 2024 RFI[40] to identifying a path to maximizing participation in PB-TCOC models, there was not a single reference to the essential critical role of the integration of behavioral health in Medicare, primary care, accountable care relationships, hence why I'm here today.

The field of science medicine and clinical care has over the past 30 years developed proven effective med/psych integration care delivery interventions. But they are not widely implemented or disseminated. What we need right now are increased financial incentives for practices that require accountability in order to build integrated care delivery into existing value-based payment models.

Secondly, we need consensus quality measures on behavioral health and behavioral health integration, including predictability and stability of these quality measures. Moreover, we need to involve patients, caregivers, and clinicians in the design of new behavioral health integration and care delivery models and in the monitoring of their outcomes. For instance, behavioral health integration models will need to be modified for different health systems and

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different health populations.

And we have repeatedly learned from past studies in model development that nothing is going to work unless patients, caregivers, and frontline providers are involved in the future. So this is not an aspirational vision for the future. It's an urgent, critical, present need.

We are living in the midst of a national mental health crisis where there is a lack of access to mental health, evidence-based mental health care, a grossly inadequate mental health workforce, and skyrocketing total health care costs due in large measure to the fact that there are so much untreated behavioral health conditions which thereby prevent or impede the improvement of chronic medical conditions and thereby escalating medical expenditures and hence total cost of care. So finally, I'd just like to say that multiple health care systems as you well know across the country have moved towards patient-centered primary care homes, ACOs, and prevention of 30-day hospital readmissions.

As they do so, they are realizing many of their highest-cost patients have med/psych comorbidity and that these health systems will have to integrate mental health care in order to

be successful in the world of value-based care and accountable care. So the ACA helped push the American health care system in the right direction. However, it's a bit like turning around the Titanic.

There are always vested interests that will fight these changes. However, the time for health care leadership, including amongst this group, for action, for reform and modernization of our national health care system to include the integration of behavioral health in medical settings is now. Thank you very much.

CO-CHAIR MILLS: Thank you very much. Appreciate your time, Florence. Now I will check in and just confirm. No other – there are no one else signed up to give a public comment. Is anyone else here present interested in public comment? No. Okay. Hearing none, I'll say that the period of public comment has ended and pass the baton to Jay.

*** Committee Discussion**

DR. FELDSTEIN: Thank you, Lee. As you know, PTAC will issue a report to the Secretary of HHS that will describe our key findings from this public meeting on reducing barriers to participation in population-based

total cost of care models and supporting primary and specialty care transformation. We now have time for the Committee to reflect on what we have learned from our sessions today and yesterday.

So Committee members, I'm going to ask you to find the potential topics for deliberation document tucked in the left upper pocket of your binder. And also, we know what to do if you have a comment. Just raise your name plate or raise your hand.

And then I know -- do we have our individuals? I can't see anybody on this screen. Josh is on? Okay. Oh, there we go. Great. So who wants to go first? And if nobody raises their hand or placard, I'll just call on you. So Josh, do you got a minute?

DR. LIAO: I have 60. No, yeah, I have a minute. I continue to extend kind of some of the things I said yesterday. I'll just carry them forward and maybe layer on some of the things I've heard from our subject matter experts today.

I think what I described yesterday about really not maybe -- addressing barriers is not to maximize necessarily participation as much as it is, I called it optimize. I think today we

heard about things like competition and really the goal being success versus competitiveness. I think those are related.

I think you're not going to be competitive if you're not successful or have the prospects of that. But I continue just to double click and underline that point that I think what we want to do is remove barriers to make this a viable option as a choice for Medicare beneficiaries, Medicaid beneficiaries, commercial beneficiaries, et cetera, across the country. So I think that just, to me, the conversation today underscored that.

The second point I appreciated is some of the -- the other point that I made yesterday about some of the trade-offs, the real ones we need to make today. We heard from a few speakers about how you can go into the market level and do primary care pretty similarly in those markets. But it's very hard to do that for a specialty, right? So I hope we as a Committee and others in the community grapple with this idea that if we want to scale and integrate, how can we do that with simplicity and avoiding complexity?

Or do we want to embrace in times of complexity because that's actually a requisite to

get some more specialists engaged? And I just think probably the only bad outcome here is to kind of not see any trade-off on the horizon. There's probably three that I see that are pretty big.

And I'll just cede the times the rest of the Committee members. I'm happy to maybe have a discussion about what I think those three would be. But I think today's conversations helped to kind of brightline that for me. And so I hope in future conversations about especially integration, about multi-payer, about scale up, again, within or across payers and purchasers that we keep these trade-offs kind of front and center.

DR. FELDSTEIN: Thanks. Larry.

DR. KOSINSKI: Well, in addition to what I said yesterday, probably the biggest thing that's going around in my mind permeated most of our discussions today. And I keep asking myself a question. It's clear that CMS doesn't really want the financial responsibility to continue the way it has.

But who does it want to bear it, insurance companies or providers? I think the theme that came out earlier today was you have a

Medicare Advantage. Well, that's insurance plans that are bearing the responsibility for the financing of care and treating the providers the same way they do in commercial plans on fee-for-service.

Or do we want MSSP with provider organizations that are actually bearing the financial risk? Or do we want both? Is that the new world that we're going to have both of those, no traditional Medicare but providers bearing risk or insurance companies continuing to bear risk?

And we were formed in the first place hoping that there would be a groundswell of providers coming up with value-based models. So I'm wrestling with this because I think if we want this to happen, then certain things have to be set into motion to make sure they happen. I want to say I'm very impressed with Josh's comment that came out at the end yesterday, and he brought it up again today about complexity.

That is something that should permeate our decision-making as well. If we want everybody on board, it can't be complex. It's got to be one size fits all which means some simplicity. I love Josh. That was fantastic.

One of the other takeaways I have is that we still don't have effective models, even from our best SMEs[41], nesting specialists into total cost of care models. We're still scratching the surface of this. We still don't have a way -- at least someone who has already implemented successfully chronic evaluation and management services for chronic disease performed by specialists in total cost of care models.

So that's still something that needs to be worked out. I said most of my other stuff yesterday. But those are my takeaways from today.

DR. FELDSTEIN: Well, and the only thing I want everybody to think about is -- and we'll get the written documentation of the entire session. What recommendations do we want to make to the Secretary to move this forward? So just keep that in the back of your mind as we go around the room.

And after maybe everybody does their initial impressions, we can come back to that if we want to. I think we're good till, like, 2:20, 2:30. So Krishna?

MR. RAMACHANDRAN: Yeah, thanks. A

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few things, I think my one takeaway for the first session was I think just us having to define competitiveness better because it felt like people are interpreting as competition being traditional, MA, and Medicare versus -- sometimes physician versus hospital. So I think, like, what are we actually trying to get a point on I think would be helpful, I think, for us to define. I assume it's largely a market-based competition, so sort of more MA was my initial definition when I heard about, like, be more competitive as opposed to competing between MA and fee-for-service providers, so just define an opportunity for us.

From an inside perspective, I liked when the panelists on, like for giving our value-based care during graduate medical education. I thought that was interesting -- like, how we make that the new model of education or at least include early in the process. I thought it was fascinating there.

And then from a smaller ACO, the sort of financial hurdle, making sure that's lowered as well because we obviously want more participation from independent providers. So those are the things that stood out for me.

Thank you.

DR. FELDSTEIN: We'll go to Lee and then Walter.

CO-CHAIR MILLS: Okay. These are just points that struck me throughout the two great conversations we had today. I'll try to put them together in a way that makes sense and kind of holds together. But first, I really appreciated the comment early this morning just about MSSP is the mechanism.

Maybe seeing my pilots are where we learn new things and test out theories. But MSSP is the chassis we're driving value-based care on. And that was, I think, powerfully said.

We did hear about -- there are ways we should think about making MSSP a bit more simple. There's the simplicity idea, whether it's possible or not. But at least make MSSP to those trying to operate within it perhaps more simple.

But then I was struck by that it's blurred with MIPS. We need to get back to the idea of making MIPS much less palatable and MSSP more palatable as an option to tip over to that magic 40 or 50 percent number that we've heard today. We did hear that regarding the comparison of MSSP and MA, each has two significant flaws

that could be fixed with policy choices that would make them stronger, first of all, for MA.

We want to fix the Stars bonus issues and the risk adjustment issues particularly that could be gained. And that goes towards leveling the playing field. And then for MSSP, we want to fix the constant ratcheting and regressing to the mean that takes away your savings. We need to address the 4 percent clawback to make that just more reasonable and then allow practices within an MSSP ACO structure to spin their savings in ways that make them more competitive to MA, like reduced deductibles or additional added benefits. I think those are all really smart.

I heard one of the speakers say -- while we're making policy choices, we're 20 years after American Board of Internal Medicine initiative. We should just not stop paying for low-value care, right? There is some care that shouldn't be delivered in certain combination and just make the decision not to cover it.

I did appreciate the comment about -- from Sean about where we are in the adoption -- the Gartner adoption curve that we've gotten the early innovators and the early adopters. That truly means we have to change fundamentally how

we're thinking about it, the words we use to describe it, the messaging, what the incentives are. That changes completely from early adopters to first half mainstream adopters. And I think that's really well pointed for CMMI to think as they go about their work and build initiatives.

We heard about -- again, about democratization and transparency of data. But that's not the goal. That's to enable more active choices so that we have more of an actual functioning free market health system that we don't have now. I thought that was powerful.

And then I really appreciated hearing -- two more comments and I'll end. But just hearing a good example of how a specialty conditioned-based model can nest within a total cost of care model. That was a great example and well thought out, and it's really got my wheels spinning.

I'm still not sure since in all honesty except for some MA plans that are full cap at risk and probably a small number of MSSP contracts that are similarly full cap at risk. There aren't many total cost of care models operating today that can do that model. So I think we need to think more on how can that work

inside an MSSP model that's not full cap at risk.

And then lastly, the brilliant idea someone mentioned about a model, the next best population to move to value-based care would be those in GME training and in how to build a model. And people that run GME training associations really hate how the funding is done and feel constantly straightjacketed. So, it may be a sweet alignment of forces that a model offering value-based, It would fundamentally change the culture of those being trained and allow for more or better funding for the types of physicians the community needs, where that's done. So I thought that was a great comment.

DR. FELDSTEIN: Walter.

DR. LIN: Thank you, Jay. So I also have a lot of thoughts. But I'll just make three hopefully somewhat brief comments about my impressions from today and actually one comment from yesterday that I didn't get to.

So, first comment, we've all heard for a long time now how unfair the playing field is between Medicare Advantage and traditional Medicare. I think today's first session just really highlighted that and made me understand how much worse it is. And it really is, how much

more unfair it is, and it really is.

And so, I just think there are things that MA can do through not only benefiting from the savings they achieve but the subsidies they get that traditional Medicare can't even under population-based total cost of care models. I think Dr. Peña made that very clear in his remarks today. And I just hope that we can continue to keep that top of mind because unless there are ways to level the playing field, it's pretty clear to me at least where all this is probably heading.

Second point, one thing that I just would like to highlight about Dr. Shetty's comments from today is the care model that he -- Humana has developed through CenterWell that supports the payment model. So this Committee is so focused on payment models as we should be. But it's a good reminder how in order to succeed in population-based total cost of care payment models, there needs to be a strong underlying care model to support that. And in CenterWell, he described the numerous high-access clinics, the home health services they provide, as well as the pharmacy that all kind of come together to provide the kind of care needed to succeed under

PB-TCOC payment models.

And the last comment I'll make is around specialty care transformation and integration. One of the kind of aha moments I had during yesterday's afternoon session was from Dr. Frank Opelka who mentioned this idea of episode compare, right? And so we're all probably familiar with hospital compare, CMS' website, CMS' website on nursing home compare in my world.

But this idea of episode compare or maybe bundled payment compare, bundles compare I think is fascinating. You know I think one way to engage specialists in value-based care is to have some sort of episode compare type idea out there where referring physicians can log on and see the value of care that their specialists in the area provide. I know -- I'm still a practicing physician.

One of the frustrating aspects of my practice is not knowing which specialist in my market are high-value specialists. And to have something like that would be really fascinating. And I just wanted to highlight that. So hopefully it gets into the report for the Secretary.

DR. FELDSTEIN: Jim and then we'll go back to Josh.

DR. WALTON: You know, I think we've made a couple of -- multiple times in the last couple days, I've heard this perspective that this is the Physician Advisory Committee around technical models. And I can't help but kind of reflect on the comments that some of the physicians that were on the front lines made. And it kind of strikes me over and over again, like, a lot of the doctors that are still practicing and what I remember when I was practicing was this notion of a social contract that we had with our patients and this idea of Medicare existing to do the most good for the most people.

And I think I agree that I think Josh calls us this question of simplicity versus complexity and can we get there from here with an aspiration of being simple. And the first thing I take away from this is that a lot of our colleagues that are trying to do this really important work of transforming the health care system in their lifetimes, over the practice lifetimes are really doing a lot of work around portfolio management of the payer sources that

they get in order to stay in business. And this is kind of how we got started with this meeting which is to get our heads in the game around what the business models are for providers who are caring for the -- are front line caring for the patients.

And the second component that seems to kind of play on this for me is competition and choice. The idea that our consumers, our patients need to be making active choices. We heard that today, and they need choices.

And so hence, we have MSSP which is the ACO for the fee-for-service population. And then we have Medicare Advantage which is de facto the ACO for the non-fee-for-service population. But to me, that's going to land in this larger economic issue which is the global budgets, a health care budget from a -- how much can the population be willing to pay for Medicare patients to get health care?

So, I think that's going to be a global budget, whether that's for MSSP or for Medicare Advantage. So, I think the products -- the way I'm thinking about it, the products for accountable care, value-based care, population-based total cost of care are kind of be both MSSP

and Medicare Advantage because that enables choice. That satisfies that one requirement.

And then the second, though, is that what we saw with the great research that our folks at ASPE and NORC did was that there was a disparity -- a geographic disparity in participation and penetration of ACO work in different regions of the country. And some regions were not getting the benefit of value-based care. And some regions were getting more benefit.

So, I think that kind of addresses this issue of quality. And so, when we think about cost and quality and the value proposition, I think that it's important for us to at least nod to this idea that there is geographic disparities in the penetration of participation. And I think that does lead to low- versus high-value care.

I think there is a distinction there. And I think that the evidence being shown as we heard earlier today that physicians -- and we heard this yesterday too that physicians are willing to change their clinical care model because it's more gratifying to practice medicine. And I think that is satisfying that

itch around the social contract.

And we heard that younger physicians and providers, non-physician providers, are moving in that direction. And they're satisfied -- or more satisfied with the health care delivery because they're working in a different care model. So policy options have to be on the table as far as what we recommend to the Secretary.

And I think, Lee, you identified some. I thought our last speaker of the public around integrating behavioral health has got to be one of the things that we write to the Secretary. That's got to be part of a policy option, whether that's incentivizing somehow that gets integrated.

So I won't reiterate the policy options that need to be kind of considered for strengthening MSSP which is our purview here. So I think that's -- the last thing I'll point out is that one thing I picked up with regard to quality is that we heard yesterday around patient goal attainment being one of the really key innovations that we might consider as a quality measure that's shared between all payers as we consider what makes a quality Accountable Care

Organization or a provider network. So I'll leave it there.

DR. FELDSTEIN: Lindsay.

DR. BOTSFORD: Yeah, thanks, Jay. I was reflecting, I think, on Lee's comments from yesterday around diffusion of innovation. It was interesting to see some of those themes picked up in our presentation today around taking a look at where we are in innovation and what population are we targeting.

The early adopters have all adopted, and we're trying to move a different group now. I think in our previous meeting, the concept of building within the MSSP to allow the continuation of programs below the surface. And that resonated again today around, you know we've heard themes around stability and the timeline of innovative programs.

But I'm wondering whether the frame shift is more around building on MSSP and having the innovation take place there as opposed to expecting people to come up with standalone models outside of that. If you look at even the proposals submitted to this Committee that have not materialized over the last few years, I do wonder if it speaks to a dwindling number of

people interested in separate payment models outside of the MSSP space and whether we've kind of tapped the well, so to speak. So I think the affirmed commitment that MSSP is where some of the innovation will happen and that accountable care models will be tested in that space might be the answer to some of what we've heard in previous presenters around the need for stability and certainty for planning for the future.

I think to Sean's points from today, that might also be one of the hurdles for attracting providers that aren't actually looking for major innovation. They're looking for the new status quo or the new normal as was referenced today. And maybe that also addresses some of Josh's concerns around complexity and not creating too many other programs and really just focusing and narrowing as opposed to continuing to expand.

We wouldn't want to lose track of the opportunity to innovate within the MSSP space and continue to solve problems that were raised and highlighted again today which I won't be -- so I do think the quality measures, some already spoke to. But I would just highlight continuing to move away from process measures, even in the MSSP

space. As we start to see more downside risk, will reduce some of the burden and I think decrease the barriers to the later adopters wanting to participate. Thanks.

DR. FELDSTEIN: Josh.

DR. LIAO: Yeah, when Jay says, come on, give us recommendations, I try to step to it. No, it's a great reminder, Jay. And I think just actually getting a chance to hear the other Committee members reflect, I mean, I go back to that idea of we heard from an SME today about how you can think of population-based total cost of care models doing different things.

But it's probably a better tool for certain things than others, right, lowering spending for an allocation under a fixed price or a fixed amount of spending. And so I kind of take that analogy and I think, what is the role here? And another SME I think I very much agree with kind of notes that there's this trade-off between accessing quality and cost.

I think you see that in the fee-for-service versus MA markets. So, to an early point from a Committee member, I think about competitiveness in that broader sense, not within a certain segment, I think across. And if I were

to kind of say this directly, population-based total cost of care models to me represent an intermediate point between that, those things, right?

The original entitlement of traditional Medicare is an open network, right? It's a uniform benefit structure. You can go anywhere you want.

The benefits of MA, supplemental benefits, but yet there are restrictions, network effects, prior authorizations, et cetera, et cetera. So that's a continuum, right? And I think population-based total cost of care models bridge that in some way.

So the real question for us is, do we think an intermediate offering, if you kind of pick up what I'm putting down here, is useful, I tend to think so. That would be a recommendation I would consider to make, that there is an intermediate that we need. And that intermediate needs to be based on the right goal and have the right value.

But if those things are both true, check, check, then we need to make sure it's competitive, right? We can't ratchet people down. We can't have a rebase. And we can't do

all these things.

We need to preserve that intermediate offering. And I'm not even saying there's three. This may be another thing to recommend that maybe there's work that we can do to kind of feather out, is it four, is it five? Someone made a -- or is it three?

Someone made a comment about MIPS. While I appreciate that MIPS is flawed in certain ways and you know I think the comment was about blending, isn't that in some ways what we want with a glide path, though, or a transition or a pathways or a step up to value? We want that in some ways, right? So, I think what we need to do, I think, for something like MIPS is we're using that tool for too many things.

We're using it for rate adjustments for everybody in the fee schedule. But then we're also using it for, like, non-advanced APMs. I think we need to adjust some technical pieces there.

But is there a fee-for-service? Is there a MIPS fee-for-service? Is there an APM built on the chassis of MSSP, the very specific, complex, but narrowly focused at market level, specialty integration models? And is there MA?

And is that world something we think we could do? I'll just leave that for the Committee's consideration. But one final thing I'll say is what that requires us to do is not try to overfit.

So, I think Jay actually had a comment about maybe this model is not right for some rural. I tend to agree. I think there are probably segments where we should not try to pull population-based total cost of care models over it because it's not the right tool for the job.

I don't think that's a defect in our system. I think that's a feature. And so those would be things I think we could maybe consider for recommendations to the Secretary.

DR. FELDSTEIN: Thanks, Josh. Chinni.

CO-CHAIR PULLURU: A couple of things that I wanted to sort of add to the conversation was you know I agree that during the course of these two days, in particular this morning, MSSP or traditional Medicare is not competitive with MA in so many ways. And the point of which is to create patient choice, particularly if that choice comes through MSSP or Medicare Advantage. How do we think about that choice in empowering patients?

So, one of the quotes that I found really elucidating was not what we pay -- there's two things. There's what do we pay for, and the other thing is what do we spend it on. So, you think about the financial model with the operational model.

And in a lot of ways, yes, MA wins in the financial model. But to be honest, it wins in the operational model, right, because there's creativity that can have a physician like Dr. Shetty and his organization be able to do what they did and reinvent the care design. And so and that's much harder to do, whether it be utilization or other things in traditional Medicare. And so that's even when you're taking risk. That's one of the issues.

The other thing that struck me was Dr. Shortell talking about low-value care being about 100 billion, possibly 300 billion. What it tells you is that as much as we struggle to find the pennies at the end of the trail, there's still money that is low-value care. And that's a lot of money.

A hundred billion is a lot of money. Three hundred billion is a lot of money. And so I think it's important to pull ourself back and

say we're fighting really hard to sort of find these pennies in these margins for patients who are very high -- very sick and high acute care. But there's still a lot of money spent on low-value care.

And then lastly, I'll say one of the coolest things was Dr. Koenig talking about orthopedics and some of the redesign he's doing and coming from a multi-specialty group where a lot of that was done in value-based care. The ability to maybe use the chassis we have and find a way to include specialists in -- and one of the things that struck me about that was we've all talked about there's obviously the bundles. And we've talked about nested models.

But having flexibility regionally or pushing that sort of flexibility down to the region when it comes to things like cardiology, orthopedics, or high specialties because specialty care is very regionally mediated in competition, right? Some places like Chicago, there's five different cardiology groups with 40 cardiologists, in each that one can pick from. You go to rural areas, there's two cardiologists, and they belong to the same group and you can't really pick.

So how do you make that work in value-based care? And so do you bundle that? I think that kind of flexibility that goes more regionally is really important when it comes to specialty care. And I feel like that's one of the things he highlighted.

And that's what also allows -- and then I'll end with one other thing is access. One of the things that comes from home health or telehealth and we speak about parity and we speak about the ability to do that. That flexibility exists in Medicare.

But oftentimes in the programs we're talking about, we don't assign a value to access. Time of first appointment, same day appointment, time of return appointment, time to specialty appointment, there should be a financial value in the delivery system that is assigned to access. And I gathered that from some of what the presenters earlier said.

DR. FELDSTEIN: Thank you, Chinni. Henish.

DR. BHANSALI: So I'll pull down maybe a little bit of what I've heard Josh say as well Chinni is to have that middle model from the fee-for-service to the fully total cost of care,

Medicare Advantage, something in the middle. You know we want that model to be viable and strong and minimize as many flaws as there are in that model to really enable better outcomes. We also heard that the next addressable market is the remainder of the primary care docs.

We also heard that there's a 13 to 1 ROI[42] and investment in primary care. So this may sound simplistic and maybe it is. But if there are folks in one of the middle models, ACO REACH, MSSP, et cetera, whatever it is, then can that fee structure be changed to increase the amount of money that goes to primary care, so on the fee-for-service chassis which is still within that construct?

Because just by doing that, there will be an increased interest in participating in these models. And then there are also multiple different conversations around conveners being a part of how a model like this can actually be adopted by the middle market. So not necessarily the early adopters but the middle adopter group, the next addressable market.

And I think one of the SMEs spoke about how there was 2 to 3 percent participation

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early on, and then now it's up to 30 percent participation through the convener enabler. There was someone -- another SME yesterday that talked about the vital role of enabler. And if enablers are working with both Medicare Advantage, as well as some of the middle products and they have a good amount of flexibility on how they can repurpose the monies that they're receiving, then you can actually put those two things together.

Improve the fee schedule which -- just by the nature of it will increase the amount of engagement with PCPs. Potentially have outcomes that are structured much more around -- or metrics that are structured much more around outcomes like utilization outcomes. Although if it's total cost of care, then it's not as necessary.

And then given that it'll create higher adoption having these conveners be able to structure payment, et cetera, to incentivize the right behavior to then drive those outcomes, that can create a competitiveness of this product while still creating a lot of the -- or still resulting a lot of the outcomes that we want and increase primary care investment and uptake. So

that's at least how I'm finding some of the things of what I've heard together.

DR. FELDSTEIN: Anybody else have any final comments before I turn it back to Lee? Okay.

*** Closing Remarks**

CO-CHAIR MILLS: All right. Thank you so much, Committee. Amazing meeting. We heard some really incredible and innovative thoughts and insights. And I think we've served up rich grist for the report to the Secretary I'm looking forward to helping craft.

I want to check with staff to see if there's any clarifying questions or other issues for the Committee. Okay. Seeing none, I want to thank everyone for participating today, expert presenters, panelists, my PTAC colleagues, and all those listening in on the livestream. We explored many different topics regarding reducing barriers to participation and population-based total cost of care models and supporting primary and specialty care transformation today.

A special thanks to my colleagues on PTAC. There was a lot of information packed in the two days, and I appreciate everybody's active participation and thoughtful comments as always.

We will continue to gather information on our theme through a Request for Input on our topic.

The RFI is currently posted on the ASPE PTAC website. And you can offer additional input to the questions we posed in that RFI up to the deadline of March 28th. The Committee will work on our report to the Secretary with our recommendations and the public input we receive.

*** Adjourn**

And with that, one final thank you to the Committee and all the expert presenters for joining us and making this a memorable PTAC public meeting. I announce the meeting is adjourned.

(Whereupon, the above-entitled matter went off the record at 2:16 p.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Public Meeting

Before: PTAC

Date: 03-04-25

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate complete record of the proceedings.

Neal R Gross

Court Reporter