

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

**March 7, 2022
10:06 a.m. – 2:29 p.m. EST
Virtual Meeting**

Attendance*

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

Paul N. Casale, MD, MPH, PTAC Chair (Vice President, Population Health, NewYork-Presbyterian, Weill Cornell Medicine and Columbia University)
Lauran Hardin, MSN, FAAN, PTAC Vice Chair (Senior Advisor, Illumination Foundation and National Healthcare and Housing Advisors)
Lawrence R. Kosinski, MD, MBA (Founder and Chief Medical Officer, SonarMD, Inc.)
Joshua M. Liao, MD, MSc (Associate Professor, Medicine and Director, Value and Systems Science Lab, University of Washington School of Medicine)
Walter Lin, MD, MBA (Chief Executive Officer, Generation Clinical Partners)
Terry L. Mills Jr., MD, MMM (Senior Vice President and Chief Medical Officer, CommunityCare)
Soujanya Pulluru, MD (Senior Director II of Clinical Transformation, National Health and Wellness, Walmart, Inc.)
Angelo Sinopoli, MD (Chief Network Officer, UpStream)
Bruce Steinwald, MBA (President, Bruce Steinwald Consulting)

PTAC Members in Partial Attendance

Jennifer L. Wiler, MD, MBA (Chief Quality Officer Denver Metro, UCHHealth, and Professor of Emergency Medicine, University of Colorado School of Medicine)

PTAC Members Not in Attendance

Jay S. Feldstein, DO (President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine)

Department of Health and Human Services (HHS) Guest Speakers

Chiquita Brooks-LaSure, MPP (Administrator of the Centers for Medicare & Medicaid Services [CMS])
Elizabeth (Liz) Fowler, JD, PhD (Deputy CMS Administrator and Center for Medicare and Medicaid Innovation [CMMI] Director)

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

Lisa Shats, PTAC Designated Federal Officer

****Via Webex Webinar unless otherwise noted***

List of Speakers, Public Commenters, and Handouts

1. Presentation: An Overview of Proposals Submitted to PTAC with Components Related to Population-Based Total Cost of Care (PB-TCOC) Models and Other Background Information

Lawrence R. Kosinski, MD, MBA, Preliminary Comments Development Team (PCDT) Lead

Handouts

- Agenda
- PB-TCOC Preliminary Comments Development Team Slides
- PB-TCOC Environmental Scan and Appendices

2. Listening Session on Issues Related to Population-Based TCOC Models Day 1

Michael E. Chernew, PhD, Leonard D. Schaeffer Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School; Healthcare Markets and Regulation Lab, Harvard Medical School

Cheryl L. Damberg, PhD, Principal Senior Researcher, RAND Corporation; Director, RAND's Center of Excellence on Health System Performance

Michael S. Adelberg, MA, MPP, Principal, Faegre Drinker Consulting

Chris DeMars, MPH, Interim Director, Delivery Systems Innovation Office; Director, Transformation Center, Oregon Health Authority

Handouts

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

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

Lawrence R. Kosinski, MD, MBA, SonarMD, Inc.

Handouts

- PTAC Member Listening Session Slides

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

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

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

Welcome and Overview

Paul Casale, PTAC Chair, welcomed members of the public to the March 7 virtual public meeting, which begins a three-meeting series of theme-based discussions on population-based total cost of care (TCOC) models.

Chair Casale introduced Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services (CMS).

CMS Administrator Brooks-LaSure began by referencing the Center for Medicare and Medicaid Innovation's (CMMI's) strategy refresh and related shifts in the design and testing of health care payment and service delivery models. She noted that CMS is working to incorporate stakeholder perceptions, including those of providers, into every phase of the development and release of CMMI models.

The Administrator explained that the Innovation Center's new strategic direction is based on five goals: 1) driving accountable care; 2) advancing health equity; 3) supporting innovation; 4) addressing affordability; and 5) partnering to achieve system transformation. She emphasized that CMS is especially concerned about health equity and will be embedding health equity into every CMMI model. The Administrator indicated that CMS views health equity as the attainment of the highest level of health for all people with everyone having a fair and just opportunity to attain their optimal health, regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

The Administrator also noted that CMS wants to ensure that the Agency's programs are operating to reduce health inequities, particularly in light of the Agency's recent review of its models which found that health equity was not always prioritized in model design, participant recruitment and selection, implementation, or evaluation. She outlined four ways that CMS is advancing health equity in its models: 1) developing new models and modifying existing ones to promote and incentivize equitable care; 2) increasing participation of safety net providers; 3) increasing the collection and analysis of equity data; and 4) monitoring and evaluating models for health equity impact.

The Administrator also highlighted three key principles that will guide CMMI's efforts to advance health equity: 1) any model that CMS tests within traditional Medicare must ensure that beneficiaries retain all of the rights that are afforded to them under traditional Medicare, including freedom of choice of all Medicare-enrolled providers and suppliers; 2) CMS must have confidence that any model it tests works to promote greater equity in the delivery of high-quality services; and 3) CMS expects models to achieve the objective of reaching underserved communities to improve access to services and high-quality outcomes. The Administrator stated that models that do not meet these core principles will be redesigned or will not move forward.

The Administrator indicated that CMMI is transitioning the Global and Professional Direct Contracting (GPDC) Model to the [Accountable Care Organization \(ACO\) Realizing Equity, Access, and Community Health \(REACH\) Model](#). She discussed how the redesign is intended to provide better care for individuals with traditional Medicare; and address stakeholder feedback, patient experience, and administration priorities—with a particular focus on the goal of creating a health system that achieves equitable outcomes through high-quality, affordable, person-centered care.

The Administrator emphasized that the ACO REACH Model builds on 10 years of experience with accountable care initiatives—improving the GPDC Model with new design elements and a more rigorous applicant screening process that will ensure that participants' interests align with CMS's vision for value-based care. She stated that the ACO REACH Model will strive for: 1) a greater focus on health equity and closing disparities in care; 2) an emphasis on provider-led organizations and strengthening beneficiary voices to guide the work of model participants; 3) stronger beneficiary protections through robust compliance with model requirements; 4) increased transparency and data sharing on the care, quality and financial performance of model participants; and 5) stronger protections against inappropriate coding and risk score growth.

To support equity, the Administrator noted that the ACO REACH Model will require participants to develop health equity plans that identify health disparities in their communities and ways to address them; use innovative payments to better support care and delivery of care coordination for underserved communities; select demographic and social needs data to monitor progress in reducing disparities; and expand access to care through nurse practitioners. Beneficiaries who receive care through the ACO REACH Model will receive help navigating the complex health care system and may have greater access to enhanced benefits and incentives, such as telehealth visits, home care after leaving the hospital, and help with copays. She highlighted that ACOs make it possible for traditional Medicare patients to receive greater support managing their chronic diseases, assist in the transition from the hospital to their homes, and provide preventive care services. The Administrator indicated that the ACO REACH Model will provide novel tools and resources for health care providers to improve quality of care, offer more predictable revenues, and will give providers more flexibility to meet patient needs.

The Administrator noted that CMS is committed to promoting value-based care that improves the health care experience for all enrollees through its health care delivery and payment models. She also emphasized that CMS is committed to strong partnership with the providers that participate in its models and continued collaboration with stakeholders. She also indicated that CMS looks forward to future collaboration with PTAC.

The Administrator introduced Elizabeth (Liz) Fowler, CMS Deputy Administrator and CMMI Director.

Dr. Fowler started by referencing the CMMI strategy refresh and discussed CMMI's vision for a health care system that achieves equitable outcomes through high-quality, affordable, person-centered care. She noted that CMMI's five goals that were reviewed by Administrator Brooks-LaSure guide its work and offer opportunities to coordinate more closely with PTAC.

Dr. Fowler noted that a central goal is to increase the number of people in relationships with providers that are accountable for their patients' cost and that are improving their care. She indicated that achieving this goal requires beneficiary access to advanced primary care and accountable care organization (ACO) models that coordinate with specialty care providers to meet the full range of patient needs.

She indicated that entities that can be accountable for patient care include physician group practices, hospitals, other health care providers, Medicare Advantage (MA) plans, Programs of All-inclusive Care for the Elderly (PACE) providers, and Medicare managed care plans. Dr. Fowler further explained that CMMI's goal is for all Medicare fee-for-service (FFS) beneficiaries and most Medicaid enrollees to be in a care relationship with accountability for quality and total cost by 2030. She emphasized that PTAC's theme-based discussion on population-based TCOC will help inform CMMI's thinking in this area. Dr. Fowler also explained that CMMI is considering incentives for specialists to participate in models that are focused on improving the referral process, reducing unnecessary referrals, limiting low-value tests and procedures, improving communications, etc., and empowering ACOs with the necessary leverage to engage with specialists.

Related to the second goal of advancing health equity, Dr. Fowler emphasized CMMI's commitment to embedding equity into all aspects of payment and service delivery models and increasing the focus on underserved populations. Dr. Fowler noted that stakeholders can help CMMI to improve collaboration with community-based organizations (CBOs) and other entities to increase the reach of value-based models to underrepresented and underserved populations. She noted that CMMI is interested in

understanding what financial supports and payment methodologies could incentivize and sustain safety net populations and help manage risk. Dr. Fowler highlighted a [Health Affairs article](#) by Dora Hughes, Chief Medical Officer of CMMI, which provides additional information about CMMI's initiative to advance equity. She also discussed an upcoming [roundtable discussion](#) on how CMMI can support safety net provider participation in value-based care and CMMI models that would be held later in March.

With respect to CMMI's third goal of supporting innovation, Dr. Fowler discussed some ways that CMMI could better support model participants, such as: helping providers to access actionable and practice-specific data, better technologies, dissemination of best practices, peer-to-peer learning collaboratives, and payment flexibilities.

Dr. Fowler then addressed CMMI's fourth goal of addressing affordability. In addition to reducing Medicare and Medicaid expenditures, Dr. Fowler stated that models should help lower patients' out-of-pocket costs. She indicated that that CMMI will be looking at strategies that target health care prices, affordability, and reduction of low-value or duplicative care.

Finally, Dr. Fowler referenced CMMI's fifth goal of partnering to achieve health system transformation. She stated that CMS needs to align its policies and priorities across the organization and work in tandem with commercial payers, purchasers, states, and beneficiaries. She emphasized that this is another area in which CMMI can collaborate more closely with PTAC.

Dr. Fowler noted that CMMI aims to create a more streamlined model portfolio and is prioritizing models that advance health care transformation through accountable care, advancing health equity, and care innovations.

Dr. Fowler recounted that CMMI has a long history of testing bundled payment models and that CMMI does not want to lose momentum from its current episode-based payment models and the care transformation observed in different specialties. She stated that there is a role for PTAC to help think through the integration of population-based TCOC and specialty care. Dr. Fowler thanked PTAC members for their work and for their continued support for health care transformation.

Chair Casale thanked Administrator Brooks-LaSure and Dr. Fowler for their remarks. He noted that since PTAC's last public meeting in September 2021, PTAC issued two Reports to the Secretary: one on optimizing [care coordination](#) and the other on addressing [social determinants of health \(SDOH\) and equity](#). Chair Casale noted that materials related to these topics, as well as other resources for designing payment models, can be found on the [ASPE PTAC website](#).

Chair Casale welcomed three new PTAC members: Lawrence Kosinski, Walter Lin, and Soujanya Pulluru.

Chair Casale reminded stakeholders that PTAC accepts proposals on a rolling basis. He noted that PTAC offers two proposal submission tracks for submitters allowing more flexibility depending on the level of detail that is available about their payment methodology. Chair Casale pointed to the [ASPE PTAC website](#) for more information on how to submit a proposal.

Chair Casale noted that one of the six pillars in CMS's strategic vision is driving innovation to tackle health system challenges and promoting value-based person-centered care. He also, specifically highlighted CMMI's goal for all Medicare beneficiaries with Parts A and B coverage to be in a care relationship with accountability for quality and TCOC by 2030. Chair Casale indicated that the

Administrator seeks to increase the capacity of providers to participate in value-based models with population-based payments and TCOC approaches. He emphasized that implementing this vision involves addressing numerous complexities, including definitional and structural issues, care delivery models, beneficiary attribution, and benchmarking.

Chair Casale explained that PTAC has looked across proposals submitted to the Committee and is holding a series of discussions during public meetings on population-based TCOC models. He further explained that these theme-based discussions will span three public meetings, each focused on a different aspect of issues related to population-based TCOC approaches. Chair Casale emphasized that the March 7 and 8 discussions will focus on key definitions, issues, and opportunities related to population-based TCOC models; the discussions will explore which services should be included when defining TCOC in the context of population-based models, as well as conceptual and structural issues related to model design. He also highlighted PTAC's particular interest in how to enhance provider readiness to participate in these models; how to structure population-based models (including payment mechanisms, benefit design, and patient assignment); how future population-based models might relate to episode-based and condition-specific models; how to create incentives for coordination between primary care and specialty providers; how these models will address health equity; and the role for multi-payer alignment.

Chair Casale announced that PTAC's June public meeting will focus on best practices for care delivery, improving quality, and measuring the success of population-based TCOC models. PTAC will invite physician executives and other thought leaders to discuss care delivery innovations and improvements that have the potential to improve quality and reduce TCOC. Chair Casale indicated that PTAC will explore performance metrics, data collection, and evaluation, and address behavioral health and SDOH.

With respect to PTAC's September public meeting, Chair Casale noted PTAC will focus on the payment considerations and financial incentives related to population-based TCOC models. He indicated that the discussion will include options for financing these models to incentivize care delivery improvements and provider participation, as well as issues such as attribution, benchmarking, risk adjustment, and moving toward downside risk. Finally, Chair Casale highlighted the [environmental scan](#) on population-based TCOC and other background materials available on the [ASPE PTAC website](#). He indicated that the series of three public meetings will culminate in a report to the Secretary with findings about best practices related to population-based TCOC.

Chair Casale provided an overview of the March 7-8 public meeting agenda by noting that the day's agenda will include presentations by subject matter experts (SMEs) on their experiences related to developing population-based TCOC models, as well as a Committee discussion. He further explained that the March 8 public meeting will include additional SME presentations, a panel discussion on definitional issues related to population-based TCOC, a public comment period, a Committee discussion, and announcement of a [Request for Input](#) (RFI). Chair Casale indicated that all background materials, presentations, discussions, and public comments are meant to inform PTAC on the latest knowledge from the field about the development of population-based TCOC models in the context of Alternative Payment Models (APMs) and physician-focused payment models (PFPMs).

Chair Casale invited Committee members to introduce themselves and their experience with population-based TCOC. Each Committee member provided a brief introduction. After introductions, Chair Casale introduced Dr. Kosinski, the March population-based TCOC PCDT lead who presented the PCDT's findings from the [background materials](#).

Presentation: An Overview of Proposals Submitted to PTAC with Components Related to Population-Based TCOC Models and Other Background Information

Dr. Kosinski indicated that the two other members of the PCDT were Joshua Liao and Dr. Pulluru. Referencing a slide presentation, Dr. Kosinski provided an overview of proposals submitted to PTAC that included components related to population-based TCOC and noted other highlights from background information. Between 2016 and 2020, PTAC reviewed 35 proposed PFPs, nearly all of which addressed the potential impact on costs, including at least 10 proposals identified before the meeting that discussed the use of TCOC measures in their payment methodology and performance reporting. Dr. Kosinski noted that the PCDT's presentation would focus on a summary of the characteristics of these 10 selected PTAC proposals that included components related to TCOC.

Dr. Kosinski presented a framework developed by the Health Care Payment Learning & Action Network (HCP-LAN) that illustrates the goal of moving payments away from FFS and into population-based payments. Dr. Kosinski pointed out CMMI's focus on comprehensive population-based payment models. He acknowledged that condition-specific substructures could be nested within more comprehensive models but reiterated the importance of emphasizing large, comprehensive population-based models. He explained that this will require increasing the number of providers that can participate in accountable care and TCOC models and increasing coordination between providers that are responsible for accountable care relationships and specialty care providers.

Dr. Kosinski indicated that a focus of the day's meeting is to define TCOC, which is characterized differently across APMs. He explained PTAC's working definition for TCOC in the context of population-based models:

- TCOC is a composite measure of the cost (e.g., the amount of reimbursement) for all covered medical services delivered to an individual group.
- In the context of Medicare APMs, TCOC typically includes Medicare Part A and Part B expenditures and is calculated on a per-beneficiary basis for a specified time period.

Dr. Kosinski emphasized that PTAC's definition of TCOC will likely evolve as the Committee collects additional information from stakeholders. He presented two different examples of TCOC definitions, from the Maryland TCOC Model and from the GPDC Model.

- The Maryland TCOC Model defined total cost of care as the aggregate Medicare FFS costs for all items and services, or a specific subset thereof, delivered to Medicare FFS beneficiaries. This Model includes only Medicare Parts A and B expenditures.
- The GPDC¹ Model defines TCOC as the average Medicare beneficiary's Parts A and B expenditures that will be compared with expenditures for aligned beneficiaries between a baseline period and a performance year.

Dr. Kosinski described PTAC's working definition of population-based TCOC models that the Committee is using to guide the theme-based discussion:

- A population-based TCOC model refers to a population-based APM in which participating entities assume accountability for quality and TCOC and receive payments for all covered health

¹ CMMI announced on February 24, 2022, that beginning in 2023, the GPDC Model will be redesigned and renamed the ACO Realizing Equity, Access, and Community Health (REACH) Model. The redesign includes important changes in advancing health equity, promoting provider leadership and governance, and protecting beneficiaries and the model with enhanced participant vetting, monitoring and greater transparency.

care costs for a broadly defined population with varying health care needs within a 12-month timeframe.

- Within this context, a population-based TCOC model would not be an episode-based, condition-specific, or disease-specific specialty model. However, these types of models could potentially be “nested” within a population-based TCOC model.

Dr. Kosinski discussed areas where there appears to be reasonably strong consensus on key characteristics of population-based TCOC models. This includes a model’s focus on facilitating accountable relationships for quality and TCOC; encouraging care coordination and integration of specialty care with primary care; improving patient experience and outcomes; helping identify and share best practices; using performance metrics to incentivize high-quality care; improving health equity; and aligning provider and beneficiary incentives.

Dr. Kosinski also pointed to areas where additional discussion is needed on important questions such as which services should be included in how models define TCOC; which types of organizations should serve as accountable entities including clinicians and other groups; the duration of accountability periods; minimum threshold on the number of covered patients; options for designing appropriate care delivery models; options for structuring payment models around TCOC; implementing technical aspects of these models including attribution, benchmarking, and risk adjustment; incentivizing participation in these models and facilitating transition to them; encouraging multi-payer alignment on model design components; and addressing overlap between models.

Dr. Kosinski also introduced the potential services that could be included in population-based TCOC models.

- Current population-based Medicare APMs often include accountability for Medicare Parts A and B expenditures, such as professional and facility expenditures for inpatient, emergency department (ED), and outpatient care. This typically includes provider-administered medications but not patient-administered drugs, which can be equally expensive.
- There may be an interest in including additional services in future population-based TCOC models. These services may include support for self-administered specialty drugs, behavioral health services, long-term services and supports (LTSS), home- and community-based services (HCBS), and screening and referral to address social needs. These additional services would promote patient-centered care and help address social determinants of health (SDOH).

Dr. Kosinski described the characteristics of 10 selected PTAC proposals that included TCOC components.

- The proposals were identified as having components related to TCOC in their payment methodology and performance reporting. Of these 10 proposals, one had an advanced primary care focus; three had a population-specific focus; and six had an episode-based focus.
- The 10 proposals varied by clinical focus and setting of care. Some of the proposed models covered multiple clinical foci and settings of care.
 - Six proposals focused on primary care; seven focused on specialty care; four were related to oncology; and three focused on chronic or advanced illness.
 - Eight proposals focused on primary or specialty care practices; six focused on hospital-based outpatient clinics; three focused on the patient home; and one focused on skilled nursing facilities (SNFs).
- PTAC has not received any proposals related to large population-based TCOC models.

Dr. Kosinski noted that the 10 selected proposed models were reviewed because they included TCOC-related components that aimed to reduce health care costs.

- Common cost reduction objectives in the proposed models included decreasing hospitalizations and ED visits, limiting costs associated with a particular episode of care, or avoiding unnecessary services and medications.
- Common cost reduction approaches in these proposed models included improving care management and financial accountability for TCOC through per-beneficiary per-month (PBPM) payments with two-sided shared risk (with some including a stop-loss provision) and performance-based incentive payments contingent on quality, cost, and/or utilization of care.

Dr. Kosinski noted that performance measures in these 10 proposed models varied across three domains: cost measures, utilization measures, and quality measures.

- Many of the proposals included TCOC for a specified group, episode, time period, or type of care component as a cost-specific performance measure. Additional cost measures included net savings/losses to Medicare and both supportive and maintenance drug costs.
- All 10 proposals included utilization measures related to TCOC, including number of ED visits, intensive care unit (ICU) days, and hospital admissions; unplanned hospital readmissions within 30 days; and medication-related complications.
- All 10 proposals included quality measures related to TCOC, including patient satisfaction, medication review, timeliness of care, comprehensive assessments and screening, and advanced care planning.

Dr. Kosinski discussed CMMI models and other CMS programs that have included relevant approaches to develop future population-based TCOC models.

- CMMI models and other CMS programs fall into three categories:
 - Population-based: MA; Medicare Shared Savings Program (MSSP); Pioneer ACO and Next Generation ACO; Accountable Health Communities (ACH); Maryland TCOC; and GPDC
 - Episode-based or condition-specific: Oncology Care Model (OCM); Bundled Payments for Care Improvement (BPCI) Initiative and BPCI Advanced
 - Advanced primary care: Comprehensive Primary Care (CPC) Initiative and CPC+; Primary Care First (PCF)

Dr. Kosinski described the current population-based models and programs.

- The care transformation strategy is based on shared accountability for quality and cost outcomes.
- Payment arrangements range from FFS to capitation and include bonus payments when costs are below a threshold.
- Incentives are based on performance bonuses for lower TCOC.
- Challenges include attribution, risk adjustment, benchmark setting, issues related to safety net provider participation, provider consolidation, and whether to include drug coverage.

Dr. Kosinski then turned to the current episode-based or condition-specific models and programs.

- Similar to the population-based models and programs, the care transformation strategy is based on shared accountability for quality and cost outcomes.
- Payment arrangements are tied to prospective payments that lead to two-sided risk for participants.

- Incentives include two-sided risk with benchmarks based on discounted historical spending and separate payments for care coordination activities.
- The models can be nested within larger population-based models.

Dr. Kosinski went on to highlight the current advanced primary care models.

- Advanced primary care models demonstrate differences from the other two types of models.
- The care transformation strategy is based on Patient-Centered Medical Homes (PCMHs).
- The payment mechanism is a combination of prospective population-based payments and per-visit payments.
- The incentives are positive performance-based adjustments based on comparison with the benchmark.
- One issue associated with advanced primary care models is that specialists and hospitals operating in a largely FFS system are incentivized to deliver high-volume, high-cost care.

Dr. Kosinski provided insights from selected Medicaid Section 1115 waiver programs.

- Care transformation strategies use accountable entities with a network of providers responsible for delivering all primary care services, coordinating care across the full spectrum of services.
- Payment mechanisms include various payment arrangements, such as episode of care, bundled payments, shared savings, and capitation.
- There have been mixed outcomes regarding cost savings, but there are opportunities for multi-payer alignment, and some of these ideas could transfer to Medicare.

Dr. Kosinski described encouraging findings on the effectiveness of population-based approaches in improving quality and reducing TCOC.

- ACOs with greater financial accountability are more likely to deliver better coordinated and efficient care for Medicare patients.
- Evaluations have demonstrated how these initiatives can reduce health care costs while maintaining or improving quality of care.
- Some programs have shown success targeting higher-risk, higher-cost beneficiaries where there is a greater potential for reducing expenditures and utilization.

Dr. Kosinski spoke to challenges related to designing effective population-based TCOC models.

- There is limited research exploring the relationship between TCOC and care coordination, as well as how models with accountability for TCOC impact health equity.
- There continue to be disparities in savings associated with various approaches for reducing TCOC. The approaches vary based on a range of factors, including geographic location, patient population, and provider readiness to participate in an APM.
- Several evaluations of APMs that include approaches for reducing TCOC have observed negative returns on investment; however, research indicates that investments in TCOC reduction approaches require time to generate savings.
- There continue to be questions regarding the impact of voluntary versus mandatory implementation of APMs under Medicare, and research suggests that mandatory models may pose challenges to provider engagement.

Dr. Kosinski suggested potential opportunities for improving multi-payer alignment:

- Multi-layered accountability structure or established governance with multiple payer participation and representation.

- Leveraging state-specific models to build upon existing value-based models and state-level delivery system reform initiatives.
- Providing technical assistance to ensure that commercial, MA, and Medicaid provider payment reforms meet the standard for Medicaid APMs and therefore qualify for bonus payment incentives.
- A key goal of multi-payer models is to bring a provider's patient panel under one set of common initiatives to align incentives, reduce administrative burden, and increase the business case for provider engagement in meaningful delivery system reform.
 - Some experts believe payer participation in multi-payer models can increase engagement in value-based payment models.
 - Examples of multi-payer TCOC models include the Maryland All-Payer Model, the Pennsylvania Rural Health Model (PARHM), and the Vermont All-Payer Model.

Dr. Kosinski identified areas where additional information is needed, including:

- A broader vision regarding the structural elements of future population-based models, and how they would compare to current models and programs.
- Services that are appropriate for inclusion in future population-based TCOC models in order to optimize patient-centered care.
- The relationship between broader population-based TCOC models and episode-based or condition-specific models.
- How to enhance provider readiness and incentivize provider participation in payment models with two-sided risk through innovative physician payment models, particularly for independent physician practices and safety net providers.
- Opportunities for addressing equity issues and incentivizing screening and referrals for SDOH.

Chair Casale invited Committee members to ask questions about Dr. Kosinski's presentation. Lauran Hardin, PTAC Vice Chair, asked whether the PCDT encountered any themes related to financing services related to SDOH and equity.

- Dr. Kosinski noted that if an entity is operating under full risk, addressing SDOH can decrease TCOC, but it is difficult to include financing for SDOH-related services in a model that does not include full risk.
- Dr. Pulluru added that there is a way to stratify risk to ensure that providers are compensated for vulnerable populations, which could be done in a way to help provider groups and systems fund services that address SDOH.

Chair Casale asked which challenges related to designing effective population-based TCOC models may be the most difficult to overcome.

- Dr. Kosinski suggested that the most significant challenge is bringing specialists into value-based care. He noted that while an increasing number of primary care physicians have experience in a value-based care environment, a vast majority of specialists are still paid FFS.
- Dr. Pulluru described another challenge related to implementing front-end investments, particularly for provider-based groups. She noted that health care systems operate on very low margins and many cannot make up front investments. These have a negative return on investment (ROI) in the short-term and it takes time to generate savings in TCOC models.
- Dr. Liao emphasized the importance of integrating primary care and other clinicians, particularly when considering accountability.

- Chair Casale agreed and noted that shared accountability as a concept can sometimes lead to no accountability. He mentioned that communication between primary care and specialty providers is one thing, but this does not alone confer accountability.
- Dr. Lin asked whether the PCDT found any innovative PFPs in its review of the 10 PTAC proposals with TCOC-related components, and whether there are ways of aligning physician behavior to achieve the outcome measures described in the presentation.
 - Dr. Kosinski noted that he would be giving a summary of Project Sonar later in the meeting, which is an example of a PTAC proposal that sought to align incentives to influence provider behavior. He also emphasized the importance of supporting providers' need to invest in infrastructure and process as they transition to population-based TCOC models.

Listening Session on Issues Related to Population-Based TCOC Models Day 1

SMEs

- Michael E. Chernew, PhD, Leonard D. Schaeffer Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School; Healthcare Markets and Regulation Lab, Harvard Medical School
- Cheryl L. Damberg, PhD, Principal Senior Researcher, RAND Corporation; Director, RAND's Center of Excellence on Health System Performance
- Michael S. Adelberg, MA, MPP, Principal, Faegre Drinker Consulting
- Chris DeMars, MPH, Interim Director, Delivery Systems Innovation Office; Director, Transformation Center, Oregon Health Authority

Chair Casale moderated the listening session with four SMEs on issues related to population-based TCOC models. He noted that full biographies and presentations for presenters can be found on the [ASPE PTAC website](#).

Michael Chernew presented on harmonized APMs. He specified that he would be speaking as a professor, not as chair of MedPAC.

- Dr. Chernew discussed his main theories on value-based payment, including that efficiency requires flexibility in how "inputs," or health care services, are used to produce "outputs" which he characterized as overall health of those receiving the services. Health care services include inputs such as hospitalization, imaging procedures, lab tests, and drugs. The goal for an efficient health care system is to produce better health with fewer inputs. He noted that the FFS system does not encourage flexibility because providers are paid for their inputs, rather than output. The goal of APMs is to lower costs, increase efficiency, and promote access to care, quality, and equity.
- Dr. Chernew emphasized the importance of identifying the type of provider best suited to eliminate waste in the health care system. He noted that while participation is not the main goal of APMs, APMs cannot succeed without participants. Dr. Chernew raised the question of whether and how to induce or mandate participation. He emphasized that no payment model is a silo, and therefore, APMs must work together. Dr. Chernew indicated that the delivery system is influenced by all the payment models in the health care system, and models must be able to function in their own unique environment.
- Dr. Chernew raised some of the issues with the "test and diffuse paradigm," in which many models are tested, and the ones that succeed continue to operate. The uncertainty about which models will continue discourages participation because participants do not want to make the

investments necessary to succeed in a model only to have that model discontinued. He noted that when many models are implemented at the same time, the resulting opportunity for potential savings for one model (e.g., a primary care population-based model) may be siphoned away by other models (e.g., episode-based models). In broader population-based payment models, if a portion of the waste that they are trying to eliminate is “assigned” to another model, such as an episode-based model, this reduces opportunities for the population-based model to recognize financial savings, reduces the impact of the incentive for the participant in the population-based model, and discourages their participation.

- Dr. Chernew provided an example of a model for treating congestive heart failure (CHF). If savings associated with more efficient care post-hospitalization were given to a hospital as opposed to being given to the cardiologists, cardiologists would be discouraged from participating in the model. When multiple models are operating, providers may choose to participate based on technical differences among models (for example, in how benchmarks are set). These technical differences result in credit for reducing waste being assigned to different participants. In this context, allocating the savings associated with reducing the waste that exists in the health care system should be viewed as an asset for some of the specialists.
- With respect to describing Medicare versus the private sector, Dr. Chernew indicated that private sector plans have more potential to achieve savings because they have the flexibility to adjust prices associated with services, while Medicare does not. He noted that Medicare does save costs from shifting care to less expensive settings (e.g., outside of hospital settings), but the savings are not as substantial.
- Furthermore, Dr. Chernew noted that sharing of savings with model participants reduces the overall savings for those paying for the services (e.g., Medicare). However, without the incentive of having access to shared savings, provider behavior is less likely to change to produce the savings in the first place. Dr. Chernew stated that while the impact of shared savings on quality or equity is unclear due to difficulties associated with measuring quality, it is possible that shared savings could result in either an improvement or no effect on quality.
- Dr. Chernew summarized how recent evidence shows population-based payment models reduce spending. He specifically noted:
 - Savings associated with a reduction hospital admissions, a shift from hospital outpatient department (HOPD) to office-based visits, and post-acute care (PAC)
 - Reductions in low-value care
 - Cost savings from independent physician groups and private sector models
- Dr. Chernew added that there is also reasonable evidence on cost savings from episode payments, but the savings are not uniform across episodes and depend on the design of the model. He noted that the concern that episode-based models could increase the overall number of episodes does not have a lot of empirical backing. Finally, he indicated that there is limited evidence that episode-based payment models influence quality due to measurement challenges.
- Dr. Chernew pointed out that, while some episode- and population-based payment models seem to decrease spending, it is more difficult to achieve per-member per-month savings in episode-based models because these payments influence a smaller share of spending.
- Conversely, Dr. Chernew noted that specialists are more engaged in episode-based models, and therefore, if there is substantial potential to reduce waste by changing care delivered by some specialists, including them through episode-based payment could increase overall savings.
- Dr. Chernew referenced MedPAC’s recommendation that “the Secretary should implement a more harmonized portfolio of fewer APMs that are designed to work together to support the strategic objectives of reducing spending and improving quality.”

- Dr. Chernew stated that in his view as an academic (separate from his role on MedPAC) he feels that instead of launching numerous new models, policy makers should think strategically about the portfolio of models as a whole and work toward harmonization toward overall goals related to cost, quality, and equity. He suggested that there should be fewer models, and they should be designed with the recognition of the other models operating in the health care system.
- Dr. Chernew provided an overview of how a multi-track population-based payment model might be designed. The amount of risk participants take on should vary by the size of the population, and benchmarks should be designed to avoid the “ratcheting effect” where better performance in one period effectively penalizes an organization by lowering its benchmark for future periods. The ratcheting effect makes it difficult for providers to gain from incentives to reduce spending beyond the first year of the model, and thereby discourages participation. He again noted that one track of a multi-track model that focuses on a particular episode may reduce costs, but that such models should be designed carefully to avoid siphoning savings and reducing interest in participation from providers involved in other tracks of the model.
- Given the point above, Dr. Chernew recommends focusing episode-based models (or episode-based tracks of multi-track models) on those episodes where there are clear triggers and episodes where there is limited ability of other providers outside of those involved in the care specified under the episode to influence savings. He also cautioned against designs where population-based savings are assigned to an episode, as this will discourage this kind of savings and reduce incentives for participation for providers not involved in the episode.

Cheryl Damberg presented on the shift to population-based TCOC models and increased value in health care.

- Dr. Damberg provided a summary of lessons learned from research on the past decade of payment reform, including:
 - Many payment models have produced modest savings, which sometimes increase with time.
 - Quality performance has either modestly improved or stayed the same, and there is still substantial room for improvement.
 - Results vary based on contextual and structural factors including participants’ infrastructure to succeed under a model.
 - The accountable entities have incentives to lower spending on care that they do not provide. For example, an ACO led by large physician organizations may be responsible for reducing TCOC and may do so by reducing the number of patients in inpatient settings which do not, under the model, affect the “bottom line” of the physician organizations.
- Dr. Damberg noted that the uptake of APMs has varied, and many high-cost entities are not yet participating in APMs. She expressed interest in understanding why some provider entities chose not to participate.
- She explained that overall progress toward TCOC payment models has been slow, noting that the majority of health care spending under APMs occurs under categories 1 and 2 of the HCP-LAN framework (i.e., two-sided risk). She also noted that even many of the models that include financial risk, use FFS as a “chassis” for provider payment.
- She further explained that her research shows that, among provider entities participating in Medicare ACOs, relatively few of their Medicare patients were enrolled in the ACO. This may be a missed opportunity to reduce inefficient spending, as her research also shows these provider

entities have higher performance on quality and low-value care for their beneficiaries that enrolled in the ACO.

- Dr. Damberg outlined the challenges for redesigning payment models, including:
 - Health systems that her team has studied report that they are not able to advance care redesign initiatives as rapidly as they would like to because only a small total share of the care they deliver is paid for under value-based arrangements (often this represents 5 percent or less of their revenues).
 - Health systems face competing forces from multiple payers with differing incentive programs. In some cases, the impetus to move toward value-based payment is low among employer-sponsored payers. Faced with different payment models, health systems attempt a compromise that balances among different ways they are paid, and the skew is currently weighted toward FFS.
- Dr. Damberg referenced a recent study of incentives for physicians in large health systems, which finds that physician incentives, while incorporating quality and patient experience, are still driven by the volume of services provided and not by managing TCOC.
- Dr. Damberg commented on the restructuring from health care markets in response to payment reforms. Policy change has contributed to significant vertical consolidation of previously independent practices into health systems. Providers integrate to:
 - Increase the population they care for to spread and manage financial risk associated with participation in value-based payment (even though relatively few participated in risk-based payment arrangements);
 - Use greater volume to offset loss of revenues due to reductions in spending stemming from value-based payment; and
 - Increase their leverage in price negotiations with private payers, which drives up prices associated with caring for the privately insured in some markets.
- Dr. Damberg then listed potential benefits of integration, including
 - Increased efficiencies by lowering administrative costs through economies of scale;
 - Improved ability to devote more resources to improving the care delivery infrastructure; and,
 - Improved integration and coordination of care across providers within a health system.
- Dr. Damberg remarked that through her research, she sees an assumption that vertical integration will generate clinical integration. She outlined three types of integration.
 1. Structural integration, seen through ownership or management of operating units.
 2. Functional integration whereby providers within the health system forgo some aspects of autonomy and agree to centralized decision-making, use the same software, or benefit from shared branding across the system. She noted variation in terms of how systems use different mechanisms for “hard” versus “soft” approaches to functional integration.
 3. Clinical integration, differing approaches with the goal of controlling costs and improving quality. Clinical integration occurs through adoption of “hardwired” clinical processes and protocols, standardized service lines, and care delivery redesign. Health systems note that they struggle with clinical integration specifically, while recognizing that this type of integration is crucial to improving performance. Most health systems indicate that they have not achieved clinical integration among their providers due to lack of structure to coordinate standardization. These health systems emphasize that

the pace of payment reform has been too slow to create an impetus to make the level of investment required to transform care.

- Dr. Damberg highlighted the importance of evaluation. She noted the need for more qualitative research on contextual factors that influence model effectiveness, unintended consequences, and barriers to implementing practice change. She also noted that quantitative evaluation of effectiveness suffers from provider selection (those that participate in these models are often the systems most likely to succeed) which creates difficulty finding valid comparison groups. She also emphasized the challenge of isolating the impact of one model where there are several being implemented simultaneously. Finally, she pointed out that evaluation currently does not produce a good understanding and consideration of patients' social risk factors or the impact of models on disparities.
- Dr. Damberg suggested that the health care system should consider the following actions
 1. Reduce the number of payment models and parameters (e.g., some health systems are contended with over 200 different quality measures to work toward);
 2. Ensure incentives to reduce spending are high enough to induce participation and that they address the need for investment needed to help systems take the steps needed to achieve clinical integration;
 3. Encourage testing of population-based payment models among private payers to achieve a true population-based payment;
 4. Encourage models that require participation to better assess impacts and avoid selection issues; and
 5. Increase real-time learnings that can be used to make adjustments to these models through more qualitative work.

Michael Adelberg presented on best practices for improving affordability and driving high-value care for beneficiaries through the MA program.

- Mr. Adelberg began by noting the general assumption that promoting high-value utilization can improve outcomes and reduce waste. He indicated that some “levers” to do this are available to models currently being tested, and others may be available for future models.
- Mr. Adelberg focused on relevant characteristics of Medicare beneficiaries:
 - Their sensitivity to costs and their tendency to under-utilize services or therapies for which there is a cost-share (particularly as it relates to pharmaceutical copayments).
 - Their limited literacy related to the implications of different cost sharing frameworks. For example, many beneficiaries may presume a 10 percent copay is better than a \$20 copay which is rarely the case.
- Mr. Adelberg then reviewed different approaches currently available to MA plans to encourage high-value care and avoid low-value care:
 - Low-cost sharing for high-value services, such as cost-free primary care and generic drugs.
 - Rewards and incentives to enhance utilization of high-value services, such as gift cards for flu shots or for participating in disease management activities.
 - Condition-specific supplemental benefits that reinforce necessary utilization, such as transportation to dialysis centers for members with kidney failure or a healthy grocery allowance for members with CHF.

- High-value provider programs that incentivize members to seek highest performing providers by means of lower cost sharing or additional benefits.
- Real-time benefit tools that alert patients and providers to the lowest cost, clinically effective drug.
- Mr. Adelberg listed levers that discourage high-value care, including:
 - Cost sharing to dissuade inefficient or avoidable care.
 - Decreasing the maximum out-of-pocket protection through deductibles.
 - Mr. Adelberg noted that there is potential for deductibles to discourage the use of high-value services, even though there may be an assumption that they primarily discourage low-value services.
 - Utilization management tools, such as prior authorization and step therapies.
 - Mr. Adelberg noted that there are concerns about how these tools are implemented, citing a study that showed that the majority of step therapy protocols do not align with clinical guidelines.
- Mr. Adelberg discussed how MA plans are increasingly focused on meeting the social needs of members to ultimately lower TCOC. Examples to address social needs include offering social need platforms, referral services, and supplemental benefits that address SDOH. Mr. Adelberg emphasized that because these are new initiatives, it is not yet clear which are cost-effective. He noted that MA plans are in a competitive marketplace, so they seek to acquire members by implementing benefits that increase plan enrollment without necessarily promoting high-value care, such as by Part B premium buy-downs and gym benefits.
- Mr. Adelberg noted that mitigating incentives that discourage high-value care requires the health care system to engage in cost offsetting. Cost offsetting is the construct for estimating costs avoided by a particular intervention and modeling overall cost reductions. He noted that actuaries are not yet comfortable with considering cost offsets that arise from non-traditional and non-medical investments.
 - Mr. Adelberg provided the example of transporting patients to a dialysis center, which should result in fewer missed dialysis appointments and fewer hospital-based emergency dialysis episodes of care. The costs of transportation would be offset by the cost savings from fewer expensive emergency dialysis episodes.

Chris DeMars presented on Oregon's health system reform journey, including their Coordinated Care Organization (CCO) model and Oregon's multi-payer vision.

- Ms. DeMars noted that the three initiatives in Oregon's multi-payer vision are health care cost growth target work; spreading value-based payment across all payers and providers; and a regional multi-payer global pilot currently under development.
- Ms. DeMars explained that Oregon's CCOs were established in 2012 to bring together physical, behavioral, and mental health providers to coordinate care for the state's Medicaid plan (the Oregon Health Plan). CCOs receive a fixed monthly budget from the state to coordinate health care by improving outcomes and quality. CCOs have the flexibility to address their members' health needs outside traditional medical services, with the aim of improving member care while reducing the taxpayer's costs.
- Oregon has made significant progress in improving health care delivery while decreasing costs. For example, from 2011 to 2019, Oregon has seen a 93 percent increase in adolescent well-care

visits and a 117 percent increase in depression screenings. Oregon has lowered projected expenditures versus their actual costs by \$2.2 billion from 2013 to 2017. As of 2019, 94 percent of people in Oregon are insured.

- Ms. DeMars stated that high-performing systems share four attributes: affordable, universal coverage; high-value and primary care; investments in social services; and decreased administrative burden.
- Ms. DeMars noted that Oregon has made progress in the four areas outlined above by building on the Affordable Care Act (ACA) to expand coverage; incentivizing the Patient-Centered Primary Care Home (PCPCH) program; creating blended budgets for CCOs with paths for addressing health-related social needs; and spreading value-based payments.
- Ms. DeMars went on to indicate that the Oregon Health Authority established a 10-year goal to eliminate health inequities. To meet this goal, Oregon aims to create a simpler system focused on equity, so all individuals are insured and have access to affordable care, high-value benefits, and culturally responsive care that promotes equity, primary care, and preventive care. She noted that the state's health care system uses a fixed TCOC global budget with flexibility to address social needs. Ms. DeMars noted that plans and contracts are designed to align with common expectations for equity, quality, access, and cost containment.
- Ms. DeMars described Oregon's initiatives and their goals, which include achieving universal coverage, implementing a statewide cost growth target, and enacting delivery system and market reforms. The statewide health care cost growth target has been set for the next 10 years, and Oregon is projected to save \$16 billion over the next five years.
 - Ms. DeMars indicated that the Cost Growth Target Committee recommended principles to adopt advanced value-based payment as their first strategy to help meet the statewide cost growth target. To meet that target, the Oregon Health Authority has implemented statewide payment goals targeted toward payers and providers, known as the Value-Based Payment Compact. As part of the Compact, CCOs are required to provide per-member per-month payments to their PCPCH clinics; achieve annual value-based payment targets; and implement value-based payments in key care delivery areas.
- Ms. DeMars highlighted the Value-Based Payment Compact as Oregon's first step at true alignment across all payers and providers toward the state's vision. Oregon also seeks to further align across markets, which would lead to increased focus on TCOC, value-based payments, and accountability toward equity, quality, and outcomes. Oregon seeks to provide equitable access to quality care for people across all insurance plans, improved access to preventive and health-related social needs, cost containment, and smarter spending.

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

- Angelo Sinopoli commented that there is not a clearly successful care model that is implementable at a primary care level or a smaller network, except for an Oregon-type model that is state-supported. Dr. Sinopoli noted that many networks may be hesitant to become involved in value-based care due to the significant associated global risk. Dr. Sinopoli asked the presenters for recommendations to address these issues, so that value-based care can be implemented across the county. He suggested that potential options may include an all-payer model or a standardized care model.

- Dr. Chernew noted that this has become a larger problem as MA grows and FFS decreases. He noted that this is one motivation for having fewer and more harmonized models but acknowledged that it will be difficult for CMS and CMMI to implement multi-state models. He suggested that collaborating with other states is helpful and emphasized the importance of aligning incentives across payers and providers.
- Dr. Damberg added that the extent to which Oregon can bring together different payers to agree on common standards is valuable. She noted that it is rare to see different payers in the marketplace, including Medicaid and Medicare, work together with private payers on aligning on measures and provider incentives. She emphasized that an opportunity exists for greater collaboration and coordination.
- Dr. Kosinski asked the presenters to provide their suggested definitions on TCOC.
 - Dr. Chernew stated that he views TCOC as the total per-member per-month costs for a beneficiary, paid by their plan or by the beneficiary themselves, for a certain time period. He added that TCOC includes all services, including any supplemental coverage and pharmaceuticals.
 - Mr. Adelberg noted that TCOC should also consider addressing health equity and SDOH. He suggested that the definition of TCOC focus holistically on the patient.
 - Dr. Damberg added that providers are paid under global budgets in some contexts. She gave the example that Kaiser Permanente can choose how to allocate resources, whether it is toward doctors, medications, or buying food for seniors.
 - Dr. Chernew agreed that increasing the budgets of models to include SDOH is important. He noted that the costs of drugs should be included in TCOC. However, he noted that the cost of drugs is included in Medicare Part D, and Part D plans are not explicitly TCOC models. Dr. Chernew considers mental health to be part of TCOC but acknowledged the difficulty for payers to be responsible for everything in a TCOC contract.
 - Ms. DeMars noted that the CCOs in Oregon that can use traditional Medicare FFS have seen decreased costs and improved ability to focus on high-cost patients through care coordination.
- Vice Chair Hardin asked the presenters what they view as the highest value investments to impact equity and SDOH. Vice Chair Hardin commented that she has seen a recent movement toward investment in housing.
 - Mr. Adelberg stated that there are actuarial studies and peer-reviewed articles that address costs and benefits associated with enabling transportation to dialysis facilities for patients with kidney failure. He added that there have recently been studies related to Medicaid programs for short-term housing support. Finally, he pointed out the diversity of the social service safety net across the U.S., which adds a layer of complexity for translating programs across states.
 - Dr. Chernew added that there is a need for more rigorous evidence on evaluations. He noted that targeting specific approaches to specific populations is crucial to improve quality and save money, including identifying how best to engage providers and to operationalize this targeting. Finally, he indicated that the sole focus should not be saving money, and the health care system should not abandon practices that improve the patient's well-being. He added that Oregon and Kaiser have made great strides with unique approaches.

- Dr. Damberg stated that health systems that have demonstrated the most flexibility have proven to be the most successful in ensuring patients attain the necessary social services. She noted that there are “ambulatory care deserts” among various communities that include patients who face difficulty obtaining primary and specialty care due to geography. She added that it is important to address the structural racism that has been built into payment policies.
- Ms. DeMars commented on the cultural issues affecting partnerships between the health care system and the community-based organization system. The health care system will need to build capacity and to improve data capabilities to bring these systems together. Ms. DeMars referenced Oregon’s social needs screening metric to assist with patients’ social needs and ultimately build a statewide community information exchange.
- Dr. Damberg added that an underlying concern about payer performance and value-based payments is the potential that they could reward more affluent groups where people of color are underrepresented and exclude people of lower socioeconomic backgrounds. She recommended both private and public payers consider back-end adjustments to value-based payment approaches that could address this disparity.
- Dr. Chernew noted that the ACO REACH Model has tried to separate the utilization from the costs.
- Dr. Pulluru asked about creating harmonized models and how best to engage specialists for patients with multiple conditions.
 - Dr. Chernew noted that it is important to have a foundational population-based payment model because too many episode-based models will lead to decreased care coordination. His proposed solution is to have fewer models and include clear triggers for procedure-type models. He encouraged spending less time building specific approaches or structures to engage specialists into models themselves and instead allowing providers in these models to engage specialists organically. He noted that engagement with specialists for patients with multiple chronic conditions can be very context-specific, but the primary care physician and specialist should be able to coordinate care in this situation.
 - Dr. Damberg stated that organizations managing global risk, rather than just professional risk, tend to be better positioned to coordinate care between primary care providers and specialists efficiently. However, this does not address optimizing quality of care for individuals with multiple conditions.
- Mr. Adelberg asked the other presenters about how to coordinate specialists and primary care providers. He inquired about what can be learned from the MA plans on how they build their provider networks and use payment structures to align incentives among primary and specialty providers.
 - Dr. Chernew noted that this is an area where the health plans, data, contracting, and incentives can improve.
 - Dr. Lin noted that the June public meeting will discuss care delivery model innovations that support the overall population-based TCOC objectives. He asked Dr. Chernew if there is any evidence regarding whether episode-based or

disease-specific payment models will support increased care delivery innovations for a specific disease or episode.

- Dr. Chernew confirmed that there is evidence that varies by episode type. He noted that attribution is a common problem because it is difficult to measure a model's success taking into account the environment in which any given provider organization operates. He stated that he believes there is evidence that episode-based models can be successful but also evidence that they are not uniformly successful.
- Dr. Pulluru asked the presenters about patient literacy and their knowledge of the health care system, particularly in Medicaid. She inquired about the best practices for engaging patients and the challenges related to designing a payment model when there is no assignment for a health system.
 - Ms. DeMars noted that Oregon CCOs are required to have a community advisory council comprising at least 51 percent Medicaid members and other representatives from the community, including CBOs. She added that this model has engaged members on the design of the CCO model, especially where the CCOs invest in health-related social needs.
 - Mr. Adelberg noted that some Medicaid and MA plans have concierge programs to deploy staff to assist high-needs patients to navigate the health care system more successfully. He noted that these interventions have proven to be inexpensive relative to the total cost of health care.
 - Dr. Damberg commented that she has noticed that the communication from ACOs and physician organizations to members is difficult to understand. She noted this leads to beneficiary confusion.
- Vice Chair Hardin commented that she has recently seen a massive proliferation of venture capital backed risk-based models for underserved populations. She asked the presenters about lessons learned from these models as they look to the next phase of TCOC model design.
 - Dr. Damberg noted that vertically integrating independent physicians to serve disadvantaged patient populations may cause financial challenges to these physicians as they may experience less revenue from commercial payers. She added that the health care system must figure out how to achieve greater equity across the different payment platforms, including commercial insurers who are paying larger amounts for services compared to Medicare and Medicaid, but are encountering barriers to improving access to care and delivering services to patients.
 - Dr. Chernew noted that he believes the core value in care delivery is finding the correct provider to promote the patient's health. Health care financing can facilitate or impede this goal. Dr. Chernew believes FFS inherently makes this more challenging, and moving toward APMs in a structured way could help.
 - Mr. Adelberg stated that he does not believe private equity should be excluded from the health care system, but there is a public policy problem when private investment is successful by focusing on the most profitable sectors of the health care industry, leaving less profitable sectors underfunded.
- Vice Chair Hardin asked Ms. DeMars if she has seen a proliferation of national or other models in Oregon.

- Ms. DeMars replied that many of their health plans are locally based in Oregon, so she is not aware.
- Dr. Chernew added that private equity can be successful in the right situation. He noted that there are new primary care organizations focusing on telehealth and mental health, which are areas of great need. He added that some ACOs involved with private equity finance have supported delivery system transformation.
- Vice Chair Hardin indicated that she has observed this trend related to use of private equity financing recently, particularly related to Medicaid redesign in California.

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

Dr. Kosinski presented [slides](#) on the role of specialty models and reducing TCOC. Dr. Kosinski noted that his presentation would draw from one of his previous projects, Project Sonar, and how these concepts can be applied to specialty models more generally.

Dr. Kosinski explained that Project Sonar was submitted as a PFPM proposal to PTAC in 2017 and became a successful commercial venture. Dr. Kosinski made points related to the motivation behind the Project Sonar PFPM.

- Gastroenterologists have a very poorly diversified revenue stream. Over 60 percent of the revenue of gastroenterology practices today comes from performing one procedure, colonoscopies, most of which are performed for preventive screening for colon cancer or for surveying patients who have a history of colon polyps.
- Since gastroenterologists' revenue stream is not very diversified, it is vulnerable to less expensive technological advances for colon cancer screening. Project Sonar is intended to diversify the revenue stream of gastroenterology and to encourage gastroenterologists to participate in value-based care arrangements.

Dr. Kosinski explained that the major disorder treated by gastroenterologists is Inflammatory Bowel Disease, which is composed of two disorders: Crohn's disease, and ulcerative colitis. He noted that patients with these conditions had a 17 percent hospitalization rate, and he investigated whether these hospitalizations could be avoided. Dr. Kosinski highlighted the following findings from his investigation:

- For over two-thirds of the patients, there were no Current Procedural Terminology (CPT) codes in the 30 days before their hospital admission.
- Patients with symptomatic, chronic diseases did not have the time or knowledge to go to a primary care provider or specialists when they first started showing symptoms.

Dr. Kosinski developed a communication system to monitor and engage with patients between their face-to-face visits. The high-touch method would allow a medical professional to decide if an intervention was necessary. His team sent out monthly questions to patients from the Crohn's disease activity index, using a patient portal. By 2013, the team had reduced the hospitalization rate from 17 percent to 5 percent. The value-based model was able to lower hospital admissions by over 57 percent, to reduce ED visits by 53 percent, and to reduce TCOC (including medications) by over 10 percent.

Dr. Kosinski submitted a PFPM proposal to PTAC in April 2017; the proposed model was recommended to the Secretary for limited scale testing. The Secretary chose not to pursue it due to the use of proprietary technology in the model. However, the Secretary did state that input from the proposal would be considered in the development of potential models in this area.

Dr. Kosinski provided an update on the SonarMD model, and the company formed to commercialize the approach. He noted that SonarMD is a tech-enabled care coordination solution for patients with symptomatic, complex chronic disease. The model is currently deployed for multiple illnesses and is contracted in multiple states. Attributed patients are enrolled in the program, three-pronged risk assessments are performance-based on disease-specific metrics, and patients' preferred modes of engagement and communication are assessed. He added that the model is now using machine learning to continue to develop a claims-based assessment of existing doctor-patient interactions. The platform engages with patients monthly, and a designated care coordinator ensures care management and coordination. If a patient's symptom scores exceed benchmarks, the program alerts the practices to the potential deterioration in the patient's condition, using a structured format. The intervention taken by the practice is then fed back to the database so the model can continue to improve the data-driven risk assessment.

Dr. Kosinski described the payment model and its performance in the commercial space. SonarMD provides flexible value-based arrangements for the health plan that guarantee minimal savings, above which SonarMD shares equally with the plan. Dr. Kosinski highlighted the importance of prospective upfront payments to help practices build a value-based care infrastructure. He added that there is currently no downside risk for the GI practice in the model, but that SonarMD hopes to incorporate this in the future. Dr. Kosinski noted that SonarMD demonstrated a 15 percent reduction in TCOC (including medication costs for medical and pharmaceutical claims). He noted that the net savings reflected declines in inpatient admissions, ED visits, non-ED visits, and non-ED outpatient expenditures.

Dr. Kosinski discussed the multiple commercial definitions of TCOC, which vary based on individuals' perspectives. For example, most commercial health plans focus on medical costs; pharmacy benefit managers focus on pharmaceutical costs; provider focus is typically specialty-dependent; ACOs focus on medical costs; patients focus on out-of-pocket expenses; employers focus on insurance rates; a self-funded employer focuses on total cost; and CMS focuses on total cost to Medicare or Medicaid.

Dr. Kosinski highlighted the following potential business model considerations:

- What percentage of total practice revenue is represented by the APM, and is there enough at risk to incentivize change?
- How can FFS versus value-based care revenue be rebalanced to favor value-based care?
- Should FFS rates be frozen to make value-based care revenue the primary revenue driver?

Dr. Kosinski highlighted direct care effects, including how the site of service for outpatient services may push patients to specific sites, as well as differences based on Part B or Part D route of drug administration. He noted that key issues include whether the institution has the infrastructure to manage the care; whether the institution is large enough to manage the risk; and whose responsibility it is to decide risk.

Dr. Kosinski concluded that TCOC needs to be defined so that risk can be managed, accountable entities can be appropriately defined for managing the risk, and care can be optimized for value with a patient focus. He added that a skeletal infrastructure must be defined, and substructures need to be developed for specialist participation, rather than for transferring risk to specialists. He emphasized the importance of understanding who has the obligation to the beneficiaries. He suggested that the Committee's review of PFPs can become a vehicle to evaluate stakeholder-submitted approaches that have the potential for deployment as nested solutions that can be adopted by entities participating in population-based risk models.

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

- Bruce Steinwald referenced the previous listening session's discussion of disease-specific value-based payment models and their applicability for larger populations. He asked if Dr. Kosinski felt that it is feasible for a program such as SonarMD to be integrated more comprehensively.
 - Dr. Kosinski noted that he does think it is feasible for a program such as SonarMD to be implemented organically. He noted that over 20 percent of TCOC for gastroenterology is represented by patients who carry a gastrointestinal (GI) disease diagnosis, but that does not mean GI disease is the dominant health care cost in some of these populations. He added that inflammatory bowel disease (IBD) is responsible for over 50 percent of the variable costs of GI diseases. He noted that SonarMD's goal is to manage the GI care and take on risk for that care on behalf of entities such as ACOs or other large population-based TCOC entities. Dr. Kosinski noted that most gastroenterology costs are disease-specific and that typically, the primary care physicians do not take care of these patients. However, it is unclear how much cost for specific conditions—such as acid reflux, IBS, or diverticular diseases—is driven by GI issues. Therefore, it is unclear how much gastroenterologists should be at risk for costs associated with these conditions. He suggested that FFS reimbursements be frozen at their current level in order to encourage a focus on value-based arrangements. This would incentivize providers to take on risk in order to experience increased reimbursement.
- Chair Casale asked about whether sub-specialization is a benefit or a barrier as the health system moves toward TCOC.
 - Dr. Kosinski noted practices want their best physicians caring for patients, which often means sub-specialists who are most experienced in treating a particular condition or in performing a specific procedure. He added that payment models should be structured with the patients' best interests in mind. For example, not every gastroenterologist should care for IBD patients because there is much potential for morbidity, and it would be too costly to require every doctor be an expert on the disease. He agreed that some sub-specialization is needed and added that payment models should be adjusted to compensate appropriately.
- Dr. Pulluru asked about navigating drug costs in this model besides managing through the physicians prescribing the drugs, such as sites of infusion services.
 - Dr. Kosinski highlighted that the risk-bearing entity controls where patient services are provided. For example, if a patient is part of a hospital-based ACO, they are going to receive their infusions in an expensive HOPD. In contrast, if the patient is part of a provider-based ACO, that patient will receive their infusions in an office setting. He emphasized that these incentives are determined by the payment model.
- Chair Casale asked if Dr. Kosinski envisions this type of structure as something that can be reproduced for other specialty models.
 - Dr. Kosinski confirmed that he believes it can be reproduced with specific criteria. He noted that some gastroenterological conditions fall into a category that he referred to as "high beta," meaning that they had high variability in costs. For example, IBD has higher variability in costs compared to other conditions. He noted that similar types of conditions exist in other specialties, such as CHF in cardiology and with asthma and chronic obstructive pulmonary disease (COPD) in pulmonology. He emphasized that the model should focus on conditions where patients' symptoms help providers determine when patients need intervention, which helps patients receive the appropriate care earlier in their deterioration. He added that most symptomatic diseases will fall into this

“high beta” category, and these diseases with high variable costs that are also symptomatic should benefit from this type of model.

- Chair Casale noted that when he did a pilot program for COPD, many of the costs were associated with SDOH and behavioral health issues. He asked whether Dr. Kosinski found that SDOH and behavioral health were associated with costs in his patient population.
 - Dr. Kosinski confirmed that he had similar findings and noted that SonarMD recently published an abstract examining the difference in TCOC for patients who answer a Patient Health Questionnaire-2 (PHQ-2) screening at enrollment. He noted that there was a statically significant increase in cost for patients who answered the PHQ-2 positively (but who may not be carrying a diagnosis) but not for patients who had a recorded history of mental health disorder. He added that if patients have a mental health diagnosis, it might be managed, but there is evidence that active psychological motivations are affecting their cost of care.
- Vice Chair Hardin asked if there is an association between domestic violence and trauma and gastroenterological diseases.
 - Dr. Kosinski confirmed that this was likely the case.

Committee Discussion

Chair Casale introduced the Committee discussion portion of the public meeting by noting that Committee members would be discussing what they learned from the listening sessions and the background materials provided by the PCDT. He also indicated that the Committee’s comments and findings would be synthesized in a report to the Secretary on population-based TCOC models after the September 2022 public meeting. Chair Casale used a framework of topics to assist Committee members in structuring their conversation.

- Vice Chair Hardin reflected on the promising opportunities to learn from states such as Oregon and Vermont that are creating integrated all-payer models, which can inform future population-based TCOC models.
 - Dr. Sinopoli agreed and noted that the listening session presentations demonstrated that integrated models are achievable at state and all-payer levels. He highlighted the goal of developing a large-scale all-payer model.
- Terry Mills raised the issue of nesting population-specific or episode-based models under a broad population-based TCOC model. He considered whether nesting exceptionally high-cost, high-risk patients within population-based TCOC models is the optimal model design and what other specific episodes or specific populations should be included.
 - Dr. Sinopoli emphasized the importance of effectively nesting episode-based payment models within population-based TCOC models.
- Vice Chair Hardin highlighted approaches to addressing SDOH within populations; such approaches are different from disease-oriented approaches and offer interesting opportunities for integrated care.
- Dr. Liao raised the issue of targeting interventions to specific patient populations within population-based TCOC models. He noted that targeted interventions are essentially care episodes. He suggested that allowing providers flexibility for targeting interventions is important because accountable entities’ populations vary. Dr. Liao argued that this flexibility is not possible unless there is a standard set of payment features. He provided SNF waivers as an example of payment features that are common but vary enough between models that they are not universally applicable.

- Dr. Liao noted that ACOs currently have flexibility for targeting interventions regardless of the evidence base. He suggested that nesting would decrease this flexibility.
- Mr. Steinwald suggested including an actuary who could speak to issues about TCOC during the theme-based discussions in June or September.
- Dr. Kosinski reflected that the day's discussions have made his definition of TCOC more inclusive.
 - Dr. Pulluru agreed that presenters shared a uniform, inclusive definition of TCOC. She suggested that a broader definition of TCOC and the services it includes leads to more innovation. Dr. Pulluru noted that her other key takeaways from the meeting related to embedding health equity into payment models and harmonizing APMs across the health care system.
- Dr. Sinopoli noted that smaller ACOs are going to have difficulty taking on risk for pharmaceuticals. He recommended making some exceptions to the TCOC definition based on the application.
 - Dr. Kosinski suggested that TCOC definitions should include either all drugs or no pharmaceuticals. He noted that a siloed approach, where only some drugs are included, allows providers to prescribe medications based on profit margins and leads to patient suffering.
- Vice Chair Hardin underscored the importance of managing patients' conditions before they become burdensome and costly to address.
- Dr. Pulluru noted that MA programs can provide insights for future population-based TCOC models. She suggested including SMEs from provider organizations with MA experience in PTAC's June theme-based discussion.
 - Dr. Liao suggested delineating both what can be learned from MA (e.g., beneficiary engagement) and what will not translate (e.g., networks).
- Vice Chair Hardin emphasized that screening for SDOH needs is not sufficient and suggested that SDOH should be included in TCOC. She noted that the most successful models integrate medical and social services. Vice Chair Hardin also noted the importance of partnerships to prevent duplicative efforts for addressing social needs.
 - Dr. Pulluru noted that incorporating SDOH services is not budget neutral and will be affected by how TCOC is defined. She noted that a TCOC definition limited to Medicare Parts A and B services is not easily amenable to including SDOH services and being budget neutral, while a global fee based on an inclusive TCOC definition would allow providers to spend resources on SDOH services as they see appropriate.
 - Dr. Lin agreed that health care organizations can allocate TCOC funds to include SDOH resources.
 - Dr. Kosinski noted that it may take significant time for SDOH services to produce a ROI. He emphasized that this should not prevent organizations from providing these services.
- Dr. Mills raised the issue of risk adjustment based on SDOH. He emphasized the importance of having health plan revenue that reflects the appropriate risk of the patient populations served. He cited evidence that current risk adjustment methodologies account for only approximately 50 percent of the variance in patients. He expressed the need for statistical modeling to determine the best way for risk adjustment methodologies to reflect SDOH.
 - Vice Chair Hardin noted the emergence of artificial intelligence (AI)-driven tools for predictive modeling based on health needs and SDOH.

- Dr. Mills noted that presenters did not mention quality metrics or pay-for-performance during the meeting. He emphasized the need for a standard, minimal quality threshold for TCOC models to be valid.
- Chair Casale asked Committee members whether specialty care should be organized within the entity that is accountable for TCOC or whether specialty care should be all prescribed episodes.
 - Mr. Steinwald stated that specialty care should be organized within the entity that is accountable for TCOC. He highlighted the method for identifying which chronic illnesses are appropriate for nesting within broad ACO-like operations that was discussed during Dr. Kosinski’s listening session presentation.
 - Dr. Kosinski recommended considering the patient point of view when determining how to nest specialty care within population-based TCOC models.
- Dr. Sinopoli suggested that it is the ACO’s responsibility to create service lines that bring together multiple specialties.
 - Dr. Liao noted that creating service lines leads to restrictions for providers and organizations. He asked whether these service lines differ from what potentially already exists in current large ACOs.
- Vice Chair Hardin raised the issue of how to identify the primary physician for patients who consider specialists to be their primary care provider. She noted that this is especially relevant for populations with serious chronic illnesses.

Closing Remarks

Chair Casale thanked the Committee members, CMS leadership, presenters, and the public for their contributions to the meeting. He noted that they explored many facets of population-based TCOC models and indicated that the conversation would continue during the March 8 meeting, which will feature another listening session and a roundtable panel discussion.

The public meeting adjourned at 2:29 p.m. EST.

Approved and certified by:

//Lisa Shats//

6/3/2022

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

 Date

//Paul Casale//

6/3/2022

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

 Date