# 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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Monday, June 10, 2024

## PTAC MEMBERS PRESENT

LAURAN HARDIN, MSN, FAAN, Co-Chair*
ANGELO SINOPOLI, MD, Co-Chair
LINDSAY K. BOTSFORD, MD, MBA
JAY S. FELDSTEIN, DO
LAWRENCE R. KOSINSKI, MD, MBA
WALTER LIN, MD, MBA
TERRY L. MILLS, JR., MD, MMM
SOUJANYA R. PULLURU, MD
JENNIFER L. WILER, MD, MBA

## PTAC MEMBER IN PARTIAL ATTENDANCE

JOSHUA M. LIAO, MD, MSc*

## PTAC MEMBER NOT PRESENT

JAMES WALTON, DO, MBA

## STAFF PRESENT

LISA SHATS, Designated Federal Officer (DFO), Office of the Assistant Secretary for Planning and Evaluation (ASPE)
STEVEN SHEINGOLD, PhD, ASPE

*Present via Zoom

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

(9:31 a.m.)

* CO-CHAIR SINOPOLI: We'll go ahead and get started this morning. We want to welcome everybody to this meeting, to the Physician-Focused Payment Model Technical Advisory Committee known as PTAC. My name is Angelo Sinopoli, and I am one of the co-chairs of PTAC along with Lauran Hardin who is actually joining us virtually. Lauran, at this point, I'm going to turn it over to you for opening remarks.

CO-CHAIR HARDIN: Thank you so much, Angelo. Since 2020, PTAC has been exploring themes that have emerged from stakeholder submitted proposals over the years. After each theme-based discussion, the Committee releases a public report to the Secretary of HHS[1] with its findings and recommendations. Soon, PTAC will be posting its September 2023 report to the Secretary on encouraging rural participation in population-based total cost of care models, or TCOC models, on the ASPE PTAC website. In addition, PTAC will be posting a series of issue briefs summarizing key insights from the Committee's work on developing and implementing

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[1] Health and Human Services

total cost of care models.

As we know from previous PTAC theme-based discussions and proposals, providers and organizations face challenges with addressing the needs of patients with complex chronic conditions or serious illnesses, particularly for cost of care models. We also know that this topic is of interest to the Innovation Center at CMS. We are honored to have Dr. Liz Fowler, the Deputy Administrator of CMS and Director of the Center for Medicare and Medicaid Innovation here with us today to give some opening remarks.

Dr. Fowler previously served as Executive Vice President of programs at the Commonwealth Fund and Vice President for Global Health Policy at Johnson and Johnson. She was special assistant to President Obama on health care and economic policy at the National Economic Council. From 2008 to 2010, she also served as chief health counsel to the Senate Finance Committee Chair, where she played a critical role in developing the Senate version of the Affordable Care Act. Welcome, Liz.

*** Elizabeth (Liz) Fowler, JD, PhD,**
**Deputy Administrator, Centers for**
**Medicare & Medicaid Services (CMS)**

**and Director, Center for Medicare and Medicaid Innovation (CMMI) Remarks**

DR. FOWLER: Thank you so much, it’s really great to be back with PTAC for the second public meeting of the year and to continue learning from the panel and discussions that PTAC has very thoughtfully lined up. I was just remarking that you chose a nice time of the year to be here, June, and then back in September so you’re missing the hottest part of D.C. But before turning to the topic of this session, I want to thank the Committee for the robust discussion we had back in March focused on performance measurement.

In particular, thanks for inviting the CMS senior physician leadership to speak on a panel about the CMS quality strategy. Our quality team has been talking about that panel and some of the points raised in other panel discussions ever since, and thanks also to the ASPE team, the ones who coordinate these PTAC discussions on behalf of HHS. We all share a common vision of transforming a health system to one that delivers the high-quality care for all patients.

As the value-based care landscape has

shifted, so has the work of the Innovation Center and also the nature of our partnership with PTAC. The Innovation Center has moved away from its "let a thousand flowers bloom" approach, and we've moved into the sort of second decade of our work, and PTAC has been really instrumental in sharing their expertise in areas that we're also focusing on, like the lessons learned from the first decade, how to expand what we know works, how to close the gaps in some of our portfolio, and how to address some of the more complex and vexing issues we face in trying to expand initiatives and innovations from our models when we know that they're working.

With all that in mind, I'm really looking forward to the discussions over the next couple of days focused on beneficiaries with serious illnesses and complex chronic conditions. This has been an area that is top of mind for us as we assess the impact of current models and develop new models to improve care for these particularly vulnerable beneficiaries.

The team is excited to share some of our lessons learned from CMMI model tests as they relate to seriously ill populations, including findings from our model evaluation reports that we're seeing in models we are testing now. What we're seeing in models we're testing now and those about to start, like the GUIDE[2] Model that starts July 1st, and also it's important to focus on what we've learned about what doesn't work or what hasn't worked. Tomorrow you'll hear from us about some of our prior efforts like the Medicare Care Choices Model, MCCM, and the Independence at Home Demonstration, both of which demonstrated improvements in beneficiary quality of care, but also both experienced challenges associated with trying to evaluate models with limited participation.

We see a need for palliative care to be incorporated more broadly into the care of patients with serious illnesses. Better integrations of palliative care throughout the continuum of illness can help support and manage different aspects of care, whether that's physical, psychosocial, or even spiritual. And as you're going to hear from my colleagues tomorrow, we know one of the key barriers to low use of palliative care at the end of life is low referral rate by primary care providers.

In response, we've provided

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[2] Guiding an Improved Dementia Experience

flexibilities in some of our models like the ACO REACH[3] and Kidney Care Choices model that encourage greater use of palliative care and concurrent care during a hospice stay, and we included those flexibilities in the hospice benefit component of the Medicare Advantage Value-Based Insurance Design, or VBID model. Unfortunately, the VBID hospice component was impacted by limited participation and operational challenges, and we had to make the difficult choice to end the model early, so that model will conclude at the end of this year.

Despite this setback, we plan to evaluate the model for lessons learned and to determine whether it met the model's goals. We also know that seriously ill beneficiaries require unique care delivery approaches. We're particularly pleased that the GUIDE Model focused on people with dementia and their caregivers has been supported by palliative care clinical organizations, such as the -- and it is the first model to address all the elements they recommend for serious illness care. As we continue to innovate, we think some of the most promising opportunities lie in building capacity,

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[3] Accountable Care Organization Realizing Equity, Access, and Community Health

expertise, and relationship with primary care providers.

So in sum, this has been a vexing problem, but it’s as important as it is hard to solve, which is why we’re really glad it’s at the center of your discussions these next two days. There’s a lot to learn, so we’re really happy that you’re taking this topic up. We look forward to the Committee’s discussion over the next two days and what it will teach us at the Innovation Center. Thanks very much.

*** Welcome and Co-Chair Update - Addressing the Needs of Patients with Complex Chronic Conditions or Serious Illnesses in Population-Based Total Cost of Care (PB-TCOC) Models Day 1**

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

For today’s agenda, we will explore a range of topics related to addressing the needs of patients with complex chronic conditions or serious illnesses in total cost of care models, including care delivery needs of patients who account for the top 5 percent of Medicare spending; strategies for improving patient-centered care, care delivery, and health outcomes; optimizing the use of post-acute care, palliative care, and end-of-life care; approaches for measuring performance and quality of care; and incentivizing improved outcomes in delivery system transformation.

The background materials for this meeting can be found, including an environmental scan, posted online on the ASPE PTAC website’s meetings page. Over the next two days, we will hear from many esteemed experts with a variety of perspectives, including the viewpoints of previous PTAC proposal submitters. Tomorrow, several staff from CMMI will be discussing lessons learned from their serious illness models. I also want to mention that tomorrow afternoon will include a public comment period. Public comments will be limited to three minutes each. If you would like to give an oral public comment tomorrow but have not yet registered to do so, please email ptacregistration@norc.org. Again, that’s ptacregistration@norc.org.

The discussions, materials, and public comments from the June PTAC public meetings will all inform a report to the Secretary of HHS on addressing the needs of patients with complex chronic conditions or serious illnesses in total cost of care models. Over the next two days, the Committee will discuss and shape our comments for the upcoming report. Before we adjourn tomorrow, we'll announce a request for input, which is an opportunity for stakeholders to provide written comments to the Committee on addressing the needs of patients with complex chronic conditions or serious illnesses in population-based total cost of care models.

Lastly, I'll note that 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 the detail of their payment methodology. You can find information about how to submit a proposal on the ASPE PTAC website.

*** PTAC Member Introductions**

At this time, I would like my fellow PTAC members to please introduce themselves.

Please share your name and your organization, and if you would like, feel free to describe any experience you have with our topic. First, we'll go around the table, and then I'll ask our members joining remotely to introduce themselves.

I'll start. I'm Lauran Hardin. I'm Chief Integration Officer for HC2 Strategies. I spent the better part of the last 20 years focused on high-cost, high-needs populations, including developing a successful complex care model that scaled to multiple states and was recognized by the National Academy of Medicine; was part of the team that established the National Center for Complex Health and Social Needs; and I currently partner with government, states, communities, and health systems designing and standing up models for complex and underserved populations. Next is Angelo.

CO-CHAIR SINOPOLI: Thank you, Lauran. My name is Angelo Sinopoli. I'm a pulminary critical care physician by training, spent most of my career working in large health systems, integrated health systems, developed several large clinically integrated networks along with enablement companies to help support those networks and particulary focused on those high-needs patients. I am presently the Executive Vice President for Value-Based Care at Cone Health. Thank you. Walter?

DR. LIN: Good morning everyone, my name is Walter Lin, and I am the founder of Generation Clinical Partners. We are a group of medical providers in the greater St. Louis area that specializes in the care of patients with complex chronic conditions and serious illness residing in nursing homes and assisted living facilities. Our mission is to help the senior living organizations transition into the world of value-based care through a medical model that focuses on delivering high-value, rseponsive primary care to this rural patient population. I also serve as the Medical Director for a PACE[4] program and the Medical Director for a provider arm of an institutional special needs plan, and am an active member of the Society for Post-Acute and Long-Term Care.

DR. PULLURU: Hi everyone, Chinni Pulluru, I'm a family physician by trade. I led a large medical group in clinical delivery, as well as value-based care transformation, a multi-specialty group named Duly Health and Care, as well as most recently was Chief Clinical Executive at Walmart, powering that COVID response, as well as powering the growth of

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[4] Program of All-Inclusive Care for the Elderly

Walmart Health, currently serving as President of CP Advisory Services, advising and serving on the board of multiple organizations that do value-based care transformation, including Stellar Health and physician retention such as Physician X, and I recently co-founded a start-up named My Precious Genes in genetic counseling. Thank you.

DR. BOTSFORD: Good morning, I'm Lindsay Botsford. I'm a practicing family physican in Houston, Texas, with Amazon One Medical. I currently work as a regional medical director supporting our practices across the midwest and Texas. This includes six practices where we exclusively care for older adults on Medicare in full risk contracts. I also chair our ACO REACH governing body as part of the Iora Health Network. Prior to that I worked in residency education and large health systems and ACOs, and I currently serve as the President Elect of the Texas Academy of Family Physicians.

DR. MILLS: Good morning, I'm Terry Lee Mills. I'm a family physician. I am owner of Strategic Health Consulting, and I've come through medical group leadership of integrated health systems in several states. I've been spending my career leading practice transformation and clinical informatics, and have had the joy of leading through and trying to operate to multiple CMMI pilots over the last 20 years.

DR. KOSINSKI: Good morning, I’m Dr. Larry Kosinski. I am a gastroenterologist by training. I’ve spent most of my career in private practice in the Chicago land area, building one of the largest GI practices in the country. For the last 10 years, I’ve been involved with value-based care from a specialty point of view, having founded a company named SonarMD which arose out of a PTAC proposal back in 2017. Currently I am retired from practice. I am on the board of Sonar, I am also the chief medical officer of a start-up called Jona, which is in the microbiome space, and this is my third year on the Committee.

DR. WILER: Good morning, I’m Dr. Jennifer Wiler, emergency physician by training. I am the Chief Quality Officer for UCHealth’s metro area in the Rocky Mountain region. I am also co-founder of UCHealth’s Care Innovation Center where we partner with digital health companies to grow and scale their solutions at the point of care. I’m a tenured professor at the Colorado School of Medicine and a former co-developer of an Alternative Payment Model that was reviewed by PTAC and endorsed by this Committee and delivered to CMMI.

DR. FELDSTEIN: Good morning everyone, my name is Dr. Jay Feldstein, emergency medicine physician by training as well and spent 15 years in the health insurance world, and for the past 10 years, I’ve been the president of Philadelphia College of Osteopathic Medicine, trying to integrate value-based purchasing into a medical school curriculum. Thank you.

Co-CHAIR HARDIN: Thank you everyone. Next let’s go to Josh who is joining us on Zoom.

DR. LIAO: Good morning everybody, Josh Liao, internal medicine physician at the University of Texas Southwestern Medical Center where I am a professor of medicine in public health, lead the division of general internal medicine, and direct a program called the Program on Policy Evaluation and Learning. Any of those things reflect what I have worked on in my career, both in doing what I hope to be impactful research on the topics of value-based payments and payment policy overall, as well as working with private and public policy makers on how to design, implement, and then evaluate those programs. And in that work, I’ve worked with IDNs, or integrated delivery networks, as well as kind of public entites on that. Excited to join today.

CO-CHAIR HARDIN: Thank you Josh, thank you all. One of our members, Dr. Jim Walton, is unable to join us for this meeting, but we wanted to thank him for all of his contributions to the meeting preparations.

## * PCDT Presentation - Addressing the Needs of Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models

Now let's move to our first presentation. Four PTAC members served on the Preliminary Comments Development Team, or PCDT, which has worked closely with staff to prepare for this meeting. Walter Lin was the PCDT lead with participation from Lindsay Botsford, Lee Mills, and Larry Kosinski. I'm thankful for the time and effort they put into organizing today's agenda. The PCDT will share some of the findings from their analysis to set the stage and goals for this meeting. PTAC members, you will have an opportunity to ask the PCDT any follow-up questions afterwards. And now, I'll turn it over to Walter.

DR. LIN: Thank you, Lauran. I would like to start by expressing my deep gratitude to my fellow PCDT and PTAC members, ASPE, andNORC staff for the tremendous amount of work putting together this presentation, as well as what promises to be an outstanding two days of learning from our subject matter experts.

In terms of the objectives for this meeting, I won’t spend too much time on this because Lauran reviewed them in her introductory remarks, but suffice it to say that we’re here to understand better the disproportionate impact that the most costly beneficiaries that Medicare insures have on Medicare spending, understand the challenges related to improving care for this population of patients with complex chronic conditions and serious illness, and identify the opportunities for optimizing the use of palliative and end-of-life care in this population of patients.

In terms of the context for this meeting, the statutory mission of PTAC is to make recommendations to the Secretary of Health and Human Services on proposals for our physician-focused payment models submitted to the Committee. Of the 35 proposals PTAC has received, at least 13 of them have included components related to addressing the needs of patients with complex chronic conditions and/or serious illness. PTAC is excited for the opportunity to do a deep dive on this theme during this two-day meeting.

In terms of the agenda for this PCDT

presentation, I will first start by reviewing relevant background information and define terms that will be used throughout the public meeting. Next, I will present findings from an original descriptive analysis of high-cost Medicare beneficiaries commissioned by PTAC for the purposes of this meeting. This will be followed by a discussion about the challenges and opportunities for caring for this patient population, and finally I will conclude with a brief overview of potential performance measures and payment models relevant to this population.

So first, some definitions. PTAC has defined patients with complex chronic conditions as those with more than one chronic condition lasting 12 months or more who usually require complex care involving multiple health providers across different specialities and settings of care. We have defined patients with serious illness as patients with advanced illness who are in their last years of life. These patients are prone to acute events that can impact their health care needs and drive up their health care costs.

I'd like to spend a bit of extra time on this very important slide showing some MedPAC[5] data about how the high concentration of costs amongst a

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[5] Medicare Payment Advisory Commission

very small group of Medicare beneficiaries drives Medicare spending. This slide is actually the raison d’etre for this two-day public meeting. So according to MedPAC data, the most expensive 1 percent of Medicare fee-for-service beneficiaries account for 17 percent of its spending, while the most expensive 5 percent of beneficiaries account for 44 percent of spending. The top 10 percent of most expensive beneficiaries that Medicare insures account for almost two-thirds of fee-for-service spending. While at the other end of the spectrum, the least costly 50 percent of Medicare beneficiaries only account for 3 percent of program spending.

Unfortunately, the fee-for-service system does not adequately incentivize providers to focus on this small proportion of Medicare beneficiaries driving most of its spending. For example, a physician can probably see two to four healthy Medicare patients in the same time it takes to see and really care for one complex patient with serious illness. In part because of these historical payment incentives, complex patients with serious illness often receive much of their care in the emergency room or hospital, which explains why in part they are so high-cost. The good news is that payment incentives can be much more aligned under value-based care and can better support care models that achieve both higher-quality and lower-cost outcomes for this expensive patient population.

PTAC has classified high-cost Medicare beneficiaries into three working definition categories. Those with complex chronic conditions which may be controlled or uncontrolled; examples in this category include late effects of stroke, diabetes with complications, and non-healing complex wounds. Secondly, those with serious illnesses is a second category which may be in active treatment, palliative care, or hospice. Examples of this category of patients include end-stage renal disease patients, patients with advanced heart failure, and patients with metastatic cancer. And those who experience a time-limited catastrophic health event, such as a major trauma from a motor vehicle accident is the third category. We will not be focusing on this latter category of patients.

This slide shows a Venn diagram of these three patient populations. The focus of this meeting will be on the intersection of these three patient populations, namely high-cost patients with either complex chronic conditions that are typically uncontrolled, or patients with serious illness undergoing active treatment, or both. Again, our meeting will not be focused on high-cost patients who are high-cost because of a time-limited catastrophic health event or patients with complex chronic conditions or serious illnesses who are not high-cost.

Now this may be obvious, but it’s worth mentioning that effective care models, treating patients with complex chronic conditions or serious illnesses, do not somehow magically cure the incurable, but rather they try to move these patients to a lower-cost status by controlling their complex chronic conditions, delaying progression of their disease, reducing treatment complications, and/or providing goals concordant end-of-life care.

This slide provides an example of a patient care journey to help make all this a bit more concrete. In this example, a 74-year-old man with a history of hypertension, diabetes, and chronic kidney disease has an acute event such as a heart attack. Genetics, lifestyle choices such as smoking and a poor diet, and health-related social needs may have contributed to this acute event. After the heart attack, this patient develops heart failure. At first, this new condition is well controlled with medications, and so the patient does not move into the high-cost category. Over time, though, as a result of perhaps his disease progression or factors like the inability to afford medications, the patient may start having multiple exacerbations of heart failure, requiring frequent hospitalizations and post-acute care episodes.

Now by age 85, other organs in his body like his kidneys have become affected, necessitating dialysis. Similarly, poor circulation has resulted in severe peripheral vascular disease, complicated by large non-healing wounds with infection of the bone and gangrene requiring leg amputation, and the patient has now developed a cardiac arrhythmia like atrial fibrillation, increasing the risk of stroke and more frequent heart failure exacerbations. Finally, after a massive stroke at age 90, resulting in the need for 24/7 total care and nursing home placement, the patient and his family decided to focus on symptom relief and comfort care rather than prolong the suffering with the placement of a feeding tube. In this example, the patient passes away on hospice peacefully at home surrounded by his friends and family.

Now I will be circling back to this patient care journey later in my presentation, so please try to remember some of the details. Up until now, I have to find and describe the population in focus for our theme-based meeting, namely high-cost patients with complex chronic conditions or serious illness. Now, some good news. Although expensive, studies have found that the majority of potentially preventable health care spending is in this exact patient populations. Organizations in total cost of care models have recognized the disproportionate impact these patients have on health care spend, and have deployed effective care models to both improve the quality and lower costs for this population. We all look forward to learning more from our many subject matter experts involved in such care models over the next two days.

Next, I am very excited to present findings from an original analysis of high-cost Medicare beneficiaries commissioned by PTAC for this meeting, to help us better understand this population in more detail. This study includes calendar year 2017 to 2023 data from Medicare fee-for-service beneficiaries continuously enrolled in Medicare's Parts A and B, allowing for death in each year. The total spending is calculated by the sum of Medicare program spending and beneficiary out-of-pocket spending.

This study had three objectives. One, describe the most expensive Medicare fee-for-service beneficiaries in more detail; two, examine trends in spending over the study years; and three, look at how stable this cohort is from year to year. The table in this graph, in this slide, shows that Medicare spending increased during the study years, albeit not in a straight line, and the number of beneficiaries decreased, resulting in a per capita spend of almost 13,400 dollars in 2017 to 16,200 dollars in 2023. This represents a 3.2 percent compound annual growth rate for overall per capita fee-for-service Medicare spend during the study years.

This slide shows the concentration of top spenders in the study years. A few takeaways, focusing on the right hand most 2023 year data, the top 5 percent of most costly fee-for-service beneficiaries in the green accounted for about 40 percent of all Part A and Part B spending. The next 5 percent in the red accounted for 17 percent, and so together, the top 10 percent accounted for close to 60 percent of spending, similar to that MedPAC data that we reviewed earlier. The bottom 90 percent of fee-for-service beneficiaries accounted for 43 percent all spending. Interestingly, this distribution held pretty much constant throughout the study years, which included the pandemic years.

This slide shows the average per capita spend in the study years. A few takeaways, in 2023, the average per capita spending for the costliest 5 percent was over 129,000 dollars, as compared to about 54,000 dollars for the top 6 to 10 percent and about 16,000 dollars for overall fee-for-service per capita spending. Over the study years of 2017 to 2023, the annual growth rate in per capita spend for the costliest 5 percent of spenders was 3.6 percent compared to 3.3 percent for overall fee-for-service per capita spend.

Now doing a deeper dive, this slide shows selected characteristics for the costliest Medicare beneficiaries compared to the average fee-for-service beneficiaries in 2021. Takeaways, the top 5 percent costliest beneficiaries had over four times the mortality rate of the average fee-for-service beneficiary, 22 percent versus 4 percent. Black, non-

Hispanic, and dual eligible beneficiaries were disproportionately represented in the top 5 percent. The top 5 percent costliest beneficiaries had almost three times the number of chronic conditions versus the average fee-for-service beneficiary, eight conditions versus three.

This slide shows spending distribution for Parts A and B services for the top 1 percent, 2-5 percent, and 6-10 percent of costliest Medicare beneficiaries over the study period. Some takeaways, the spending distribution remained relatively constant in the top 2-5 percent and 6-10 percent categories, but on the left most graph we see that for the top 1 percent, Part B drug spend, in the purple, increased by 10 percentage points with a significant drop in Part A hospital spend, in the green. Of note, Part B drug spend includes those drugs that are typically provided in a clinician’s office. PTAC was surprised by this finding and feel that it warrants deeper investigation, and the value of increased Part B drug spend is unclear at this point.

Finally, this analysis looked at how stable the top 5 percent costliest beneficiaries is year to year. Compared to the previous calendar year, 27-29 percent remained in the top 5 percent category, while an additional 12-13 percent moved into the top 6-10 percent category. Thus, about 40 percent of the costliest beneficiaries remained in the top 10 percent in the following calendar year. This is actually critical from a care model design perspective. I will note in passing that although approximately 60 percent of the costliest beneficiaries moved out of the top decile in the following calendar year, preliminary findings seem to indicate that a significant proportion of these patients passed away. So stay tuned for further analysis of this data.

Finally, the analysis looked at the top 5 percent costliest beneficiaries who stayed costly versus moved out of the top decile of spending. Beneficiaries in the top 5 percent who remained costly in the following year were on average younger, had more chronic conditions, were more likely to be dually eligible and non-Hispanic Black, and to live in zip codes with lower socioeconomic status.

Next, we will look at the challenges and opportunities for caring for this patient population. As one would expect, there are many challenges associated with caring for this complex population of high-cost patients. From a model perspective, these include prospective identification and robust risk stratification, since the composition of this cohort does not remain the same from year to year, as I just detailed. Implementing a multi-disciplinary care model to provide team-based goals and concordant care that addresses a need for care coordination, specialty integration, and safe care transitions is another challenge, and effectively engaging patients and caregivers in addressing their health-related social needs and clinical care is also a challenge.

From our environmental scan, PTAC has found evidence that intensive outpatient team-based medical care and/or formal disease management programs can improve health and reduce medical costs for patients with complex chronic conditions and serious illness, and an increased focus on palliative care and hospice can do the same for patients with serious illness. Of course, these opportunities to improve care are not mutually exclusive.

With respect to an increased focus on

palliative care and hospice for the seriously ill, this slide shows two of many possible trajectories for end-of-life care. Now recall the congestive heart failure patient care example I described in the first part of this presentation. After the patient’s massive stroke at age 90, resulting in the need for 24/7 care, the patient and his family decided in that example to focus on symptom relief and comfort care rather than prolong the suffering with placement of a feeding tube. This is depicted in the soft landing trajectory at the bottom of this slide, where more and more palliative care is in focus with final care under hospice.

In this example, the patient passes away on hospice peacefully, surrounded by friends and family. Contrast that to the hard landing trajectory at the top of the slide, where in this example, the patient’s family decides to actually go forward with placement of a feeding tube and continue full aggressive care, including dialysis and frequent hospitalizations for aspiration pneumonia, wound infections, and heart failure exacerbations. In this example, this patient ultimately succumbs at the age of 91, in the ICU, on a ventilator, with all sorts of lines and tubes in him from overwhelming septic shock with multi-organ failure. The palliative care literature is replete with studies showing that aggressive medical interventions at the end of life often do little more than prolong the patient's suffering without significantly improving health, function, or survival.

We will now look at some strategies commonly employed under value-based care to improve outcomes with this costly patient population and ongoing CMMI models by the three different subgroups represented by the areas one, two, and three in this slide. Again, area one is the intersection of high-cost and chronic care and are those patients usually with uncontrolled complex chronic conditions, area three is intersection of high-cost patients with patients with serious illness under active treatment, and area two are those with serious illness and complex chronic conditions who are high-cost.

Before getting to the strategies, though, I would like to highlight some important objectives for improving the care of this costly patient population. These include providing goals-concordant care, delaying progression of chronic diseases, catching acute exacerbations early to enable outpatient treatment, and reducing treatment burden and complications of treatment.

Some commonly employed strategies to achieve these objectives in this population of patients include involving specialized multi-disciplinary care teams with a focus on care coordination, patient navigation, medication management, and frequent goals of care discussions. As patients progress to serious illness, palliative care and hospice become increasingly important. These care models are very difficult to operationalize under fee-for-service and typically require some sort of value-based payment arrangement.

Examples of such payment arrangements are seen in the various CMS and CMMI model column on the right of the table. These include chronic and institutional special needs plans, the TEAM model, which stands for Transforming Episode Accountability Model, the PACE program, which is the program of all-inclusive care of the elderly, ACO REACH and high-needs DCEs[6], Medicare Advantage Value-Based Insurance Design, or the VBID model. Under seriously ill models, these

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[6] Direct Contracting Entities

include the Kidney Care Models, which include comprehensive ESRD[7] care, Kidney Care Choices, and End-Stage Renal Disease Treatment Choices, and the Oncology Care Model.

Lastly, this session will conclude with a brief overview of performance measures, financial incentives, and payment models relevant to this patient population. This table shows some possible performance measures for this patient population. The four categories of performance measures can be seen in the four row headings, namely process measures, outcomes measures, utilization measures, and cost measures. PTAC has provided some examples of possible population-based, episode-based, and palliative end-of-life care performance measures for each of these categories, as can be seen in this table.

Under process measures, a population-based measure might be, for example, the percentage of patients with advanced care planning discussions documented, an episode-based measure might be the percent of transitional care management visit completion rate, and under palliative end-of-life care, a

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[7] End-stage renal disease

measure might be hospice staff visits to patients in their final three days of life. A population-based utilization measure might be inpatient admissions per thousand, an episode-based measure might be 30-day rehospitalization rates, and palliative care end-of-life care measure might be percentage of patients admitted to hospice for less than seven days or greater than one year.

Many methodology challenges exist in the design of value-based payment models for this costly patient population. These include attribution challenges, since multiple providers may be involved in overlapping episodes of care and in multiple settings of care. Potential approaches to addressing this challenge might be shared attribution by the PCP[8] and specialist team, and concurrent episode-based attribution. Aligning incentives across settings of care solutions might include rewards for participation in transitions of care programs and increasing incentives for appropriate palliative care. Benchmarking the costliest beneficiaries against the general Medicare population hides the disproportionate impact these patients have on spend, and so it’s important to benchmark like

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[8] Primary care provider

with like, in other words, benchmark similar patient populations to allow for appropriate comparisons.

Appropriate risk adjustment is necessary to allow for appropriate provider payment in this very costly patient population. Potential approaches to addressing this challenge include stratifying practices into risk groups using HCC[9] risk scores for attributed patients and using complexity tiers. Retrospective reconciliation denies the use of real-time data to manage performance, and a potential solution might be to implement more models that offer prospective payment methodologies, such as per beneficiary per month payments or bundle payments.

Designing effective, scalable models for the costliest 5-10 percent that we are focused on is exponentially exacerbated in rural locations, where providers often have small patient panel sizes to begin with. A potential solution might be incorporating more multi-payer or all-inclusive models, all-inclusive payer models, and identifying effective payment models within total cost of care is a challenge that can

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[9] Hierarchical Condition Category

be addressed by models that focus on and offer incentives for providing care of coordination and transitional care services.

Finally, I would like to leave everyone with a few big picture takeaways to prepare us for our upcoming panel discussions. Firstly, Medicare spending is highly concentrated. The top 5 percent of Medicare fee-for-service beneficiaries account for 40 percent of Medicare Parts A and B spending. Average per capita spending for the top 5 percent is growing faster than for the overall fee-for-service population. Approximately 40 percent of beneficiaries in the top 5 percent remain in the top decile of spending in the following year. Secondly, the majority of potentially preventable spend is among this high-cost beneficiary population, but historically fee-for-service has not promoted the efficient care of this complex patient population and those with serious illness, because of the payment incentives involved in volume rather than value.

We have two big goals for our two-day meeting together. We want to understand existing effective care models that are efficiently addressing the needs of this population in terms of how they work and the outcomes they are able to achieve, and we want to explore further opportunities for developing new payment models that can improve quality of care and lower costs for this patient population. This slide lists the various panel discussions and listening sessions that we will be having over our two-day meeting, and we as a Committee very much look forward to learning from our subject matter experts who are already, in many cases, involved with this work. Thank you.

CO-CHAIR HARDIN: Thank you so much Walter for an excellent presentation, and also thank you to Lindsay, Lee, and Larry as part of the PCDT. Lindsay, Lee, Larry, are there any additional comments you'd like to add to the presentation?

DR. KOSINSKI: No, I think Walter said it all very well. He did most of the work.

CO-CHAIR HARDIN: I know you all worked on this. For the Committee members, do any of you have follow-up questions for the PCDT? And to indicate if you have a question, please raise your name tent, flip it up or Josh on Zoom, please raise your hand. And it's difficult for me to see your tents, so Angelo if you see a tent raised if you wouldn’t mind calling on that person.

CO-CHAIR SINOPOLI: Sure. Jennifer?

DR. WILER: Thank you so much for a very interesting presentation and analysis. I’m curious, when you were going through this process, what surprised you about the findings that you presented today? Something maybe that was unexpected?

DR. LIN: So I’ll also let the rest of the PCDT opine if they would like to, but I’ll start by saying actually looking at the original analysis of Medicare claims data that was commissioned for this public meeting surprised me in a few ways. One, just the sheer expense of even the top 1 percent of spenders, 129,000 dollars per capita versus the average of 16,000. So we’re talking multiples of the average fee-for-service spend. Even the top, the next category, the 54,000 average spend in the top, I think it’s the top 5 percent, is also very expensive.

What was also surprising was that only 40 percent of patients stayed within the top decile of most costly patients in the following year. I think that was original analysis that was very interesting. Initially there was some discussion amongst PCDT and the broader PTAC Committee about the 60 percent that moved, dropped out of the top decile of spend, and so we kind of look forward to further analysis. There's some initial data that suggests that maybe a lot of them died, but I think there's just not a lot of opportunity to both improve care and lower costs in this population of patients.

CO-CHAIR HARDIN: Thank you Walter.

DR. KOSINSKI: I'd like to make one more comment on Jennifer's question. I was surprised, very surprised, by the slow growth in overall spend on the Medicare fee-for-service population from the years 2017 to 2023, an average of 3.27, which I would imagine is below the inflation rate for that period of time. So that was very encouraging. That being said, we are seeing a significant bulge in the component that's for Part B drugs, and it would be very interesting to see the same data for the Part D drugs, because I would imagine they're growing as well. But I was surprised that the non-pharmacologic medical expenses in the fee-for-service Medicare program only rose at 3.27 percent.

CO-CHAIR HARDIN: Any other questions from the Committee?

CO-CHAIR SINOPOLI: Chinni?

DR. PULLURU: Not a question, but another comment on the data. The arbitrage between the top 1 percent and the rest I find incredibly surprising. The other thing, and to Larry’s point, typically when we see hospital costs go down, we would think that that is a positive sign, the patients are being treated better, kept out of the hospital. However, the Part B spend on drugs sort of balances that out, so it’s not that necessarily they were being spent on stuff like palliative care, professional services, but on a unit cost rate of drugs, and so I think that is -- without prolonging life, and without necessarily adding to a movement from that top 5 percent downwards that we could find, so I think it definitely lends itself to asking questions about is this, are we just moving and shifting costs from what used to be a hospital cost center to now where we’re giving high-cost drugs?

CO-CHAIR HARDIN: And then briefly, Josh, we just have a minute or so before we go to break.

DR. LIAO: Great, I'll be very brief. I think it was a great presentation. One reflection and maybe one comment for Walter and the PCDT. The reflection is, I think as Walter alluded to, that 60 percent and really kind of having this analysis which provides really important insight in thinking about kind of people that stay in the next year, versus people who stay for say two, three, four years, to the extent that I can't imagine a payment model or a delivery model only be around for one or two years. So over the life of what we might anticipate a model to be, three, four, five years, et cetera, what would the stable population be there? Perhaps there is future work to be done.

I guess my question is really around this analysis being very important, and framing everything around top utilization and spending. What I appreciate about Walter's presentation was the focus also on the complex care needs, and I wonder, is there a world in which if we thought any other way about people that have the most complex needs or the highest needs and we kind of thought about the top X percent of those individuals in that population if we might come to additional insights. So just another way of thinking about this population that moves us a bit away from cost, which I know is not the focus of this, but I wonder if Walter has any initial reflections on that.

DR. LIN: Yeah Josh, I appreciate your question. You know, I think the goal for all of us is to provide higher-quality, more goals concordant care. It’s our hypothesis that this type of care will also be lower-cost care, because in part, of what the palliative care literature shows around how aggressive interventions do very little to improve health and survival towards the end of life, and in fact palliative care literature, hospice literature also shows that patients and their families are usually much more satisfied with care that follows a soft landing trajectory in hindsight, both the family and caregivers report that it’s much less traumatic. And so I think there’s potentially a win-win here, to not only focus on providing better care through improved care models for this expensive population, but also to lower costs at the same time.

CO-CHAIR HARDIN: Thank you Walter, and I hear that Lee has a question, and again if you can make that briefly, we are about ready to go to break.

DR. MILLS: Sure, thanks. Following up the question about what struck us or surprised us, I was really struck just as other people were, slides 15, 16, 17, looking at how the population changed over time, and I was struck especially on slide 17, that those that start out in the most expensive 1 percent, 40 percent are sticking the next year in the top 1 percent, but 60 percent have dropped out of the top 1 percent for various reasons, which makes me aware that building programs or pilots chasing today’s costs or diagnoses is going to ultimately be unsuccessful. And slide 17 points to characteristics that seem to predict who sticks in that top 1 percent. And so as we go through this conversation, thinking about things that have worked, what pilots or program tracks may be successful, makes me think to even lean into building pilots, programs around characteristics, not diagnoses or today’s costs, since that can be fleeting.

CO-CHAIR HARDIN: It’s such an important point, and I also strongly see the crossover of behavioral health and health-related social needs is impacting that. Excellent presentation PCDT. We really appreciate all of your time and commitment in pulling this together and really setting a great foundation for our day today.

At this time we have a break until 10:30 Eastern. Please join us then as we have a wonderful lineup for our first panel discussion on providing patient-centered care for patients with complex chronic conditions or serious illnesses and total cost of care models. We'll see you back at 10:30.

CO-CHAIR SINOPOLI: Thank you, we'll adjourn.

(Whereupon, the above-entitled matter went off the record at 10:28 a.m. and resumed at 10:37 a.m.)

CO-CHAIR SINOPOLI: Good morning and welcome back to the PTAC session after the short break. And I am going to immediately hand it off to my co-chair Lauran.

CO-CHAIR HARDIN: Thank you so much, Angelo.

## * Panel Discussion: Providing Patient-Centered Care for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models

Welcome back. Walter and the PCDT shared our starting point for this public meeting and some of the questions we want to explore. At this time, I'm excited to welcome our first panel discussion.

In this session, we have invited four esteemed experts to discuss how they provide patient-centered care for patients with complex chronic conditions or serious illnesses in total cost of care models.

After each panelist offers a brief overview of their work, I will facilitate the discussion by 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'll briefly introduce each of our guests and give them a few minutes each to introduce themselves. After all four introductions, we'll have plenty of time to ask questions and engage in what we hope will be a robust discussion today.

First, we have Mr. Erik Johnson, who is the Senior Vice President of Value-Based Care at Optum Advisory.

Erik, welcome. Please go ahead.

(No audible response.)

CO-CHAIR HARDIN: And we can't hear you, Erik. You need to unmute. Thank you.

MR. JOHNSON: There we go. Thanks, Lauran.

It's a privilege and an honor to be addressing the panel today. I appreciate the invitation, and hopefully, this will be a good setup for the rest of my panelists.

So it's important to note up front that I come from the Optum Advisory Services branch of Optum. I know Optum is a vast enterprise. I am in the consulting arm of Optum Insight. I run the value-based care and population health practice here, been doing that for the better part of nine years. And I've been a health care consultant probably for longer than I to care to admit, about 28 years now at this point.

Optum Advisory is a consultancy of about 2,000 consultants who are focused exclusively on health care across the gamut.

My particular practice focuses on providers who are looking to move closer to what I would call first-dollar premium risk. That doesn't necessarily mean that they're going to get all the way there, but they are looking to engage in risk-based contracting arrangements and develop, deploy, and implement the population health programs that they need in order to manage the attributed or enrolled populations that they're responsible for.

Our goal really is to move decision-making as close as possible to the point of care and to eliminate as much abrasion between the patient and the provider and the member and their benefit as possible. And I think those are two very different vectors that we need to keep in mind as we think about delegated risk arrangements, particularly with respect to complex and poly-chronic populations.

So, with that in mind, if we could just go to the next slide, Lauran, we'll lay out a little bit of how we think through at a very high level, how we sort of organize this work.

The first element that we always strive to accomplish is a consistent risk stratification of the population pool. I should probably say it's also a persistent risk stratification of that population, particularly though, that population that represents actuarial risk. It's changing. There's churn in who is most at risk at any given time.

So we like to run that type of stratification at least monthly for our clients and the populations that they serve. What we have found is that, particularly with complex populations, they go from hidden risk, to rising risk, to risk relatively unpredictably. And we want to make sure that we are tracking those populations and changing work flows accordingly, as we run that stratification.

So the first is to understand really who are we focused on and who should we be investing the most interventions in. The second is to organize the care team around those populations.

We really focus on promoting and designing team-based care that incorporates the increasing insights that we have in the social determinants of health and health-related social needs, documenting those variables in a patient's record, and documenting it with the patient's family.

At the very end of the previous session, I heard Dr. Lin talk about the importance that families have really placed on palliative and hospice care and how glad they are that they were able to avail themselves of that. I think that's incredibly important point, but I also think we are increasingly availing ourselves of family and caregivers for complex populations that are not in a palliative or hospice state of affairs.

And then, finally, once that care team is organized, what we really tried to do is to bridge the gap between providers and payers for that identified population and remove some of the barriers to access that a lot of patients are facing in the marketplace today. Again, we particularly see this with the six populations.

The barriers to access to care and the barriers of access to their benefits has become a real problem that we will talk about a little bit when we get into the Q&A. We have some case examples and some ideas that we found to be pretty successful in managing that type of smoothing of the care continuum.

So that's kind of how we organize our risks: stratify, organize, and remove barriers. That's generally the three guiding lights of our approach to managing these populations.

I will say that we focused -- we do focus quite a bit on the complex and poly-chronic, largely because that's where the money is. And I hate to sound like the cold, black-hearted, dead-inside consultant that I am, but that is, if you are taking a risk on a population, that is where there is money to be made, that is where there's utilization to be eliminated, and that is where there are quality opportunities to be obtained. So that's where we really focus.

We also focus quite a bit on the annual wellness visits and making sure that the non-chronic population gets access to care, but in a delegated risk environment, we're really focusing on this particular population.

So, as a tee-up, that's kind of how we think about it, and I will hand this over to my fellow panelist, Dr. Feifer, to get into national on the ground care models.

CO-CHAIR HARDIN: Thank you so much, Erik.

And next, we have Dr. Richard Feifer, who is the Chief Medical Officer at InnovAge.

Rich, please go ahead.

DR. FEIFER: Thanks. And it's pronounced InnovAge because we have a very older population. And in fact, to Erik's point, it's where the money is, and it's where the clinical opportunity is. So, again, thank you also for having me join this group today.

I am the Chief Medical Officer [CMO] at InnovAge, where I lead all clinical services, population health analytics, and network management.

And before that, I was the CMO at Genesis Healthcare, the largest operator of skilled nursing homes -- skilled nursing facilities and nursing homes, where we started up the first long-term care ACO through the Medicare Shared Savings Programs. We can talk about that, if you want, later.

But PACE, InnovAge is the largest provider of PACE programs in the country, which is sometimes called LIFE in some states. PACE has been around for about 30 years, but it's one of the least recognized, and yet most mature, value-based payment models.

PACE is for the frailest of the frail, mostly elderly. It provides a concierge-like integrated care model where approximately 30 percent of our population's costs are provided through care that we deliver versus care that is delivered outside of us to our network or through acute care and post-acute environments.

Our participants, which is what we call our patients, see our primary care providers on a very frequent basis, and our PCPs carry very, very small panels. They only see three to seven people a day but are very busy with population health and other activities throughout the day as well.

We receive dual capitation from Medicare and Medicaid. And so, back to Erik's point, where the money is, our monthly -- excuse me -- our annual capitation combined is roughly 100,000 dollars. That's because we're responsible for everything that happens.

We're responsible for all the traditional Medicare A, B, or C costs. We're responsible for residential costs if people need them if they need to move to assisted living or long-term care, and obviously, acute care. That's all on us. So we have a very, very strong incentive to keep people independent as long as possible.

So InnovAge operates 20 centers in six states, and nearly 7,000 participants.

If we could go to the next slide, some highlights for us around high-value care delivery approaches -- and I hope we get to talk about them more during the Q&A -- is that PACE programs focus a lot on interprofessional team-based care. That is the legislated model, and it works very well. All care decisions are made by a team that meets every single day to discuss their population.

There's an enormous focus on goals of care and advanced care planning, as there needs to be for this population.

We integrate end-of-life care. We integrate palliative care as much as we can because it's interwoven in care delivery versus something that should be delivered by somebody else.

We focus on holistic care versus disease-centric care. So, as we think about disease management, and we think about our quality metrics, it's very important to have that perspective because one can very quickly go off the rails, in terms of population management, if we get too disease-focused for this population.

For us, everything is about ER[10] diversion because our population, when they roll into an ER, they all look like someone who could be admitted. But in fact, with the right wrap-

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[10] Emergency room

around care and the right ambulatory services, many of them did not need to be.

We focus more and more on creating high-performance networks of assisted living and nursing facilities and skilled nursing facilities versus what would be in any willing provider network because these are our partners in care delivery.

And we have every incentive to address social determinants of health because there are, frankly, no limits to what we can cover out of our capitation.

Some watch-outs, watching out for polypharmacy, which sometimes arises from too much of a diseased-focused care.

Watch out for trying to create too much cancer screening that is not appropriate for the life expectancy of this population.

And watch out for Part D pharmacy coverage, which is the one exception to the holistic, fully integrated, capitated model for PACE because, in fact, Part D has some risk sharing in risk corridors. But for the most part, it's a pass-through cost, so that creates an interesting dynamic. So all else is out of capitation. Part D is carved out and managed separately. We do manage Part D, but a lot of that is pass-through.

But with that, I'll turn it over to my colleague, and we'll come back to Q&A later. Thank you.

CO-CHAIR HARDIN: Thank you so much, Rich.

And next, we have Dr. Kristofer Smith, who is the Chief Medical Officer of Landmark Health.

Welcome, Kris. Please go ahead.

DR. SMITH: Thank you. Good morning.

And Rich, thanks for your comments. I agree wholeheartedly with them, and that PACE is a great program that we need to have more of.

So let me tell you a little bit about my background. And I'm currently both the Chief Medical Officer for Landmark, but I'm also the Chief Medical Officer for Optum at Home, which is an umbrella organization within Optum Health, that includes Landmark, as well as a legacy Prospero Company, and our duals program.

So, currently, this Optum at Home program is at risk for about 1.15 Dually Eligible Special Needs Plans patients, and over 600,000 Medicare Advantage group and individual lives.

We meet the needs of patients across this continuum through a variety of in-home care models, so we provide home-based medical care to the most complex patients within those populations. We have about 150,000 patients who are engaged in that program.

And then we provide a variety of care management services, depending upon the level of complexity for patients.

The scale is rather large: 35 states, over 3,000 clinicians, which has its own challenges around how do you know that the program you have in your PowerPoint presentation is the actual clinical care that's being provided at the point of care with patients and families. And hopefully, we can talk a little bit about that.

You know, personally, I bring the experience of having been in the population health space for the last 16 years. There's almost no program that I haven't had the challenge of trying to stand up, whether that's home-based medical care programs; bundled payment programs; programs for high-risk, community-dwelling Medicaid patients; payment integrity; affordability.

And so, a lot of the comments that you'll hear from me today are steeped in the real practical challenges of moving from a concept of yes, high-cost, highly complex patients need better services to working through the day-to-day challenges of making sure that we are attending to their needs in such a way that they don't need to go to the emergency room.

And so, with that, if you could turn to the next slide, a couple of key learnings. I've tried to not repeat Rich's key learnings since I think we have very similar experiences.

But I think that -- and we'll get into this, and we already heard earlier that not all complex patients are persistently high-cost. I think you'll hear from our comments about different subpopulations that we think have more durable high costs.

We also, in the work that I have done over the years, these patients have multiple chronic illnesses. Disease management programs tend not to be particularly effective.

But in order to be effective, one of the things that conceptually we like to talk about a lot in the programs that we build is you have to have sort of a reactive component to your program, and a proactive component to your program.

The reactive is, patients are going to think of you, and family members are going to think of you when their loved one deteriorates. Like, you have to be ready to provide a meaningful response to those patients in a manner that is timely. And timely is important to the patient, not based on what the program can do.

And then proactive, this is where we need the proper care plans for patients, proper evidence-based medicine for patients so that they have fewer of those exacerbations.

And so we think, broadly speaking, about having a reactive part of our model and a proactive part of our model.

And then, finally, some key learnings over the last several years is that the financial reconciliation in this space continues to be fraught.

And without an ability to understand how you're performing in-year and how that will lead to positive or negative financial reconciliations, as well as how do we accommodate for changing baselines as these programs first get set up and then continue to grow and move forward -- so if we don't figure that out in a more predictable way, we'll continue to have programs that initially seem to be quite successful but then stumble in the out-years of these programs.

Next slide. And then, finally, just a few things to watch out for. I like to call it the tyranny of the easy-to-implement. You know, that's the telephonic case management program that doesn't work, hasn't been shown to work, yet it's really easy to operationalize as compared to something as complex as PACE.

One of the things that we've been seeing is the trap of top-of-license. As you build interdisciplinary teams, one of the big challenges is everybody wants to only do top-of-license activity, and the next thing you know, you've hired a new role type, a new role type, a new role type. They all have overlapping responsibilities, and you diffuse who's responsible for the total outcomes for patients. And so, I think our interdisciplinary teams need to stay tight and not be super diffuse.

And then the siren song of efficiency, this is where, you know, isn't better to have a nurse instead of a doctor; isn't it better to have a community health worker instead of a nurse? And slowly, you move down the efficiency chain, and you've lost some of the real recipe and the adherence to the evidence about what we know works for complex populations.

Scaling too fast and saying culture is important but not living it in decision-making I think is another area where, particularly as we have these disruptor organizations who have interesting early results, and then they decide they're going to scale very quickly, can't maintain culture and are focused more on scaling for a turn or an exit as opposed to maintaining the integrity of the model that got you there in the first place.

So thank you for having me, and I'll turn it over to Marshall.

DR. CHIN: Thanks, Kris, and good morning, everyone. I'm Marshall Chin. I'm a general internist and a health services researcher at the University of Chicago. Clinically, I do mostly outpatient work, and I'm in the middle of an inpatient general medicine attending block right now. I just came back from rounds where most of our patients are of the topic today of complex patients with multiple chronic conditions and serious illness.

My other two roles which are relevant for today are that for the past 18 years, I've directed or co-directed one of the Robert Wood Johnson Foundation's major health equity programs. The current iteration is called Advancing Health Equity: Leading Care, Payment, and Systems Transformation.

We're working with 12 teams of diverse stakeholders. A team consists of a state Medicaid agency, a Medicaid managed care organization, at least two frontline health care delivery organizations, and community-based organizations. And each of these state teams is trying to align payment and care transformation to address medical and social needs through advance of equity, all within an anti-racist culture of equity.

For the past three years, I've co-chaired for the CMS Health Care Payment Learning and Action Network with their Health Equity Advisory Team. The so-called Learning and Action Network is a multistakeholder group of 200 to 300 different stakeholders. And the Health Equity Advisory Team, we have a model of change which has three main levers: care and delivery of organization, payment, and performance metrics.

Next slide. So I think you're going to find a lot of similarities across all four of us on the panel regarding our overall take on the field. And what I'm going to do over the next hour, I'll try to take the equity lens. So with each of the different issues in question, really try to think about it through an equity lens.

And so, when you do the literature review on this topic for what is an equitable intervention, it's basically what everyone else has mentioned so far. It devolves down to holistically addressing medical and social needs, effective communication and strong relationship with patients, close follow-up and monitoring of patients, team-based care, cultural tailoring, heavy involvement of families and communities. So it's not rocket science. It's really, in some ways, an implementation issue as opposed to really conceptual issue.

For equity, it doesn't work unless we intentionally design the different interventions to advance health equity.

And then, the third, also an important one, that it's not payment reform for payment reform's sake, but the payment and the accountability metrics need to support and incentivize the intended care transformations.

And these need to align with social return on investment. And this is a big problem because right now, the system is not aligned to incentivize social return on investment. This is actually the major thing we're working on with the Health Equity Advisory Team of the CMS group over the next year, this idea of social return on investment and payment in performance metrics.

And then, also, these transformations need to align with interventions that address the spectrum -- it's the spectrum of health care equity interventions, health-related social needs -- there's a lot of attention on that right now -- and then also structural social drivers of health.

I think, right now, there's just too much magic carpet thinking in our field. Basically, you do a 30,000-foot intervention, a policy intervention, a payment intervention, and then you magically think it's going to then connect the dots along this -- on these different components of the disturbed bullet. But you have to connect the dots, and we're not really doing that very often.

So, for example, we got the discussion questions for our discussion maybe on Friday. And I think they're the questions that will generate a lot of good discussion. But in some ways, I think they're not really the right questions.

A lot of the questions assume that there's sort of a magic bullet solution that, you know, one of these model programs -- the reality is that all -- everything is context-dependent, and it needs to be contextualized context.

There's also sort of a subtext in many questions of like, what are the patient characteristics, what are the provider characteristics, which can devolve down to a blame the victim approach, as to a heavy emphasis upon thinking about what are the structural systemic problems that are driving the issue here. And I will say that one of the problems we have right now is that we have largely skirted addressing the unwanted structural systems.

And what an equity person would say is that there's a lot of, like, the current system is -- which is rooted in structural racism, classism , like two-tiered systems and all.

And then a lot of the current

solutions tend to build upon the chassis of a traditional system and the chassis of fee-for-service and all, so we tend to undervalue primary care and prevention. We undervalue care coordination. We undervalue good communication and trust. We undervalue addressing social needs. And then, as I like the last person before our panel today talked about, we under-value integrating medical mental health in substance use systems.

And so, a lot of it has been incremental and not really addressing the fundamental problems. We tend to have a short time span, in terms of more of a medium-term of addressing the longer-term issues.

So thank you, and I look forward to particularly adding the equity lens on a lot of the issues today.

CO-CHAIR HARDIN: Thank you so much, Marshall.

And I can tell all four of you, very interesting perspectives. And I want to encourage you to take these questions to the next level with what you'd like to discuss because I think you've all brought up really important points.

So I'll get us started with a few basic questions that you were sent ahead, and the PTAC panel group is also going to be asking questions.

So, first of all, the first question is what are the most important clinical characteristics and challenges associated with treating high-cost patients with complex chronic conditions or serious illnesses in total cost of care models?

And Erik, would you please start?

MR. JOHNSON: Be delighted to. Well, the biggest challenge is knowing who they are. That's why we spend a little bit of time at the top of my comments talking about risk stratification and persistent stratification of the population to know who is starting to move into the key element of the bullseye.

That can be difficult to do if you don't have a good attribution model, so you can actually track patients against primary care doc. But if you do have a good attribution model in place -- and I think CMS has given us a lot of good attribution models over the last 12 years -- it's not that hard to know who needs care.

The next question, I think, the really big challenge is what kind of care do they need, and in getting to the root cause of what their needs actually are. And I think a lot of that, based -- building on the last set of comments, is understanding the context in which they are trying to get care. What is their social situation like? What is their access like?

So answering the question why aren't these patients getting timely and coordinated care often means gaining an understanding of that patient's circumstances. And once you even have that understanding, that understanding doesn't necessarily get reflected in EHR[11] very well.

There are all sorts of technical challenges in addressing these populations, and interoperability remains a big issue 15 years after the stimulus bill.

But I think beyond that, just being able to ask a slightly different set of questions about what is making these people sick, what is keeping these people sick, are going to lead you to non-medical answers, and incorporating those non-clinical answers into a plan of care, I think, is the biggest opportunity. And I think

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[11] Electronic health record

it's one that the industry is starting to get smarter about. And there's a lot of investment going into it, but I think that's -- it's still very new.

CO-CHAIR HARDIN: Rich, how about you?

DR. FEIFER: Yeah. So, a slightly different perspective because we've got a different population. We have, within PACE, the sickest of the sick or the frailest of the frail, same thing within the long-term care ACO that I worked in. So we knew who they were. That wasn't the issue. It wasn't identification.

It was around how to pivot their management. Whereas, before they became part of our care delivery model, they might've had, and they often did have fragmented care, uncoordinated care, or the overall lack of care. And so, pivoting toward a primary care model that's integrated, and it's less dependent upon the ER, is one of the challenges. And that requires a lot of trust-building and, frankly, cultural change.

Second, I alluded to during my introductory comments, which is a clinical challenge of not being disease-focused, not falling into the trap, but really thinking of these folks as complex people who happen to have diseases and are on multiple medications that often aren't thought about together, so looking at that holistically and being concerned about polypharmacy; I mentioned that.

Behavioral health is a huge issue in our population. Fifty percent or more of them have a diagnosis of dementia. Eighty-five percent, roughly, have a psychiatric or behavioral health diagnosis of some kind. So one can't forget that and then the need to work with caregivers and proxies.

And the last clinical challenge is introducing goals of care conversations and advance care planning at the right time and on an ongoing basis so that palliative care can be woven into care planning. And at the right time, there can be an appropriate shift away from curative care, when it's no longer likely to be helpful and it's futile, and toward more comfort measures.

I think I'd leave it at that.

CO-CHAIR HARDIN: Excellent.

Marshall, Kris, I'd love to open it up to you here. Would you like to add, Marshall?

DR. CHIN: Sure. Well, I think you're

hearing some themes of like, ultimately, we have to tailor individualized care to given populations, that all these patients are going to have multiple chronic conditions, oftentimes mental health issues, a variety of social challenges.

And from an equity standpoint, typically, like the first cut is well, they're different identities, right?

So looking at like race, for example, sexual orientation, gender identity, so the ability in data systems to be able to have that data. Right now, for example, race, ethnicity, language data, the gold standard is self-report of patients. A lot of systems don't have that right now. Or something like sexual orientation, gender identity information, again relatively new in terms of systems creating this information.

The deeper cut is -- besides your intersectionality that, in some ways, it's too crude, like general racial categories or like a general thing like sexual orientation, gender identity.

So like the within race/ethnicity, ethnic subgroups can differ. So, among Asians for example, big differences between if you're an educated Chinese American or if you come from a Southeast Asian immigrant refugee history, right? We don't have that level of granularity.

And then, like just again, it's the mesh of then race and ethnicity with class, for example and all, so we need better data systems.

Our general approach is that you can't have the one size fits all approach, that I think we've given like different themes. But in any different geographic area or population area or patient population and all, there's got to be the more specific root cause analysis of what's driving the poor outcomes or the inequities in that particular population.

There'll be some common themes, but some things which will vary across different sites and whatnot. And then the tailoring of the approaches to meet those needs.

So, for example, a thing that’s come up -- we talked about like a good relationship, good communication. And oftentimes, for racial ethnic minoritized population, trust is an issue, right? So the way that is dealt with, in terms of having like the trust to launch into a relationship is going to differ, right?

So we need to have the granularity of

identity to be able to identify populations, do the root cause analysis, then the tailor of the solutions to be holistic -- and again, another common theme. And then tailored for the particular individual patients' communities.

CO-CHAIR HARDIN: Oh, true.

Kris, did you want to add?

DR. SMITH: Yeah, a couple of last thoughts on this question.

So the first thing is, I didn't want to run past one of the things that Rich stated about the population in PACE, and I think it's super important for PTAC, as they're thinking about model design and which patient cohort. Part of what makes PACE effective and sustainable and well-matched is because it's the intersection of medical complexity with frailty.

And what we found in our work is, as we're trying to identify patients who are persistently high-cost and persistently need high-cost programs, it is that intersection of medical complexity with frailty, functional impairment because that indicates a group of patients who are unlikely to get better and continue to have high-cost moments that we can ameliorate through high-intensity care models.

A couple of other challenges I think that are important for PTAC to consider is getting patients to say, yes, frankly. I mean, many of us have the experience of building wonderful programs, and you only get 15 percent enrollment or engagement of the identified population.

And so, as PTAC is thinking about what models to support and how they can go about helping us get the patient and caregiver incentives to participate in high-intensity care models are something that I think really need to be looked at. We see great engagement when we're able to offer some incentives to patients.

I think other things that are challenges in this space -- co-management versus primary management. And what I mean by that is we have in the literature, whether it's the VA Home-Based Primary Care, whether it's CMMI Independence at Home, whether it's the PACE program, those programs are not care coordination only programs. They are taking responsibility for the care being provided to patients.

And they tend to be more successful than the programs that are co-management models where you have a patient on 18 medications, and you're going to the PCP and saying, could you please maybe de-prescribe a medication that I know is unsafe for the patient versus if you're in the primary seat, you just de-prescribe. So I think that that is an important consideration as we're looking at care models.

And then, related to that is this idea of care coordination versus actual care for patients. Care coordination in these complex environments with patients with such high, high needs, urgent care needs, et cetera, they don't need to be care coordinated. They need to have care either brought to them or someone who can provide care at the point of service and not be waiting for a call back from someone who is actually able to take the pen and prescribe.

So I think those are important challenges with these populations and important insights to this team as they're thinking about which models to support. Thank you.

DR. CHIN: Let me talk about Kris's point because I think I forgot -- I had it as a bullet that I think I forgot to cover, and Kris had it in his slides also.

You remember, Kris had a point about everyone says culture is important, and then, all too often, people don't incorporate culture. And I think Kris probably meant a variety of different things by culture.

One of them may have been that point that, you know, we have these buzz words like care coordination, but -- and it sounds very basic, but you know, it's basic caring for the patient that we're trying to do.

The point about equity that I want to point about on my slide was that it's the same thing that -- like, a lot of mission statements say they're patient-centered, or we care about equity and all. But when push comes to shove, equity is not prioritized and valued highly enough.

And we found, for example, that when we have focused on the more technical things, so like the care delivery organization part of it or thinking about payment policy, that will only get you so far because to actually get the inter-organizational change needed to have it to actually happen, people have to truly believe that, in this case, equity is truly important, and we're going to do whatever it takes, across the whole organization, to do the care delivery organization, do the payment reforms to meet that goal.

So, in this analogy, probably the more general point that Kris was making that the same thing that people have to truly care about the wellness of the overall population, and it's just not an efficiency thing that we're just going to do what we have to do to basically make the efficiency goal without truly doing the caring part.

So I think like there's a tendency for us to fixate too much on like the technical parts of the conversation, which are important, but hopefully, you spend enough time on the remaining half an hour to -- also on what's it mean regarding what we can do to encourage and incentivize this culture that goes for the patient and community health and the equitable outcomes.

CO-CHAIR HARDIN: I also think a lot, when we speak about medical frailty or physical frailty, but also the constellation of social frailty. So I see that a lot in my work, the crossover between trauma and poverty, interpersonal violence, behavioral health, the constellation of things that make for an equal complexity that's where we have so much opportunity to deepen how we understand and address that.

Chinni, I see you have your card raised. Please go ahead.

DR. PULLURU: First of all, thank you to all four of you for your excellent presentations and thoughts.

So my question is more around the pathway to taking on global risk. For a lot of organizations, as we know, there's two sets of worlds. One is how do we get people to take on more risk and get to more value-based care principles? And the other side of it are organizations that have already done that and can allocate resources to that. So I think those are two different conversations.

What I'd like to ask all of you, starting with Erik, Drs. Feifer, Smith, and Marshall is, as you think about a pathway to risk -- and I've heard all of you speak about coordinated care and care teams being important -- how would you -- what are things about the payment mechanisms today, on that pathway to risk, that would help incentivize better the care teams that you're speaking about? What are we not paying for that we should?

And then, I'd like you to also think about the patient side of it, right? I've heard a couple times we need to get patients to say yes. So what are things that from a payment mechanism could potentially help patients say yes more than 15 percent of the time?

MR. JOHNSON: Did you want me to kick that off, Lauran?

CO-CHAIR HARDIN: Sure.

MR. JOHNSON: Okay. That's a big question, and there's a big answer. I'll try to offer part of that big answer.

There are a lot of models that we should be thinking about incorporating into other parts of the Medicare program. And I think a lot about the annual wellness visit in Medicare Advantage. That is a metric that people pay attention to, they organize incentives around, they organize activities around. And it generally drives pretty good adherence when a provider group is taking risk in Medicare Advantage.

What are the other visits that need to be paid for or emphasized or stressed in the delivery of fee-for-service medicine, in an ACO, or in other risk-bearing models that prompt a different set of questions?

And I think part of this is -- building a little bit on what Marshall was saying earlier, I think the medical -- I'm not a doctor, okay? So I apologize in advance. But I think the medical profession isn't used to asking the questions that need to be asked. And I'll give you an example, and I think, Chinni, you've probably heard me use this example before.

We had a health systems safety net, health system looking to take risk on duals and Medicaid-eligible individuals. And they identified something that they called the 20 dollar problem.

That is, after an individual was discharged from the hospital, they were discharged with two things that they needed to do. One was to fill a prescription, and the second was to check back in with their primary care doc within 10 days.

This is a transportation desert that the safety net hospital is serving, so there wasn't a lot of bus service. There wasn't a lot of rail service. So that individual is going to have to pay for two cabs or two Uber rides, and they couldn't afford it. These are Medicaid individuals. They can do the drug, or they could do the check-in with their physician, but they couldn't do both.

As a risk bearer, the questions that they started to ask at the point of discharge was do you need a ride? Do you need a ride for one of these visits? And that's the kind of question that isn't always asked at the point of discharge that will drive activity down the line and MA[12] plans have increasingly adapted non-emergency transportation services as part of their supplemental benefits.

It provides a huge benefit, particularly in rural areas, for individuals. But I don't believe it's on the Medicare fee schedule. Should we be paying for that? Should we be encouraging folks to schedule the follow-up visit, paying people to schedule the ride to the pharmacy? I think there are a lot of tactical things that start to take in the contextual situation that the patients find themselves in.

And I don't mean to be an apologist for Medicare Advantage, but I think Medicare Advantage plans have started to think about what is the next step that we should be asking for in

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[12] Medicare Advantage

order to better manage the risk that we're taking on.

DR. FEIFER: If I could build on Erik's comments, I think your comments about what should Medicare be paying for on this path toward total cost models, you know, that's an important one, paying for transportation.

And what that reminds me of is the shift over the last few years, and this has been very favorable, toward paying for unlimited, essentially, advance care planning conversations. That's really important, especially for this population. That was a very important and meaningful move, and it's much appreciated.

On the other hand, there have been some attempts to improve care through payment of services that maybe haven't gone exactly as planned, or one could say that they're a little more controversial. And there, I'm thinking about Kris's comments about the difference between coordination of care and care, right?

And what we really want is the primary care hub to deliver care, and the primary care hub to coordinate care. And one can really question the value of having care coordination occur outside of that hub.

And I think well-intentioned payments for care coordination might have led to more fragmentation rather than more integration at the primary care level. I don't know if you'd agree with that, Kris, but your comments reminded me of that.

DR. SMITH: I would totally agree. I think one of the big challenges to the question of getting patients to say yes is they're bombarded with people calling them to try and coordinate their care, coordinate their transition, help make sure that their social determinants are uncovered. Each individual program had a good reason for coming together.

Each individual caller has a good mandate that they're trying to solve for. And so, I think, if we want to get higher engagement rates, we need to be a little bit more clear on who is responsible for the patient, and then, as importantly, who is no longer responsible for the patient and should cease and desist activities that confuse patients and families.

I think we should think about paying patients to participate in some of our really successful programs. You know, 25 dollars a month to answer the phone call when your care navigator is calling might actually be really helpful to keeping patients persistently engaged in programs over time. We can talk about trust, and we need really high-quality clinicians to build trust, but you know, 25 bucks a month might actually help things.

Some other things that we need to do to improve the performance of provider organizations, health systems, their willingness to take full risk, things like concurrent risk adjustment would be really helpful.

I think we need to move out of demonstrations and into programs that are now law. And therefore, we can business plan for 10 years as opposed to two years.

When I was in the health systems side, and I would go to our CFO[13] and say, I would really like to put us into this risk-based environment, we would look through all the requirements and the changes that were going to happen. And they'd say, okay, so after 48 months, you're going to change the baseline.

So if I'm performing really well over the first 48th month, what you're guaranteeing me

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[13] Chief financial officer

is I'm going to put in expensive infrastructure, and then you're going to take away the revenue in years 3, 4, and 5.

If we don't fix those problems, we will not get more providers into this space because they are reasonably saying, I'm living on a 1 to 2 percent margin; I can't tolerate the risk of going into years 3, 4, and 5 with this expensive infrastructure that's required to manage total cost of care.

I know these are things that have been said before and that you've heard, but we still, 15, 20 years into population health haven't solved them completely.

DR. CHIN: So I'll answer the two questions from the perspective of the safety net. So I do a lot of work with Federally Qualified Health Centers and safety net hospitals, institutions. And so, the concern is that similarly, as Kris said, very small margins, and so really at risk if things don't pan out.

Oftentimes, not the data infrastructure and analytic infrastructure to be able to initially do well strategically. And this is one of the concerns with some of the existing programs, like local hospital readmission program, which found that like the safety net was often particularly harmed. Probably one of reasons is because of not having the infrastructure to do well regarding like the quality improvement programs and all.

And so, it may seem that, well, first that having like some of the up-front infrastructure money or some of the per member per month or capitated money up front, along with coaching to help with that infrastructure.

So like the IT and the analytics and whatnot, and/or partnerships with other parts of then the network or system that would be able to help with that particular skill set that may not be as common amongst some of the safety net.

Also the idea then, as in many other programs, of the ramp up, so like pay for reporting, upside risk, the upside and downside risk. So needs to have like a sort of a gentler glide path.

And in particular, the part about the technical assistance and coaching part, I don't think we do that nearly enough. Assuming that well this money will do it and all, or the overall incentive, having some type of coaching and TA[14]

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[14] Technical assistance

support available, some plan for that I think would be helpful also.

Your second part of the question about like patients, well, actually, I'll answer maybe even -- well, I think maybe a more vital part of it is that we talk about involvement of patient communities. Oftentimes, they give us lip service.

And if we really want to have the culture change and if you really want to have North Star on patient and community health, actually involving patients' communities in the governance structure, power sharing is the way to go.

With the most recent version of our National Advisory Committee for our Robert Johnson Foundation program, three of our current national advisory members are current and former Medicaid beneficiaries with advocacy experience. It's just changed the total dynamic of the discussions and all with the different teams and all.

So, again, going beyond lip service to -- if you want to have meaningful change and really sort of mutually put the patient communities first and have the focus stay on that as opposed to other non-patient community health goals, power sharing with communities is important.

MR. JOHNSON: I do want to build on one thing that Kris said earlier about paying patients to participate because I think that's a really astute observation.

I think the other thing is we need to figure out a way to monetize and incentivize the participation of caregivers and families. They become incredibly important parts of the care team, particularly with this population and especially if you're moving to complex and frail, and I don't think we've unlocked that door yet.

And I don't have a recommendation, but I think it is an area worthy of research and investigation about how do we put money on the barrel in order to get providers to engage with families and for families to engage with the provider team.

DR. FEIFER: Erik, I'm glad you added that. That reminds me of paid caregiver programs. We have that going in a few states, and it's important for two reasons. One is the reason you stated, absolutely, 100 percent agree. It's also important because we have a huge talent shortage among caregivers that we might want to hire, and we can't find. And so, it helps us on both sides.

CO-CHAIR HARDIN: Also a really interesting equity issue.

So, Angelo, please go ahead.

CO-CHAIR SINOPOLI: Yes, thank you, Lauran.

So I've heard some things during this conversation that over the last year or more, as we've interviewed a lot of subject matter experts, the two themes that keep coming up is the importance of team-based care and the importance of non-telephonic, you know, personal outreaches to patients and how often those occur.

Now, I've heard you all reiterate that somewhat in this, but also acknowledge that even a team-based approach can get fragmented and actually decrease outcomes as opposed to improve outcomes.

So I'm curious, how do you all actually define what team-based care -- what's team-based care mean to you all, and what things do you put in place to make sure it doesn't become fragmented like I heard described? So I'd like to start out with Richard on that.

DR. FEIFER: Well, thanks. And if I could, first, just comment or clarify something you said about lack of telephonic.

I would argue that telephonic can be just fine, depending upon the situation, if it's coming from the primary care team. I think the problem that I heard earlier from Kris -- and again, I don't want to put words in your mouth, Kris -- is this fragmented telephonic outreach coming from a variety of organizations that have nothing to do with the care delivery team. That's the problem.

But to have frequent touch points, whether they be in person or video or telephonic, whether they're in the center or office or in the home, coming from the broadly defined primary care team, that's great, and we should encourage that as much as possible. That's the most important point that I want to make on that. Others?

CO-CHAIR SINOPOLI: How would you define team-based care then --

(Simultaneous speaking.)

DR. FEIFER: Oh, sorry. Team-based care. PACE is defined for us. PACE was defined by the enabling legislation decades ago, and it involves 11 members of the interdisciplinary team. But I don't think that's really what you're getting at.

What you're getting at is what's important for team-based care. And I could define it kind of conceptually as, well, that depends on what each patient needs, right? Someone who has a complex, let's say, cardiovascular episode, you want that cardiologist or someone advising on that to be in some manner integrated with the team. But I don't think that's what you're asking either.

I think more commonly for our population -- again, the frailest of the frail -- it's very important for the team to involve in all cases therapy: PT[15] and OT[16]. It always comes up. These are folks, whether they have acute or chronic mobility issues or functional issues, they're part of the team.

Social work is always part of the team. Primary care and nursing are always part of the team. Then you get beyond that, it depends upon individual characteristics. But the more we can have the payment model provide the right incentives for the team to coalesce and deliver

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[15] Physical therapy

[16] Occupational therapy

services together versus in a fragmented way, the better.

CO-CHAIR HARDIN: Marshall, please go ahead.

DR. CHIN: Yeah, I was going to build upon Rich's comments, and I agree with everything Rich said.

I was like reviewing the National Academy's Primary Care Report recently -- actually, last night, in breadth -- and you think about it, like a lot of principles of primary care are the ones that I think apply the answer that there is someone in charge that is ultimately responsible. They have a trusting relationship with that patient and family. There is some type of longitudinal relationship.

There are a variety of different specialties, or services, physical therapy, whatnot that may be involved. Ideally, they are seen as part of the integral whole. So that's the promise of the telephonic interventions.

If it's like some outside group that is not really sort of viewed as coordinating with the team or that has that trust and relationship with the patient, and well, it could be a model so that at a minimum, then that primary team is truly coordinating and orchestrating.

But I think a lot of it devolves down to like those basic principles of primary care, which can be applied then to the definition of team-based care. The trusting, the relationship part, the communication part being two of the critical ones, which again are the things which just tend not to be valued either culturally or financially in our systems.

CO-CHAIR HARDIN: Kris, did you want to comment?

DR. SMITH: Yeah, just a couple other thoughts to add on to Marshall and Rich about what is the interdisciplinary team.

I think one of the mistakes we sometimes make in this space is -- and I'm going to use an example. I'm not picking on pharmacists, so if there are pharmacists listening, I love pharmacists. But like, there's some good data that you can have a pharmacist helping in a primary care environment, right? But in most primary care practices, the percentage of patients who have severe polypharmacy that is impacting patient outcomes is less than 5 percent.

And so, but then you have some of

these complex programs where every patient has polypharmacy or 20 percent of the patients expire each year on service.

And so, within those programs, your physicians or your APCs[17], they should be able to have, you know, some abilities in primary palliative care, for example, and some abilities in managing medication complexity such that you shouldn't need necessarily to keep increasing the interdisciplinary team to have a pharmacist, to have a palliative care physician.

Like, the team should be a little bit tighter. It should be a doctor, a nurse practitioner, a nurse social worker, with some physical therapy. And we ought be careful not to continue to proliferate role types when a lot of that work should be done by the primary team.

CO-CHAIR HARDIN: That's so interesting. And I think I'm just going to add my own additional question about that.

So you've talked about the importance of anticipatory management or proactive identification. And I think it's very interesting to think about what discipline or what training creates that ability and sustains

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[17] Advanced practice clinicians

that ability.

So I'm going to go next to Walter. And then Josh will be next.

DR. LIN: I just wanted to start by thanking our panelists for such a rich discussion. I'm learning so much.

I wanted to say, one of the underlying theses for this two-day meeting is that for this particular population of patients we're talking about, better care management, more intensive primary care can actually both improve quality and decrease costs compared to an unmanaged population. And so, one of the reasons we asked each of you to speak on this panel is because you have experience in running real-world programs that have achieved these kind of outcomes.

I'd just like our panelists to paint a picture of what is possible from both quality and financial cost perspectives in a tightly managed program compared to unmanaged fee-for-service, the more specific the better. So if you can give us kind of -- just paint a picture of the opportunity out there that Medicare can look at and try to perhaps emulate.

DR. FEIFER: Well, I might kick it off, Walter, since there weren't any other takers yet.

But you know, what I think of is a recent experience in my own organization where the financial model created an enormous incentive to invest in care delivery, and that's really what we're talking about here: to invest in care improvement. How do you create an enormous, compelling incentive to do that? And we had that here in our population.

Again, PACE, which is very much a frail, often end-of-life population that largely lives independently. And we were seeing very high costs that were attributable to end-of-life experience and direct costs related to hospice.

And as you know, hospice is fully carved into the capitation at PACE, whereas in the past, it has not been fully carved into other payment models, but it is in PACE.

And we ask the question, are people receiving the right experience through that, and we are very passionate about palliative and comfort care, but in many cases, they were not receiving the right experience.

It turned out that it was more fragmented than it was integrated, and our whole model is around integrated care. So that created an incentive for us to do it better internally.

And so, we're investing an enormous amount, given our scale, in palliative care training, in hiring staff, 24 by 7/365, that we can go into the home. We can bring people into our centers, and we can provide what people need internally and having that be fully part of our care process.

I think it's a good story. It's a good case study of how to create the right incentives and then let the care delivery system figure it out on their own because it's compelling.

MR. JOHNSON: That's a really big question. What does it look like? You guys are asking big questions today. I think a lot of what Rich just said I'm going to steal. From the standpoint of the Committee, I think about four big things that constitute what you're trying to get at.

One is putting programs in place that reward scale. I think from an actuarial standpoint, from an investment standpoint, from an amortization standpoint, you want to be able to scale across geographies and aggregate as many populations as you can.

The second is -- this is probably a bell that's been rung a thousand times in the last 30 years, but reward primary care and try to drive primary care attribution that way.

The third element, I think, getting back to some of the investments in technology that I've heard other people mention, and I wholeheartedly agree with this, providing clear visibility into the populations that are attributed or assigned and what their needs are going to look like over the course of the next 12 to 18 months. And I think the analytics exist to do that.

And then the fourth element I think that the Committee should consider -- and I think you already are -- is aligning incentives in Medicare and Medicaid. I think that gets to the scale question that I mentioned up front.

When you think about large physician groups, integrated delivery networks, they are serving a lot of different types of payers. And it's hard to optimize for the Medicare frail population when it represents less than 20 percent of your patient groups.

There are going to be investments that are sort of bespoke to that population. And again, back to my comments earlier, that's where the money is. But you want those investments -- I think that you're asking for health systems and physician groups to make -- to amortize over multiple programs.

Now, whether that's MA[18], PACE, Medicaid Managed Care, ACOs, it's got to be aligned. And I think that that is happening slowly. We're seeing that withREACH and AHEAD[19], and I think that's good, but more needs to be done.

DR. CHIN: So I'm going to build upon Erik and Rich's comments and get to the equity perspective. And you remember Erik's slides? He had like the risk stratification. That was your first point, Erik. So it's all a spectrum, of course.

And then, on the most severely ill and all, then you have your highest percentage of people where you have cost savings opportunity.

I think like from the equity field, there's been a concern that sort of the dual standard regarding the overall discussion so that sort of a strict cost savings perspective applied to marginalized populations moreso than other

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[18] Medicare Advantage

[19] All-Payer Health Equity Approaches and Development

populations.

And so as I think Rich was saying in his comments, as you go lower in that pyramid regarding the overall severity of risk and all, you're going to have then a fair amount of care that's not necessarily going to be cost savings, but it's going to probably be high-value.

Rich mentioned like the patient experience for end-of-life care or just like the overall disease outcomes, condition outcomes, and overall health then for the marginalized populations.

So I know that part of the discussion that you have as a Committee is like, well, the cost savings component of the discussion. I think within your wider role of just sort of put on the table of just being careful regarding like not having the double standard for marginalized populations and not undercounting the numerator part of the value equation, especially for marginalized populations and policy.

CO-CHAIR HARDIN: Kris, did you want to add anything?

DR. SMITH: No, I think we can keep moving. I think everybody's comments covered my comments. Thank you.

CO-CHAIR HARDIN: That's great.

Josh, please go ahead.

DR. LIAO: Great. Well, thanks, everybody, for really thoughtful presentations and the discussion so far.

You know, I know that Erik mentioned kind of big questions. I'm going to try to give big context but land a small question perhaps for the group.

One thing that came up just a little bit ago that struck me was this question about care versus coordination of care. And it's something that I know our group and many others have been thinking about; no doubt all of you have been thinking about it as well.

And often, I think the conversation is framed as we don't have enough care coordination. You know, fragmentation comes from not enough of this. And I heard a few of you allude to the fact that we might have too much. You know, that there may be double, triple duplication, maybe some of that.

So I'm curious, if we take both sides of the issue -- and I'll focus more on the latter because of that -- if you had pen to design the model today, what is the one thing you would do to fix that issue?

I heard a term cease and desist. That's not exactly a friendly, give-a-hug type of action. There's some firmness behind that. So what would that thing very practically be?

DR. FEIFER: Well, I think I'd like to start with a short answer, which is to provide every incentive for the primary care provider and the primary care system itself to be responsible for care coordination and to be responsible for any failures of care coordination, whether that's through payment model or other measures.

Because if one does that right -- and I believe in PACE it's structurally designed that way, but you want to extend that model to other systems. If done right, then the primary care system will figure it out. They will care coordinate.

DR. SMITH: Josh, I'll answer your question in a slightly different direction. So I think we have to be super clear on what it is that we're trying to accomplish.

So there's oodles of literature and data that care coordination can improve certain things. I mean, it certainly can improve patient experience. There's some evidence that it can improve caregiver burden or burnout, but if you're looking for total cost of care amelioration, care coordination is like the wrong tool, right, if it is a standalone service.

And so, I think if we are really looking for total cost of care improvements, there has to be an interdisciplinary team, whether it's the primary care provider or some disruptor where the patient is removed from a failed primary care relationship and moved into a new one.

But somebody, some entity has to be responsible for being able to provide longitudinal care, urgent care, and probably if we're talking about this population, palliative -- a mixture of palliative, social determinants, and behavioral health, depending upon what the patient needs.

But I think part of why care coordination programs fail is in almost every care coordination, one of the key boxes that you have to check is does that patient have a follow-up appointment with their primary care provider. Well, there's a like a big logic fallacy there, right?

Part of the reason why that patient is

failing is because they are in a care environment that is not meeting their needs. And all our care coordination programs can do is try and keep pushing them back into that care environment.

And so, if we don't address the fact that part of why patients are failing and therefore rising up in the claims is because their current provider isn't structured to meet their needs, we won't make the progress that we need to make.

That's a bit controversial, so but I think it is part of why we see care coordination programs fail. They just keep pushing patients back into systems that aren't responsive to their needs and wonder why they're still in the emergency room.

DR. CHIN: So, Josh, I love your question and how you started big picture and then came down to a focused question. And I'll give you sort of a qualitative answer in response.

So I'm actually on the general medicine service right now, and most of our patients fit this category. Two in particular have very involved family members. And in some ways, the family member has played the care coordination role across different systems of care: inpatient, outpatient, clinic, specialty services, rehab facilities, et cetera.

And so, to me, the thought experiment is, well, how would the system be set up so that it doesn't have to be that person that's tying it all together? I mean, who would be the person or team or structure such that this is sort of assembled together so it's an easier discussion for that patient and their caregiver, advocate, and all? Harder when it's not an integrated system. Hard even with an integrated system.

But I think it partly gets back to the issue of like, sure, there probably can be incentives and all that can help encourage this, but it gets back to the cultural point too that the system has to prioritize that this is something we're going to do because this is a heavy lift implementation wise. Again, finances will help, but it has to be cultural too, so they go hand in hand.

But that's a thought experiment. Do you have like what would be necessary so that the patient advocate doesn't have to do all that time together on their own?

CO-CHAIR HARDIN: Erik, did you want to comment as well?

MR. JOHNSON: No, I think my comments have been well covered more articulately by the other panelists.

CO-CHAIR HARDIN: Excellent.

Larry, I'm going to turn it to you.

DR. KOSINSKI: Thank you, and thanks to the panel. This has been a very stimulating discussion. I've been hanging on right there by my threads with this conversation.

I'm going to bring out a couple of comments that I jotted down. Erik made the comment that we need to bridge the gap between providers and patients. Kris spent some time talking about reactive versus proactive care. We just had a very in-depth discussion with the last question about how we would get primary carers to actually implement this.

I don't know what primary carers you're seeing in your organizations, but I'm seeing primary care doctors seeing five patients an hour. And they're hanging on for dear life too, especially in these very seriously ill patients. And they wind up bouncing specialist to specialist to specialist who are all paid fee-for-service and aren't in any kind of a risk arrangement.

And we're going to have our meeting in September talking about the glide path that we have to go on to accomplish value-based care. I don't know that I've heard from the four of you concrete items as to how we glide these primary care doctors into the model you want them to be on.

The only way I can see it is if the compensation model drastically changes because they don't have the time, they don't have the staff, they don't have the wherewithal to handle these complex patients under our current model.

DR. SMITH: So, Larry, I'll start. I think there are practical things that we can do if the question is how do we activate our primary care workforce.

So the first is we've got to offer prospective payments to those provider groups to be able to participate in these, and it's got to be real money so that they don't have to see five to six patients an hour, right?

And then we have to protect them from the downside of some of the early years in the transition. And that's what you see right now in the private equity venture space, is everybody is trying to grab these primary care practices by providing protection from downside risk in the first several years while you get your capabilities up to speed.

So we can continue to allow that to be something that's done in the for-profit space, or we can figure out how to do that in some of these demonstrations because the for-profit space takes some of that money out of the system for profit. So I think we need to do that.

And I think we need to be super clear about what we expect to be invested in. And I think we have enough evidence over the last decade to say, like, if you're going to take risk on highly complex patients, you have to invest in urgent care capabilities, same-day urgent visits within your practice. If you can't do that, patients won't come to you when they're having an exacerbation.

So how are you taking this seed money and, whether it's creating space within your schedule to see patients if they call, like what's the measurement that we can do for in-bound clinical calls, what percentage of them get a same-day appointment, for example.

And then, I think, you know, you've heard it several times. Like, how do we incentivize high-quality palliative care where probably the terminal measure of percentage of patients who expire on hospice is really the right measure because if you're holding folks accountable to that, you have to put a lot of activities in place rather than just enough documentation to get paid the advance care planning code within the Medicare fee-for-service.

So I think there are practical things that we can do to get our primary care workforce to be more successful in this space.

I'll leave it to the rest of the group.

CO-CHAIR HARDIN: Erik, I think you had your hand up first.

MR. JOHNSON: Sure. Just to build on those comments. This is kind of a Cortez, burn the boats kind of question, I think.

I think a lot of the incentives that have been put in place in front of primary care docs just are insufficient. And I've talked to a lot of primary care physicians who sort of surprisingly to me have said can you move me to risk as fast as possible? That's not a conversation I was having five years ago.

But when you dig deep into that why they're asking for that, it's just pay me capitated payment or something up-front to smooth my cash flow and give me the freedom to call the patients I know I need to call because I know they need to be seen, and I need to intervene. Because right now, in a fee-for-service world, I'm just dialing for dollars, and I'm filling my slate of appointments as much as possible, with whoever answers the phone.

Putting in place a care coordination fee, not a bad thing. Putting in place quality payments, not a bad thing. But I think we really need to go much faster towards something that really makes a tectonic shift in the economics of primary care to make it worth their while to make that.

And I think, in addition to that -- and this gets a little bit to what Kris was describing -- we need to have a readiness template before we do that with those physicians. In order to participate in this type of Medicare payment program, you need to be able to demonstrate that you have these types of capabilities in place to manage that risk.

With that in mind, I think you would

see a lot of willingness in primary care to move into something that looks like capitation or a PMPM[20]. But the incremental adjustments that we're making to the fee schedule in order to encourage this, it's not going to work.

CO-CHAIR HARDIN: And Marshall.

DR. CHIN: Yeah, amen, Larry. Thank you for that question, which I think really is one of the ones that gets at the root of the problem.

You remember we talked earlier on about like the underlying systemic structural problems. I think you hit your head on the nail with what may be the fundamental problem is primary care, or more generally, the types of services and functions that are represented by primary care, and we're talking things like the care coordination, the good communication, the trust, the holistic view, addressing the social, integrating the medical, the mental, substance abuse, and whatnot.

I mentioned last night I read the -- the chapter I read in the National Academy's Primary Care Report was the payment chapter, which I would recommend that maybe the

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[20] Per member per month

Committee and staff take a look at again.

And the story is that like the first National Academy's Primary Care Report was 15, 20 years ago. And you know, in some ways, like not much changed. Much of their recommendations were not implemented.

So the charge for this most recent report, which came out a couple years ago, was implementing. It's actually in the title: Implementing the High-Quality Primary Care Report, of which a big part of it is going to be then like the payment and all of the regulatory mechanisms.

And then, this particular payment chapter, they go through like four different options, ranging from pure fee-for-service to hybrid models of fee-for-service and capitation, pure types of local payment models, and then the fourth one is like if you actually say a priority, we're going to devote X percent of the health care budget to primary care.

And their review, at least of that time, was that this is a nascent area. So CMMI has had a variety of different demos and also a few demos, but there's clearly not sort of a clear answer here.

I think like Erik talked about some of the principles that these programs have tried to do, and certainly there are nuggets there, but that's the challenge really of the Committee for this topic of given those goals of it can be structural goals of primary care, prevention, care coordination, communication, trust, social needs, integrating medical, social, substance abuse, how can that be done both in terms of the incentives and payments and then the culture?

So I would be suggest taking a look at that chapter in that report just as a refresher regarding some of these existing data and whatnot.

CO-CHAIR HARDIN: Thank you, Marshall.

Rich, please go ahead.

DR. FEIFER: Thanks. I just had two reactions to my colleagues that I thought I'd add to some things that they said.

The first, Erik, you said, around primary care incentives, give them the freedom to do what they need to do. And I think there is something incredibly valuable there. You said it really well. It's the freedom. It's the error cover. It's the financial incentives. And let them figure it out.

And it may be the individual primary care provider, or it may be the leadership of that primary care delivery system that has an even more compelling incentive to get their primary care providers to figure it out or to bring additional resources to bear at the primary care level. That is the essence of what's necessary here.

It doesn't solve for workforce shortage issues, which is a whole separate category we could discuss another time. But where we have the right staff, that's how you get from the five or more visits an hour to two or one visit an hour because that hour-long visit is going to avoid a hospitalization or an emergency visit, it pays for itself. It's how you get that to happen.

The second thing I wanted to react to very quickly is Kris's comment about hospice. And it begs the question, what are the right performance metrics? Everything isn't about financial incentives and payment models, right? But there's also performance measures, whether it quality or operational performance.

And Kris, you mentioned a common metric, which I've used in the past, which is the percent of a population that ultimately dies on hospice. I've gotten away from that in several organizations because, for us, that's created the wrong incentive.

And what we've implemented instead, which we find very helpful, is the percent of the population that had a hospitalization in the last month of life. Of course, it's never going to be zero.

But if you use that as your goal, then you're going to put in place whatever is necessary to proactively identify people with a high short-term mortality risk, that put in place the right incentives for primary care to have advance care planning conversations and goals of care conversations, and to think about introducing palliative care at the right time, and to put in place all the resources you need so that when the prognosis is, in fact, dire, and curative care is likely to be more harmful than helpful, then there's a pivot, and people tend to not be hospitalized as much.

So that, to me, is a golden metric that hasn't been used enough in health care.

CO-CHAIR HARDIN: This has been incredibly rich dialogue. Each of you have a very valuable perspective, and I feel like we're just getting started, but we only have about three more minutes left. So I wanted to give you each a chance to add any additional comments that we didn't get to that you think would be helpful for the Committee to hear.

And Erik, you came off first, so I'm going to go to you first.

MR. JOHNSON: That we didn't get to today, I think we need to spend a lot of time thinking about how do we integrate specialty care into these models. I don't have an answer to that.

I'm fascinated to see what the Committee actually delves into on that, but I think, particularly with this population, addressing some of the specialties and getting them involved and having some skin in the game is incredibly important.

CO-CHAIR HARDIN: And Rich, you had your hand up next.

DR. FEIFER: Well, I had my hand up as a legacy from the last comment. But since I'm unmuted, very quickly, I heard as we were joining before, maybe it was during the Q&A after Walter's initial presentation, the difference between identifying people based on diagnoses versus characteristics. One of the Committee members mentioned that, and I wrote it down. That's precious for this population, and so I'd like build on that.

What characteristics? Characteristics are frailty. Characteristics like recurrent falls. Characteristics like using the ER on a recurring basis for non-emergent needs. That's a behavioral characteristic. That's how we identify people for outreach. And characteristics like mortality risk, so much more important than disease-focused. So I thought I'd give some more granularity to that.

And then, of course, what we need to do on the delivery side -- and this has been said a few times -- is to make sure that we are providing the 24/7 access for this population so that they trust that we're here for them and that they're not using more expensive and lower-value sites of care.

So I'll leave it at that. Thank you.

CO-CHAIR HARDIN: Thanks.

Marshall? Kris?

DR. CHIN: So in the appendix of my

slides, I have a recent NEJM[21] piece that Alicia Fernandez and I wrote that came out maybe a month ago about health equity. We talked about like three different areas. Two of which we've talked a lot about during the past hour: care reorganization and payment.

The third and one that I would highly encourage the Committee to think more about how that can be aligned then with your payment policies and whatnot is the category of values in governance because ultimately, all of this depends upon everyone truly valuing these principles of care management and things like Erik said truly managing holistically the patient and communities with these complex patients.

But all too often, really, the systems and incentives aren't aligned to really care about patient and community health as really the North Star.

So that's I'll sort of end with that to refer to my NEJM paper that Alicia and I wrote, and then thinking about how can that be integrated through the values in governance piece with what we've talked about regarding payment and care transformation.

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[21] New England Journal of Medicine

CO-CHAIR HARDIN: Thanks, Marshall.

All right, Kris, please take us home.

DR. SMITH: Yeah, so the last advice I guess I have for the Committee is I haven't looked at all the different groups that you're bringing in today, but if you don't have a CFO panel, then you're going to miss out on one of the key voices in figuring out how to get these programs to be adopted more widely and scaled more substantially. They hold the key to yes or no, are we going down this path?

And I think that there continues to be, as I've mentioned a couple times, a lot of challenges with the way in which many of these demonstrations are financially structured. If you heard those voices, I think you would understand to even greater depth how things need to be constructed going forward.

CO-CHAIR HARDIN: It's a great point when we think about interdisciplinary teams. And I think part of it, really important to think about. So we've covered a lot of ground today.

We want to thank all four of you. We know your time is very valuable, and we really appreciate all of your perspectives. You're welcome to stay and listen to as much of the meeting as you can over the next two days.

At this time, we have a break until 1 p.m. Eastern. Please join us then. We have a great lineup of guests for our Roundtable Panel Discussion on Provider Perspectives on Improving Outcomes for Patients with Complex Chronic Conditions or Serious Illnesses in Total Cost of Care Models.

We'll see you back at 1:00 p.m. Eastern.

(Whereupon, the above-entitled matter went off the record at 12:01 p.m. and resumed at 1:00 p.m.)

*** Roundtable Panel Discussion: Provider Perspectives on Improving Outcomes for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models**

CO-CHAIR SINOPOLI: So welcome back. I'm Angelo Sinopoli, one of the Co-Chairs of PTAC. At this time, I'm excited to welcome the experts for our roundtable panel discussion who will share provider perspectives on improving outcomes for patients with complex chronic conditions or serious illness in total cost of care models.

You can find their full bios and slides on the ASPE PTAC website. At this time, I ask our panelists to go ahead and turn their videos on if you haven't already done so. I'll briefly introduce each of our guests and then give them a few minutes each to introduce themselves.

After all four introductions, we'll have plenty of time to ask questions and engage in what we hope will be a robust discussion. So first, we have Dr. Matthew Wayne who is the Chief Medical Officer of CommuniCare. Welcome, Matt.

DR. WAYNE: Thank you. Thank you for having me today. I'll spend just a couple minutes giving a little background. I look forward to our discussion.

I'm Chief Medical Officer for CommuniCare Family of Companies and Personalized Health Partners. CommuniCare is actually a family-owned business. And as you can see from the logo, it's our 40th year in existence starting with a couple nursing homes in Cincinnati and has since expanded to about 130 skilled facilities in seven states.

Personalized Health Partners or PHP is CommuniCare's medical practice. And at present, we started that practice about four years ago. At present, it includes about 12 full-time primary care physicians.

We actually have expanded into behavioral health and physiatry as well. And we have about 100-plus nurse practitioners that support the team. Of note and I think one of the things that has accelerated our kind of transition to value-based is that about 25 percent of our residents on any given day are in some sort of capitation of care model, specifically institutional special needs plan, as well as we have a high-needs ACO REACH.

And it really helps to kind of provide a motivation to transform and change the way we engage both in care and how we're engaging our residents. Just a real brief background about myself. I'm board certified in internal medicine and geriatric medicine. I've been Chief Medical Officer for about 15-plus years, nine with CommuniCare.

Actually, as a background and I'm certainly happy to speak to it if the need arises. But I have been a Chief Medical Officer for a successful ACO called New Health Collaborative in the Akron market. We have about 20,000 Medicare

Shared Savings participants in that ACO, as well as engaging in other value-based contracts with some managed care plans. Next slide.

As far as key takeaways, and again, I want to start very basically but again more strategic than tactics. I think we have some time to get into tactics. But strategically, I think sometimes we overcomplicate this.

And when you distill this down, everything that we do is based on creating a connection or relationship with our patients, with our residents. That drives everything else we do. And so the way in which we engage and the time in which we take to engage is predicated on forming those connections.

And we can see that where these connections form in meaningful ways, good things tend to follow. And so what happens, first you start with that foundation of the relationship. Once that's established, obviously, we seek to define goals of care, understanding our patients, what matters most to them in the context of their chronic disease and their health concerns.

And then how does that then translate into a better understanding of goals or care, what they want, what they don't want. Beyond the advanced care planning, we embrace best practices and chronic disease management. While there is a lot of art in medicine, there really shouldn't be 25 different ways to take care of heart failure or diabetes.

And so we should embrace best practices. We should agree on those best practices as a medical practice. And then we should hold ourselves accountable to those best practices.

And then last, I think accessibility, right? I mean, so it doesn't get more complicated than that. But we need to be present and there when our patients need us as opposed to when it's most convenient for us.

So everything we do as far as our availability and as far as how we build our schedules is geared around that flexibility. So that obviously we can see folks routinely when needed. But when the issue arises and they need to be seen more urgently, we have the flexibility to do so in almost all cases. So again, I look forward -- thank you for having me, and I look forward to having further discussions this afternoon.

CO-CHAIR SINOPOLI: Great. Thank you,

Matt. Next, we have Dr. David Gellis. He's the Vice President and National Medical Director for Medicare Population Health Programs at One Medical Senior Health. Welcome, Dave.

DR. GELLIS: Thanks. I'm going to try to make the title as much of a tongue twister as possible. Thanks for having me. I'm excited to be here and already hearing resonance with what Dr. Wayne was sharing previously.

So I've worked at Iora Health which became One Medical and is now part of Amazon Health for over 12 years now and helped to practice in and grow what's become a nationally scaled model built around senior-focused practices. It's almost exclusively operating under global capitated risk, started Medicare Advantage, and then was one of the early joiners in ACO REACH and the direct contracting program. Our care model embeds population health in the practice team.

Again, along Dr. Wayne's comments, it's about relationships with patients in primary care and how we can leverage that to improve outcomes and decrease cost over time. But in addition to that robust care team which has behavioral health and health coaches and lower panel sizes, we're also increasingly deploying home-based and virtual programs around that for some of the more complex high-needs patients. That's the topic today.

As I said, we join the GPDC[22]/ACO REACH model in the first round. And today, that comprises about 15,000 of our total risk lives. And we've had really great results in quality and cost savings. Next slide.

I went a little bit more technocratic with my takeaways. And we can talk more about the patients and the longitudinal journeys that are at the heart of this. But I do think for us, global risk contracts has been the key to being able to make those investments and see our patients more often, bring those services to bear, and focus on health equity.

But to do that, these programs need to have some key features. And we can go into more on this. We need to see stability and predictability.

It takes a long time to invest in changing folks’ health and supporting them. And we need benchmarks that reflect the acuity. We need to think about quality metrics that are

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[22] Global and Professional Direct Contracting

specifically appropriate for a complex population.

ACO REACH has been a great structure to help bring what we have been doing in Medicare Advantage. And also what we've been doing for traditional Medicare patients as well, both out of a business model previously. And there's a lot of structures there to align incentives for patients for PCPs, for specialists, for the broader system.

But I think there's some ways that through payment and program design, CMS could strengthen those levers. And finally, we have to talk to about AI and ML[23] somewhere. And I do think there's a real role particularly in supporting the care for complex patients.

This is not going to be the chatbot solution to solve a runny nose easily over a video chat. But I do think in identifying, stratifying, and just handling the massive amounts of information that a complex patient generates and accrues across the health system, those technologies are going to be key. So happy to talk more about any of that or anything else.

CO-CHAIR SINOPOLI: Great. Thank you,

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[23] Artificial intelligence and machine learning

David. Next, we have Dr. Cheryl Phillips who's a Program Consultant at the John A. Hartford Foundation. Welcome, Cheryl. You're here in person.

DR. PHILLIPS: Thank you. I'm delighted to be here in person. And I won't go through my resume because I'm kind of the grandmother, I think, on this panel in terms of both experience and age. But I'm not ageist because I'm proud of it.

But I've had just the absolute pleasure and delight of a career that's intersected clinical work, health care systems, health policy, and payers. My clinical work -- and Walter and I have some wonderful intersections as well -- has been post-acute long-term care. Also of interest to our prior panel, I was the first Chief Medical Officer of On Lok which is the originator of the PACE program.

So I have deep roots in looking at models of care. Most recently, I was the President and CEO of the Special Needs Plan Alliance. And we've heard some references to special needs plans, whether they are chronic care special needs plans, institutional special needs plans, or dually eligible special needs plans, again, a subset of Medicare Advantage.

And so I've had the ability of looking at payment, regulation, delivery systems, all with the intent of focusing on the highest-risk, highest-needs individuals. We can go to the next slide. Because -- and Matt, you touched on this a little bit. So 30 years ago, I was working with the health care system in northern California trying to teach them about high-risk, high-needs complex care individuals.

And the same principles and premises -- with the exception of AI. So we didn't have a lot of AI 30 years ago. But the concepts are still the same.

And in fact, I would argue that our complex care has become far too complex. And we've touched on so many reasons throughout this panel earlier today whether it is the plethora of disconnect -- I mean, the specialist work is phenomenal. Our integration of specialty providers is fragmented.

Even if we're using the same cut and paste EHR, we're still not communicating well. Our team-based care is fragmented because it is multi-disciplinary, not trans-disciplinary. And

I'll touch a little bit on that.

And then we have a cacophony of what I call poly-management syndrome because we have all of these managers starting 30 years ago when we were looking at disease management, but even now when the care managers, care coordinators that are not yet integrated. So some of the key principles and I'll move along quickly. And we've touched on them. But any strategy that we have has to have a targeting and identifying high-risk, high-needs populations, even when we talk about those dually eligible.

That's not a targeted population because within that subset, there is such a heterogeneous mix of needs. We need truly value-based payment models. And while, yes, global payments are a step, if we have managed care that's nearly paying all of the clinicians a discounted fee-for-service, we have a different payment model from CMS to payers. But we haven't transformed delivery.

And then when we talk about integration, and we've again in earlier panels talked about the whole person, the function of the social needs, the caregiver support, we can identify a lot of risk just by knowing who has whom to help care for them and where do they live. Meaningful team-based care as I touched on, I think PACE is the ideal model of the trans-disciplinary. Multi-disciplinary is where we all chart in different parts of the medical record.

Interdisciplinary is where we may talk to each other. Trans-disciplinary is where we blur our perspectives and disciplines and have the individual person at the center. We need to measure what matters.

And I know that in the next panel, Dr. Blaum is going to be talking about that. Ultimately, it has to be -- and I'll look to the 4Ms from the John A. Hartford Foundation focusing first on what matters. So goal-oriented care across our continuum that's built into our health record that transcends all of our team-based care, all of our specialty services so that it's all focused. And we need to have a meaningful basis of primary care.

And that too was talked about earlier that it's not just triage. It's not just referrals. But it's actually that coordination of holistic care, and we don't yet have a payment system that supports that.

And so I'm looking forward to the next

30 years where we won't repeat the same conversations. But as we're starting to now, start to look at form follows finance. We get what we measure, so we change what we can measure. How do we use those tools to really drive high-needs complex care? Thank you.

CO-CHAIR SINOPOLI: Great. Thank you. Those were great comments, Cheryl. So thank you for that. We also have Olivia Rogers who's the Vice President and Chief Nursing Officer of the Visiting Nurse Association of Texas. Welcome, Olivia.

MS. ROGERS: Hi, thank you so much for including me on the panel. Dr. Phillips is definitely hard to follow. But my take on this is a little bit more pinpointed to one specific thing which I'll share in a minute.

But I am the Chief Nursing Officer, Visiting Nurse Association of Texas. And we are a 90-year-old organization this year. And actually, this year we also celebrate our 40th birthday in hospice.

So we have been a provider since 1984. We were part of the Medicare pilot before the Medicare benefit came into play. We currently have about 320 patients in 16 counties, both rural and urban.

And going to the point of really the patients and residents in our area who are underserved and had really poor social determinants of health is our very large Meals on Wheels program. We serve 8,000 -- excuse me, 8,000 home-delivered meals a day, hot meals. We say that it's more than a meal because we're actually asking questions oftentimes when we drop off those meals.

How are you doing? Have you had any changes to your health? We developed an app by which the drivers can enter information about the client that they're visiting.

And if those needs are related to health care, we then have an ever-growing community health worker program and health workers are employed then to go out in the community and visit those Meals on Wheels clients who have expressed that they have a high need clinically. Oftentimes, that's something as simple as they have not seen a primary care physician in many years.

Their medications are maybe somebody else prescribed in an emergency room. Often that's the case, and they don't have refills or a way to get them. They don't have transportation, poor access to health care, and food insecurity.

So this is a big push right now for the Visiting Nurse Association because within our safety net as an organization, we have countless residents in Dallas and surround that are just really struggling. We also at VNA, we're a participant. And this is what I'm going to talk about more in the next slide.

But we were a participant in the model for the Medicare Care Choices Model which was to test essentially what I call community-based support palliative care and done by hospice providers nationwide. We jumped in with both feet to that program. And I feel that it had a tremendous impact on our community.

So I think this is a really brilliant way to address these really complex medical patients that are really struggling. Many of them are very, very ill. And they are not ready for hospice or maybe don't ever want hospice, but they are falling in the gaps in a lot of cases and ending up in the emergency room and ending up in the hospital because they don't have that safety net of health supportive palliative care.

MCCM addressed this in a beautiful way. And we were a participant in that program. We continue to provide supportive palliative care with our own program called the Care Choices Model in VNA.

And we have modeled it after our participation in the MCCM model. We can't do all of the things that we were doing in the MCCM model because of the lack of payment. But it really has formed, to me, the best way to provide supportive palliative care.

And I like what Dr. Wayne said about it's based on the relationship. That really taught us a valuable lesson that if you can establish a relationship with a patient, it improves their health outcomes. And they have someone to call 24/7.

They know who their nurse is. They know who the physician on the team is, their social worker. That was why MCCM in my opinion worked.

And it also set up best practices as you said so that it was not up to each individual provider how to provide supportive palliative care. There were strict guidelines from many care conditions and participation. We also were a participant in the ACO REACH model.

And we continue to provide supportive palliative care to WellMed and their Medicare Advantage patients. Next slide. So one of my concerns from where I sit running a fairly large hospice in these counties that we serve is the late admissions to hospice which can result in adverse impacts on patients and their families, as well as on Medicare spending. Patients who may need hospice or at least need someone visiting them in their home that is sort of that line between maybe home health and hospice.

They're right in the middle. They are probably too sick for what home health can reasonably provide or they run their course of home health but they're not ready for hospice yet. Maybe they're still pursuing chemotherapy or some other disease-directed therapy and treatment.

They still need someone to help manage their care and to bring all of -- like Dr. Phillips said, all of the specialists, all the providers together to actually coordinate what's going on with this patient as they decline. But unfortunately, we do that oftentimes way too late. And patients when they are appropriate for hospice are coming on in the final days.

The average length of stay in 2021 according to NHPCO[24] was 17 days. We see that at our organization as well. But indeed, hospice does save Medicare a lot of money in the last year of life compared to beneficiaries who don't utilize the benefit.

So one of the things that MCCM did is it allowed earlier access to the hospice benefit for those who want it. It's not everyone's desire to ever choose hospice and that's okay. Still even if they didn't go to hospice while they were on the program, in-patient admissions decreased by 26 percent.

Outpatient emergency department visits decreased by 12 percent. Aggressive treatment in the last 30 days of life decreased by 15 percent. It saved about 7,000 dollars per enrollee on the MCCM program.

And again, though, back to quality, which is the most important thing, I think, as it relates to any type of health care, but no more so when our patients are so vulnerable toward the end of life. The surveys that went out for the families of those who were enrolled, patients and

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[24] National Hospice and Palliative Care Organization

families in MCCM show that it improved patient satisfaction. They had more health -- better health with advanced directives and planning.

They were able to make their needs known and their final wishes known. And we were able to help them carry that out. And as a benefit for those who wanted to utilize the hospice benefit, they were 18 percent more likely to use hospice if they were a participant in MCCM as if they were not. So my desire, I would love to see a relaunch of MCCM in some way or form.

I know there needed to be some changes to improve enrollment, also to get more hospices involved in the program. But we really saw that this was transformative in our community. And I think one of the things that's most important to me again is that it set up a standard of what in-home supportive palliative care would actually look like versus everyone kind of trying to create their own which is not always in the best interest of the patient. Thank you so much.

CO-CHAIR SINOPOLI: Thank you for that. And thank you all for those great introductions and comments. We're going to move on to some questions. And we have a list of questions to ask you, but we have a question from the floor that I'd like to go ahead and start with.

So several of you have mentioned that you participate in REACH. And I think, David, you mentioned that REACH provides structures to align incentives across stakeholders, that CMS should strengthen those levers. Can you comment about both of those comments?

DR. GELLIS: Yeah, I mean, I think from just a first principle standpoint, global capitation with advanced -- enhanced and advanced primary care payments give us a lot of flexibility, right, and sort of puts the CMS program in a lot closer to equal playing field with MA in terms of some of the flexibilities and investments we can make, beneficiary enhancements, the Part B cost share waivers. And just in general, safe harbors for value-based care have been instrumental and helpful in thinking about how we engage our patients, build new programs, and help them coordinate care. I think the -- some of the areas where I can see additional development, one is just the program is scheduled to sunset in two years.

And so the glide path from that to

MSSP[25] is difficult or unclear how that's going to work. And when you're talking about making investments in patients' health, it'd take multiple years to play out. Now in the case of some of the complex patients, some of those we can see a return sooner just from the past comments. The end-of-life needs are tremendous and do often align better outcomes with lower costs.

But in general, stability of the program and understanding where it's going is key. I think one of the -- just it's a funny challenge we've run into as patients align and de-align to these programs, we've got even within the CMS book patients who we desire to kind of treat the same. And we're going to go and make investments in their future outcomes.

But from actually a legal standpoint, some of those flexibilities aren't there. We run into inducement concerns, and we may not be able to fully take advantage of the safe harbors to provide care that we think is important and necessary. And so just we've actually run into that trouble with the Part B cost share waiver, just being able to track at the moment that

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[25] Medicare Shared Savings Program

someone is in -- are they in the program?

Are they going to be in the program? We're rapidly growing. We do a lot of voluntary alignment. And obviously, some of the fear of running into waiving services that we would not actually be at risk for from a legal standpoint was a challenge.

I think the third is less about the program. It's not a fault of the program but an area where we're looking for support. We have a significant number of lives under risk nationally.

But in any given market, we're a small little pea in the world. And so there's a lot of interest on our end to craft specialty contracts that align incentives there. And I love that framework around getting behind multi-disciplinary to trans-disciplinary care.

And we've done some experiments being in not just an EMR[26] but actually have multi-disciplinary rounds with our specialty partners. But our ability to actually be part of enough of a meaningful part of their book of business as a primary care ACO hasn't been great. And so is there a way to pool the resources and the buying

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[26] Electronic medical record

power or piggyback on other work from CMS. I think the shadow bundles are a good start to leveling the playing field and getting us some insight into how our specialist partners are performing. But I just would encourage CMS to continue to think about how to support primary care-led specialty integration versus moving on to exclusively working with the specialist to craft models there.

CO-CHAIR SINOPOLI: Great. Thank you. And Olivia or anybody else, who's got some REACH experience? Any additional comments?

DR. WAYNE: Yeah, I'll add -- it's Matt Wayne. Yeah, I think those comments were great. We actually -- so again, and I want to couch these comments specifically.

Our high-needs ACO REACH program is predominately focused on a post-acute long-term care setting, so a nursing home setting. What's interesting is that if you look at and had kind of five-plus years of experience doing this in a managed care population, typically the average cost of care on an annual basis for these beneficiaries is about 35,000 dollars a year. If you look at traditional Medicare, it probably goes up to about 45 to 50,000 dollars a year.

Now what I can tell you -- and again, this is all comers. My organization on any given day, we usually have an average daily census of about 13,000 residents living in our 130 communities. Now that's all comers, so it could be traditional Medicare.

It could be Medicaid only. It could be some combination of managed Medicare and managed Medicaid. But what I can tell you is of those 13,000 lives based off of a current ACO REACH high-needs criteria, we only have about 700 folks that qualify for that high-needs ACO.

So even taking a very large population, we found that one of the biggest challenges and barriers is actually meeting that criteria. So it's interesting because we certainly could partner and start to grow with other entities. But I think that's where the models tend to get diluted, and you lose your core beliefs and values and approaches.

And so we found that some of these barriers are challenging to get to 1,000, to get beyond 1,000 residents to stay in the program. One of the things that I will note specifically in the post-acute and long-term care settings, that a lot of the risk adjustment to actually be part of the program is based off of Medicare claims that you don't traditionally see once someone is in a nursing home. So durable medical equipment and these types of things are more bundled in a nursing home.

So there's no way to capture it. And so what we found is ironically enough, even though the nursing home resident is a higher-cost resident from a medical standpoint, the risk adjustment doesn't necessarily show that. And we've had that challenge.

So again, we love the program. We think the program really supports our transformation in delivering care in a different way. But we just found some of the technical aspects of that program to be challenging to continue to remain viable within the program.

CO-CHAIR SINOPOLI: Thank you. Anybody else have comments? If not, we'll move on to our next question. So what are some effective approaches for proactively identifying high-cost patients with complex chronic conditions or serious illness and addressing those needs? Maybe we can start out with Cheryl.

DR. PHILLIPS: Thank you. So as we started earlier in our conversation, targeting the populations are critical. And there have been a variety of tools, none that have been widely scaled or replicated.

But it really gets down to not the sum of their diagnoses, the sum of their function burden, the sum of their social needs. And we hear lots of that from CMS right now of integrating social risk factors and social needs. It's also the sum of their living environment and their caregivers or their absence thereof.

And so when we look at that overlaid with a core group of identified diagnostic categories that pretend risk, that's when we start to really target that population that maybe is costly now. You raised that point earlier. Are they going to be costly just this year and then revolve back to the mean? Or are they actually going to continue to be costly?

And I would argue that it's identifying the social, the caregiver, the environmental, and the functional risks on top of the categories of diagnosis. That's what we're missing predominantly in much of our risk adjustment. It's missing in most of our measurement. And I would dare say it's also missing in most of our global payment models.

CO-CHAIR SINOPOLI: Great. Thank you for that. David, do you want to take that question?

DR. GELLIS: Yeah, just as you're speaking, I'm thinking about where we need to go next because we have not done this yet. But we've seen some success in using an ML model to help with this prediction. And we have a custom built EMR.

We're able to capture whatever we want in the structured format wherever we want which is wonderful. It doesn't help with interoperability challenges in the world,but we're able to get the information from our care teams.

And then we're able to combine that with claims data and run a machine learning model that sort of spits out predictions, looking specifically at predictors of rising risks. So cost blooming to sort out some of the regressions to the mean, and then pairing it with an outcome around mortality, specifically in the sort of poly-chronic, multi-morbid. Not looking so much for advanced cancer but COPD[27], CHF[28], who's going to get in trouble.

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[27] Chronic obstructive pulmonary disease
[28] Congestive heart failure

And one of the nice things about the model is that it's got built-in explainability. So we're able to see what factors for a given patient are rising to the top of the list. And we use that to identify them for various programs.

I think the really interesting opportunity coming forward is how do we get to all of the social and all of the contextual stuff that we have. They're in the narrative notes. We’ve got health coaches that are spending an hour with a patient and capturing who's at home and what's going on.

And we've tried to force that into little button clicks in the EMR. But it just means one more button click people don't want to do. And I think that's where generative AI, it's, like, not a huge leap to say – point a GPT[29] at the note and say, find me patients who are living alone or have talked about these various social determinates and then be able to pull those things more prominently into the model. And so I think that's sort of probably where we're going next around that. But I do think having a system that gets beyond just claims and gets beyond

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[29] Generative pre-formed transformer

provider gestalt but incorporates those things has been helpful.

CO-CHAIR SINOPOLI: Great. Very insightful. Any of the other panelists have anything to -- they want to add to those?

MS. ROGERS: I was going to add just as a social services provider, we're a little bit unusual in that we're sort of on two ends of the spectrum and we have our hospice and palliative care. But then we also have this big Meals on Wheels operation. And it's not only 8,000 clients that we deliver to their homes every day.

We also serve another 1,000, 3,000 maybe meals to congregate site, senior centers and that kind of thing. So I wonder. I'm sure someone has thought of this.

But to me, it would make sense to loop in these social service organizations into these models because that's your high-need population right there. All of our Meals on Wheels clients are seniors of one end or the other. And they are unable to provide meals for themselves.

So generally, they have an unstable caregiving situation or they live alone or they don't have transportation. They check all the boxes of all the things that then lead to poor health outcomes. And we really saw this illustrated during COVID.

This ZIP code crescent right on the south end of Dallas had very poor health outcomes during COVID. But interestingly enough, we really started looking at that then, all the hospital systems, the county hospital system. All the safety net organizations were really looking at that.

But that did not improve after COVID, and it was bad before COVID. And so I feel like these organizations like ourselves that are embedded in the community, that already have a relationship with these clients and can see where these things are headed. And again, yeah, they may not be the client, although we do have them that have metastatic and stage cancer, but the ones who have totally uncontrolled diabetes, we know where those things are headed. We have access to those clients already. And we're not the only ones.

We're a very, very large Meals on Wheels provider. But we're not -- they're everywhere, right? They're in every county across the United States.

And there's always social services

too. This is just one example. But I think these are the people to really get in touch with because that's the high-risk population in the United States.

CO-CHAIR SINOPOLI: Great. Thank you for that. Any other comments? Cheryl?

DR. PHILLIPS: I'll just briefly add onto that because Olivia, you're so right. And with our community-based organizations, our payers don't know how to speak to them. They don't know how to exchange information.

They don't know how to track outcomes. You can't ask a senior center what their NPI[30] number is for their contracts for Medicare. So we speak different languages and we have a disconnect.

And so payers will often -- and I'll look at the special needs plans. They will also talk about the importance and the richness of community-based organizations. But they're flummoxed for how to do that. And then don't even get started with the poor primary care physician or physician networks that are, like, we're not here to make all these coordination’s work. So I think that's another mechanism that

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[30] National Provider Identifier

is essentially important is create that knitting between the community-based organizations, the provider communities, and the clinical side and the payers.

CO-CHAIR SINOPOLI: Perfect. Thank you for all those comments. PTAC members, do you all have any questions you want to follow up on this topic? If you do, just flip your thing. Walter.

DR. LIN: I have several questions, but I'll just start with one. First, Matt, thank you so much for sharing some numbers around kind of what a total cost of care model can do with an appropriate care delivery model for this population of chronically complex, seriously ill patients. So I think I heard you say a traditional fee-for-service cost per capita for one of your patients in the nursing home is 45 to 50,000 dollars per year whereas under -- kind of a total cost of care model, whether that be I-SNP[31] or ACO REACH or some other model, you guys are coming in 20 to 30 percent below that. My question is, how are you doing that? Like, what kind of things are you doing to achieve those results?

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[31] Institutional Special Needs Plan

DR. WAYNE: Thanks for the question, and I think it's a great question. It's interesting. I mean, I think a lot of the differences -- the value-based models of care allow for a commitment to the infrastructure around transformative care.

So some of it is very likely due to the support infrastructure around our managed care plan. I mean, that's probably one of the traditional differences between a fee-for-service and a managed care. But I will tell you clinically -- and this is what I have found most exciting is that these programs have really allowed us to commit a much stronger infrastructure around kind of routine coordinated care but then care also that provides access 24/7.

So it's interesting, Walter. If you look at, again, specifically post-acute and long-term care, the medical expectations in this setting go back 30 to 50 years where a physician visit is timely on admission if it occurs within the first 30 days. And then it's once a month for the first 90 and then every 60 days.

It's so ironic because you visit the residents most likely the day you're seeing them.

They don't need to see you. Why are you here, doctor? It's nice to see you.

But when they need you most, the regulations don't drive that responsiveness in that way. And so I think these programs have created a commitment to having embedded care. So just having folks that pop in and pop out aren't good enough.

And so we really look to embed that care so we have a provider in our facilities anywhere -- again, obviously it varies by size and complexity. But I would say we typically are in a building between three and five days out of the week, depending on that size. So that predictability creates continuity.

But the other thing is it's allowed us to invest in telehealth. And so we provide telehealth if we don't have a provider in the building that day. But we also provide our telehealth for after hours and weekend coverage as well.

So our nurses have the ability to take a clinician actually to bedside and deliver care for change of condition. So again, within that fee-for-service or typical environment, it would be much more challenging to kind of make this type of commitment. But again, it goes back to the strategies that I talked about initially.

I mean, it really is. It's very basic. We have to connect and form these relationships. But we need to be accessible when our patients need us. And I think that's one of the most difficult challenges is do we as a medical practice or health care system have the flexibility to respond and be there when our patients need us the most?

CO-CHAIR SINOPOLI: Thank you for that. Larry?

DR. KOSINSKI: Thanks to the panel for coming and especially Cheryl for being here in person. So I'm going to pick on you since you're here in person. Not pick, I'm going to just pick your brain.

You use the terms multi-specialty care versus trans-disciplinary care if I remember correctly. And you talked about the fragmentation of specialty care. As a specialist, I know all too well how the hub and spoke of the PCP to the specialists fails when you need trans-specialty communication.

And you can't go in and out. You should be going across. So expand a little bit on trans-disciplinary care. Give us more detail, granularity on what you're trying to monitor.

DR. PHILLIPS: And when I think about it, it's also more than the physician disciplines. It's also the other disciplines, social work, nursing, pharmacy, physical therapy. But even looking within the specialty disciplines of physician care, first of all, having goal-oriented care.

What matters to the person? That, to me, is the center of the hub. And that's often missing and rarely in any of the medical records. And when they see you for their gastroenterological issues.

That's what you need to focus on. That's why they're there. But the problem is it may not connect. So I would -- without creating -- if I were a queen, we have primary care wrong.

If the primary care actually could function as the central high-risk, high-needs coordinator of services that brings those voices together starting at the hub with the goal of the person, what matters to them. We need to pay primary care differently because we've already talked about that in an earlier panel. I don't think that we have to spend a lot of time with a gastroenterologist and the oncologist and the cardiothoracic surgeon and the nephrologist all on the phone together because that's not realistic.

But we need to have ways of aligning goals of care so that when we're looking at a treatment plan, it's not the sum of the person's diseases. It is the sum of their goals looking at the broader picture. And that's what I think is the role of primary care that's missing right now.

So it's not fault-finding with any of our interdisciplinary providers. It's that we don't have a good platform and mechanism. So going back to what Matt was saying with whether it's I-SNPs. The PACE program is a really good example.

That center is the primary care team. And all of the services are still provided. They're still coordinated. They're still communicated. But it's based in a substantial and functional and meaningful primary care team that serves the person at the center.

So while PACE is hard to scale, we've already challenged that, there are some important laboratory lessons, whether it's in nursing home settings or home and community-based care or hospital at home that we have the hub as being truly owning that partnership with the patient. And I'm being too wordy. But I think that's where we've missed the boat. We have relegated primary care to triage and referral and a whole list of health care maintenance issues which for this population has less and less meaning and relevance.

DR. KOSINSKI: One follow-up, though. We're dealing with a fixed sized pie. And so if we're increasing the size of the primary care pie to totally recreate primary care and to value it higher, it has to be paid for from the rest of the pie. In your experience, have you been able to succeed in getting specialists to agree to share some of their income with the primary care?

DR. PHILLIPS: I think you know that answer.

DR. KOSINSKI: That's why I asked the question.

DR. PHILLIPS: And whether it's at the RUC, the Resource Utilization Committee, and the AMA[32], nobody wants to give up their pie. But what we are seeing in this panel and the whole

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[32] American Medical Association

reason we are here is the current pie isn't feeding the right people. It is reinforcing a very, very fragmented and expensive subset of services that are not meeting the needs categorically on this higher-risk, highest-need, chronic burdened population. So no. Are the specialists rapidly excited about cutting the costs of cataracts or whatever? I mean, I'm not blaming --

DR. KOSINSKI: Colonoscopies.

DR. PHILLIPS: Yeah. I won't even blame any subspecialty. It's that we're spending a lot on the wrong pie.

DR. GELLIS: Just to jump in for a second. I love the pie analogy. And that's why I think total cost of care, global risk models are so important is because they give me the pie first. I get the first bite of the pie.

Now I'm giving 85 percent of that pie almost immediately on to specialists and hospitals and others. But just the accounting mechanism of having that flow through and putting my business partners and I in the position to think about how do we change those incentives and pay differently. I think the problem is that -- and all of this is still built on a chassis of fee-for-service, right?

Like, we do not have a way to account for and count the things. And that sort of goes back to some of my perverse frustrations with Stark Laws and inducement concerns. I just don't -- I don't want to pay on a per pieces basis for any of these things.

I just want to say this is part of primary care and wrap my arms around it. And we were even successful like with behavioral health. And that's been very impactful. But I don't think putting the control and the starting position as running through risk-based organizations, if those organizations truly are provider-led and close to the patient and not just an insurance company in another name.

CO-CHAIR SINOPOLI: All of that's been so well articulated. I appreciate that. And Chinni, do you have another question?

DR. PULLURU: I do. This is regarding, I think, going back to the pie. I'd love to hear from Dr. Gellis, Phillips, all of the panelists actually. So when we talk about the pie, what’s often struck me is we keep speaking to patient care-focused providers, right, whether it be primary care, specialty, nursing.

But if you actually look at the spend of the health care dollar, not a huge amount of it is in the physician seeing the patient or the nurse seeing the patient. There's a whole bunch of money in between. And I'd love to hear from the panelists because I do think there's a world where the specialist and the primary care physicians can be compensated appropriately if we can take out the middle. And so I'd love to hear what administrative burden you feel is low hanging fruit and can be decreased in order to save money.

DR. GELLIS: I'll take a crack first. I mean in going back to the comparison of traditional Medicare and Medicare Advantage payers, the ACO REACH program is a 2 percent discount built in. I think it goes to 2 and a half or 3 next year in the professional direct versus Medicare Advantage is taking 15 percent premium off the top and it's going somewhere.

To Dr. Wayne's point, that's not all waste. Like, there are things that end up better coordinated in a system in which a health plan is involved and does have some data and has flows. But I don't think all 15 percent of that -- I think we can do better with that premium dollar.

And why are my PCPs who are at risk and responsible for those costs and outcomes, why are they going through prior auth processes in the same way that others aren't in that incentive? I think you can reduce a tremendous amount of waste there. I think again the sort of entire end to end on claims processing, I think the risk adjustment systems do create -- I think there's value created.

We have to have a risk-adjustment system. I think it does make sure that risk groups are paying more attention to the chronic diseases that end up driving outcomes. But the amount of health plan and administrative waste that exists around that, and I think of any wellness visits -- in-home wellness assessments that have no connection to care and all those dollars.

And I do think there's just so much inherent complexity in the amount of -- the ways patients have to move through the systems, that there's going to be administrative need there. And that's where I'm hopeful that technology can streamline parts of that. And even we're not going to make the concept of alerting an insurance company that a patient is going for care disappear entirely. It could be much less friction full and more efficient.

DR. PHILLIPS: And I'll just add briefly because I agree with everything that David said. But we have -- our payments are driven by settings for the most part as we all know. So we have inherent redundancies in service, redundancies in administrative cost because we're driving our services by the setting where we find the person to get the service.

And then if they are episodes of service, even if they are home-based care like home health, we repeat the cycle of an episode of care which is driven by the setting. So it's all the things that David mentioned. And it's our inherent structure of payment by setting which is not dependent on the specialist or the primary care as you pointed out. But then I would also argue we're the ones that are sending people to various settings because that's where the settings are. So we start the cycle all over again.

DR. WAYNE: Well, I would love to add too. I think it's a fantastic question. I agree with my two colleagues. I think what I would like to add to it -- and there is, right? I mean, there's so much inefficiency and potentially over-waste in the system.

It's interesting because the question is really targeted around how do we make sure that the dollars are flowing to the folks that are actually delivering care, doctors, nurse practitioners, nurses, social workers, et cetera. And I love that concept. The three areas -- and again, it's not that it's unnecessary.

But the way the system is built, it becomes inefficient and oftentimes wasteful. The first area is contracting, right? Because our health care system is so complicated with multiple payers and multiple things to navigate. There's a lot that health care organizations invest around contracting.

The second is actually finance, right? Because every organization's lifeblood is revenue. And so whatever programs are created, you need finance folks who understand how to make that revenue flow and to make sure that you stay afloat.

So again, the more complicated things are to understand financially, I will say from this physician's perspective, it's horribly --

it's just so above my ability. You need that infrastructure. And the last one which is huge -- and I think we do -- folks around this table may have the ability to impact at is reporting.

So these programs have tremendous reporting demands, quality measures and data and outcomes that all require FTEs[33] to go in, drill down, create reports, and send that information. So again, it isn't that reporting isn't necessary. But we need to be very thoughtful about what we're asking to report because I can guarantee you there's a lot of this reporting and it isn't effectively driving better care. And so I think those are three huge buckets where we could become much more efficient and reduce cost of care as it pertains to health care as a whole.

MS. ROGERS: I would like to add on, kind of going back to the pie analogy. The pie or company such as mine is often fairly fixed. You can grow and there's some economies of scale.

But when we look at people like VNA and providers all over the country who are serving a combination of urban and rural patients but particularly our rural patients which require quite a bit more time and effort and money to

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[33] Full-time equivalents

serve and oftentimes are the highest-need patients, that pie is fairly fixed. And so if we're going to add reporting for this or that or if we're going to add audits for this or that, something else does have to be taken away because the pie is relatively the same size. What we don't want to do that adversely impacts the patient and family is hire more FTEs to manage back office functions and don't result in better care.

It may result in protecting the organization from kickbacks and that kind of thing which is important. And of course we want to do that. But if you look at it from the seat of the patient, they never realize that additional money that's going toward this process.

And meanwhile, we're not serving well some of the patients who are the highest-need because either we can't find them, we don't know who they are. Kind of anecdotally, when we first started our program to sort of bridge the two halves of our company with the Meals on Wheels clients and what types of clinical care they may need, we immediately found out it was very, very hard to identify who the sickest clients were.

And we know them. We see them every day.

But still it's not just the sum of their diagnoses. And how do we figure out who they are? And I think there has to be really some standardized way for providers. And I'm not a physician, but for all providers, for specialists and for PCPs and everybody to identify who is going to be the costliest and who has the highest likelihood of dying in the next six months or a year or five years so that we can put our money toward the right people who need it because I know the pie is one size. But I love the analogy that it's not necessarily feeding the right people, those who are most vulnerable and live alone and that kind of thing.

CO-CHAIR SINOPOLI: Thank you. And Walter, you have a question?

DR. LIN: All this talk about pie is making me hungry. Actually, my question is going to be around risk stratification. And I think our panelists have all kind of touched upon this. But Cheryl, I think you kind of brought this up in your slide.

Individuals with serious illness are not the sum of their diagnoses. We kind of also heard themes of -- similar themes in the first panel this morning as well. But unfortunately, that's how our current risk stratification system is based, right?

That's the HCC score, the RAF[34] score. And that's how payments are made is the sum of the diagnoses. Like, literally the sum of their diagnoses is what drives payment in value-based care.

And so I guess -- you mentioned before -- and you mentioned integration of function, social needs, social support, behavioral health into all these assessments. Have you seen that done well in other places? And this is not just for you. It's for all of our panelists. Is this being done somewhere else where the stratification is more robust and can be actually thought of in terms of making payments off of?

DR. PHILLIPS: Well, I think we're early on this. I think we would all agree that using the RAF scores as they exist right now doesn't really get to this population. And David pointed out well, so we've had all of these systems that they're mining for HCCs.

So they go out and they meet with people. And they have long lists of diagnoses.

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[34] Risk Adjustment Factor

But there's no record of it in the clinical care model. So how is it that that's driving cost?

Putting that aside, I think that we're early on in this. I don't think that our current risk stratification captures the function, the behavioral health, the social, the caregiver needs and burdens of the individual that really is the sum total of their risk. I think we have lived and breathed by HEDIS[35] measures for stars for health plans in addition to the risk scores.

And many of these measures and I know I won't take away Caroline Blaum's discussion to follow in the panel. We aren't measuring what matters for this population. So we need new measurement to address appropriate risk scores.

To that end, NCQA[36] is very aware of that. CMS is aware of that. But we right now have a very different model of HEDIS and other quality measures. The second part, and you raised the question of where are the 4Ms?

So the 4Ms coming from John A. Hartford Foundation of which I'm a consultant and IHI[37] and the American Hospital Association, looking at really forward domains of care. And there's an interesting soon to be published

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[35] Healthcare Effectiveness Data and Information Set
[36] National Committee for Quality Assurance
[37] Institute for Healthcare Improvement

report that came out of Oregon Health Science University, OHSU. They looked at the outcomes where 4Ms were used.

The greatest impact was actually in the highest-needs complex patients. So when the 4Ms were integrated into the medical record and across settings of care, hospital days went down. The admission rates went down. Total cost of care went down.

And I won't take away the thunder of the paper that's going to be coming out. So there are ways for us to integrate predominately starting with goal-centered care, what matters and then integrating the other elements. But we're not measuring the right things yet. So, long answer.

CO-CHAIR SINOPOLI: Matt, anybody else have any other additions to that?

DR. WAYNE: Cheryl had a wonderful response. The only thing I would add from a risk stratification that I think is underutilized is actually measures of frailty. And again, I show my bias as a geriatrician.

But certainly frailty isn't necessarily exclusive to the post-acute and long-care setting. But really fleshing out rather than chasing one's tail with cost or high-cost patients or disease-based algorithms. But frailty at its core is just a measure of a collection of things, impact on a person's ability to be independent.

So measures of function, their activities of daily living, falls, skin issues, nutrition. And so incorporating that because it does matter. And it's interesting.

If you look at -- in its purest sense, frailty really is age and diagnosis independent. So it really doesn't matter whether you have one severe illness or seven. Really what matters most is its impact on the individual. And that truly is what should drive the services, the coordination, and the care to help bend the cost curve. So I think trying to find measures that can be incorporated with risk adjustment that are frailty-based I think would be very helpful.

MS. ROGERS: If I can add one thing to Dr. Wayne's points about frailty. Everything you described is what you have to look at as the criteria for whether someone is hospice appropriate, right? So in the MCCM model, because it followed essentially the Medicare conditions of participation, the patients who are admitted to the MCCM model had to be hospice appropriate.

And if relaunched, we could do the same thing or it could be different. But one of the benefits of that is you are measuring the Karnofsky and the FAST[38] score and the Braden scale. And you're doing all of the things that you said, Dr. Wayne, to determine if they were appropriate for supportive palliative care, MCCM, or hospice. Even if you took that further upstream and patients were allowed to enter the program at a year or 18 months, the same is true and that is you are immediately getting them access to that interdisciplinary or trans-disciplinary team right away because based on those scores which I think work.

I think that all those scores are already created. And sometimes no need to reinvent the wheel. They are already out there, and I think they do work to predict someone's mortality.

CO-CHAIR SINOPOLI: Great. David?

DR. GELLIS: No, nothing to add. I mean, other than in our ML model, one of the features that jumps predominantly is a frail --

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[38] Functional Assessment Staging Tool

it's not a frail scale but it's a claims derived frail measure.  You can imagine this would also solve some of the issues of gaming in the risk adjustment systems to make it a bit of a black box, right?

Like, you could go and have far too many coefficients to build direct programs around.  There'd be some down sides to that.  But if it got us a richer set of inputs around what's actually happening to a patient, I think it would improve the predictive accuracy and some of the policy problems.

CO-CHAIR SINOPOLI:  Perfect.  Thank you.  And I think Lauran has a question.

CO-CHAIR HARDIN:  Thank you, Angelo. So first, some really great themes, the value of interdisciplinary teams, the need to have a really great responsive reaction system.  So accessibility to the coordinated holistic assessment based on what matters to the client.

I think another principle that's come out is the ability to really provide anticipatory or proactive disease management and anticipatory symptom management.  And so I'd like to hear from each of you what you've seen to successfully translate that with providers to teach it, to build it in. Which disciplines are most successful with that?

And then how is that also playing out in the social realm? So in my bias, I spend a lot of time in this space. So there's a correlation with anticipatory or proactive management of social complexity as well. So go from there, anyone who wants to start.

DR. PHILLIPS: Well, I'll jump in and then I'll let the other wise voices follow. First of all, and David has referred to this, I think the potential for AI is profound because I think it can start to draw from sources of information right now. Just like we have fragmented care, we have fragmented sources of information and certainly fragmented integration of social information as you would recognize.

And so having a mechanism to pull that in. But even if we pull that in, what do we do with it? Is it primary care? Is it the specialties? Is it the case manager of the health plan?

So who owns that? And most importantly, who owns it in partnership with the person and/or their family caregiver team? So I think we have some tools that will be yet developed. I think we have some hope for integrating this information. I'm very optimistic and I'm not just being deferential to CMS.

But the focus on looking at the whole person, looking at the integration of social needs and health equity as part of that holistic view is the starting point. We need to have measures that matter and we need to have goal-oriented care. And then we need to bring all those voices together and somebody needs to own it. And so that's all part of our journey that we're all talking together.

DR. GELLIS: Not to be a broken record, but the 4Ms have been incredibly useful for us as a framework. And again, I think more important than the substance, it's a shared language to help reframe. I didn't learn medicine that way.

I'm an internist. And I got exposed to this. But I didn't have a way to communicate to others or to my patients what I was learning from those rich encounters. And a really cool experience recently, we're working with an integrated cardiology program.

It's virtual first. But we figured

out ways to bridge the tech divide for our homebound patients. And we're now talking that language with them, right, when we're talking about this is not figuring out exactly what the valve area is and when that valve is going to get replaced but what matters to the patient and what their mobility is and what else is going on.

And so yeah, it's small, subscale. But I think again it will enhance. We're all in it to help patients, right? And if we can sort of get out of the rubrics that we've been working under, we can make some progress.

MS. ROGERS: The one thing I think we've done successfully in the last two years or so is we did partner with an HIE[39] that after a while of us explaining why we felt we should be a part of the HIE and why it mattered if the hospital systems and providers knew our clients were on Meals on Wheels. We finally were able to get a contract with an HIE. So now many of the big -- most of the big systems in Dallas and surround, we serve 16 counties, can see that a patient is also on Meals on Wheels.

And our hope is that flag informs the care. It certainly informs it for us because of

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[39] Health information exchange

course we can then stratify patients based on how many ER visits they've had, how many hospitalizations. Do they have a PCP? But our hope is also that we're feeding them information that they may not get in any other way except acknowledging that them being on Meals on Wheels would be a big driver for their health outcomes.

So I think we are making progress. And I didn't actually plan on talking about our Meals on Wheels program. But everything everyone has shared really makes me think that these social organizations are at the heart of predicting health outcomes. And how can we capture that?

DR. WAYNE: I will just add -- and I don't know that I have a -- like, a great thought on what the answer is. But I think I can articulate what some of -- drives the behavior that you're observing. And I would contend that the fee-for-service visit by visit mentality perpetuates that.

Because if you think about it, right, it's all about what's happening in this moment and what I need to do to move on to my next patient. And so if the patient doesn't have complaints and they're feeling fine, even if they have a ton of risk factors, what's the incentive to actually engage in a lengthy conversation when you're being paid in 10- to 15-minute increments? And I think that's the challenge, right?

We have to break -- that's what doesn't work. So I think it would be easier to educate and get clinicians and engage patients around how it is important to be proactive and how we need to make sure you're on the right regimen, how important it is to take that medicine and to eat appropriately. But again, it doesn't fit into that every 10- to 15-minute visit mentality to help kind of keep someone moving along.

I think that's a big challenge. It certainly speaks volumes towards more of a capitated model where you can start to break down that fee-for-service mentality and really focus on what matters most in that time frame because you're right. So much of this could be averted with just a little bit better anticipation and proactiveness in how we deliver care and how we educate our patients.

CO-CHAIR SINOPOLI: Thank you. And I think Chinni has a question.

DR. PULLURU: This is a specific

question for Olivia. One of the things we struggle with as we think through this is in a budget neutrality environment, how do you compensate for all the things that drive social needs? And it sounds like you guys have cracked the nut on it.

So my question to you is the Wheels on Meals program. And I'm sure there's a transportation component. Is that a subcontract with the Meals on Wheels provider? Does some of that come out of your total cost of care funding? Like, how do you guys think about paying for some of the things that ultimately lead to good outcomes that aren't necessarily direct clinical care?

MS. ROGERS: That's a great question and I think our daily struggle. So we are a large nonprofit organization. So we doquite a bit of fundraising.

We raise about eight to nine million dollars a year to pay for Meals on Wheels for clients who have no payer source and also to pay for hospice care for people who don't have a payer source. But in addition to that, we have a lot of state contracts for the Meals on Wheels themselves. And yes, there is enough of an overage there that we are able to partner with other organizations to support transportation.

Our community health worker program is actually paid for out of some community block grants. And also we have very generous donors in Dallas who are very interested in testing these kind of pilots. And so we have a lot of reporting, of course, that we have to do.

But it has shown so far to be very beneficial in keeping people out of the hospital largely because that community health worker program is not a standalone program. Their goal is to connect these clients with the health care that they need. So we have developed very good relationships with some physician groups who make home visits.

And I don't know what that's called -- Visiting Physician Group, so where nurse practitioners and physicians go out and see our clients rather than the unrealistic expectation that us telling our client that they need to be compliant with making a physician visit when what that requires is them getting on multiple buses and then the dark train. And they have mobility issues, right? And they're using a walker.

And so we try to be very -- we have a

screening tool that we developed at VNA. And we use that. Our community health workers go out. They have to answer a lot of questions.

But the clients are very engaged. We do not get a lot of pushback on it, I'll be honest. And that addresses their medication compliance, the fall risk, whether they live alone, caregiving status, advanced directives, I mean, just a myriad of things.

And we use that then to communicate with someone, usually a house calls physician group to communicate what their need is. Sometimes they need hospice and palliative care. But oftentimes, they need something in between.

But yes, the contracts that we have with the state, contracts we have with individual cities like the city of Irving, which is a suburb of Dallas, has seen so much benefit from our community health worker program in Irving that they are paying for it on an ongoing basis actually. So it's all one day at a time, and trying to find payers for this is not easy. However, the outcomes are so good.

And every year in the budget, we look at how many more, and it's ever growing, community health workers do we need to hire and who's going to pay for it? But I was going to say this actually before you ask the question that I think sometimes -- and again, no one wants to give up their money including me, right? I mean, I get that.

But I think sometimes simplifying this back to something like a community health worker is incredibly valuable to the success of these types of programs. It doesn't have to be someone who's formally trained in the practice of medicine or nursing or social work. It's someone who's willing to sit down and help them fill out a questionnaire that then can be communicated.

We actually use those numbers from the questionnaire to come up with a score that tells us how high-risk they are or not. And that type of employee is not as expensive as sending a nurse practitioner, for example. So it's a long winded answer, but thank you for the question. I hope that answered it sufficiently.

DR. PHILLIPS: Well, yeah, so who pays for this? Now I'll look at it from the Medicare Advantage side which has its own pies. So everybody is eating pies these days.

And the Medicare Advantage plans will say, we don't have new money. There's no extra payment for supplemental benefits. But it comes out of our quality bonuses.

And our quality bonuses come out of our stars and our RAF scores or our HCC. So we're going to maximize our HCCs. We're going to figure out how to do better data for our stars reporting so that we get better quality.

So then we can use the difference between our bids. And anyways, that's where the money comes from. So we start this kind of odd circle of not really recognizing -- and even MedPAC has pointed out.

Look, if these supplemental benefits are so important, let's step back and say, what are we paying for? How are we paying for it? Is it just something for MA?

Does it apply to original Medicare? But right now we have these odd give and takes that probably drive unintended consequences in the other way trying to get to the payment to these. When you truly have a global payment for the whole person and we don't have many models but there are examples, then you can start to look at why paying for transportation as Olivia pointed out makes a big difference because they're actually getting to the doctor that we're paying for the outcomes for.

But the only thing about global payment right now and both David and Matt touched on this, it has to be down to the provider level including the physicians. When you have a global payment that is merely paying PCPs to see 30 people a day, the global payment isn't driving the outcomes that we want. There's not new money for this, but we've got to figure out how to incorporate all of these supplemental benefits as we've labeled them into that broader picture of care because I think that's what's driving -- the failure to do that is what's driving a lot of the costs of care.

MS. ROGERS: And I guess a thing I can add is who is not paying for it, a lot of health care plans. And so that would be something we would love to see happen because it is a huge driver.

DR. GELLIS: I think there's another angle on this which we've seen play out over the last years is the need to be judicious and stratified and segmented in those benefits as well. I mean, we saw health plans sort of paint a very wide brush in times plenty a year or two ago. And then I'm sitting here paying out.

I said, these over-the-counter benefits am I actually seeing improved outcomes, decreased costs from those. And that's sort of a pass through. Within our model, we had a very universal and global transportation benefit that I don't think we could show the returns on investment that we needed to sustain.

And so it goes again to the point of figuring out not all dual eligible patients are the same. Not all complex needs are the same. And so how do we align the right incentives, the right supports.

And ultimately, that's going to have to come through a caregiver of some sort. An insurance company is never going to be able to know who needs what. And so that's where, again, putting the risk and the accountability closer to the patient getting care as the only solution.

CO-CHAIR SINOPOLI: Great discussion. Jen, you have something?

DR. WILER: Thanks to all of our panelists for a really interesting discussion. I'm going to direct this question to Olivia first but would appreciate others’ response. So earlier on, our PCDT team presented this model for serious illness ultimately leading to death, a hard landing versus a soft landing that included palliative care and hospice care where appropriate.

So my question, Olivia, is for you. You made a comment around a solution. So I wanted to give you a chance to describe why you think it's an important solution. And that's adding to the MCCM model, allowing patients to choose palliative care in the home without foregoing disease directed therapy.

Can you talk a little bit more about why you think that's so important? And then any other conversation around how do we allow or engage more patients in this opportunity to have a soft landing instead of a hard landing, either with incentives or where appropriate penalties? Or what does that look like from a payment perspective?

MS. ROGERS: Thank you so much for that question. Yeah, so MCCM really was a concurrent care model. Interestingly enough, in the time that the program ended and today, we launched a pediatric hospice program.

And because of the Affordable Care Act, children and their families who were choosing hospice do not have to forego aggressive measures or disease directive care. So patients who are on hospice who are under 21 years of age can continue chemotherapy. They can continue hospitalizations, whatever it is that they need to do.

The benefit is in many cases, they don't because they have a supportive hospice team that's coming to their home regularly, often daily. So what's interesting to me is in the time that we stop doing MCCM and today, we’ve actually continued to run a concurrent care model which is our pediatric program. And in that, you see that while they can continue to do all the things that they want to do to pursue their hopeful recovery or even just palliative, things like palliative radiation, things that will improve their outcomes and their quality of life.

The cost savings was still realized with MCCM because they have that relationship. What we did strategically with the MCCM program is we kept their care team the same. So whether they were on MCCM or whether they bridged to the hospice program, we didn't change the nurse. We didn't change the physician overseeing the team. We didn't change the chaplain.

And that was very, very successful. I

think some -- at VNA, 75 to 80 percent of the patients who are on MCCM did go to our hospice program. And again, that's not everyone's goal, and I'm not a proponent of pushing hospice when someone doesn't believe in it or it's an affront their cultural beliefs or didn't want it.

However, most -- what was interesting is what happened, though, is we didn't have to call them or make the visit and say, I think it's time for hospice. We had phone call after phone call after phone call from families saying, I think it's time for hospice. And so through that relationship and that supportive care in the home, they were able then to realize I think we need more help and it's time for hospice.

And the numbers at our organization and the numbers from the final report from MCCM mirrored each other very closely. I attached in the appendix actually if you click on the MCCM final report, you can read the whole thing, and it's very brief.

But I think that it actually did achieve all the goals of CMMI, the quality outcomes, reduction in cost, patient satisfaction. And to me when we talk about these complex patients who oftentimes are falling into gaps, falling through the -- whatever the word is, gaps, where they don't have an appropriate roadmap, right, as to how to access the care at the right time, at the right place, in the right setting. And support palliative care in the home can meet some of those needs and address some of those concerns because they have someone who's available 24/7.

We had an after hours team that was specific for this program that made after hours visits. So it wasn't just a phone triage. If a patient was declining and was on our palliative program and is to this day on our palliative program, we send a nurse out to make a face-to-face visit.

And we're a small, relative to a lot of people on the panel, we're a small organization, right? And we're a regional organization. However, I think we are a good example of what nationwide can be done.

The way that we would need to get more hospices enrolled in MCCM, because there was some attrition, it started out with, I think, the 140-ish hospices. And then a lot dropped off because the payment wasn't enough. It's was 400 dollars per patient per month.

I think we determined that anywhere from 600 to 800 would even capture a lot more hospice participation and improve enrollment. But I also think that naturally over time as supportive palliative care in the community has grown as a program, a lot of hospices and a lot of home healths are now offering that as a service. People are more aware of that benefit.

And I think enrollment -- patient enrollment would go up because I think that just like hospice word's gotten out. This can help you in your home. And so I think that times have changed even in the short period during COVID.

But yeah, I would like to really see this relaunched in some form or fashion. And there are things that can be tweaked. One thing is I think we should expand the diagnoses required for enrollment.

There were only four diagnoses that were accepted. I think that we can expand that some. But I don't think that we would have to raise payment a lot. I think raising payment a little bit would attract more hospices to provide this type of care. Thank you.

DR. GELLIS: Let me just piggyback. We have a program called One Medical Home that is an in-home nurse practitioner care model for these patients that we're talking about but sort of of two flavors. One, stabilize and manage multiple chronic illnesses for a prolonged period. We think that we can turn a corner.

And then others who are almost certainly going to be hospice -- are hospice appropriate -- are going to be hospice appropriate. We don't care differently for those two segments because it's both of them are going to the 4Ms and understanding what's going on. But just the ability to be in home with patients and community health workers who are now bringing nurse practitioners in via tablet for some of the intercurrent care.

I'm pulling on a theme someone else referenced in terms of just being able to take our dollar of investment and spread it even further. And these are the conversations we're having with very similar outcomes. I'd say where we've had Aviva design that allowed concurrent hospice or in the CMS program where we're at risk for hospice, I think we've had early signals. But just those programs were too widely spaced and there wasn't enough density for us to build that real handoff and to know which patients would be able to connect and continue that care in the next step of their journey.

I do think the connections back to our primary care teams were super important because as much as electing for hospice is sort of a decision node and decision point in a patient's journey.

Just changing the locus of your relationship from your PCP if you have one to somebody else who is spending more time with you is also one. And so by being able to bridge that, patients, we do switch the PCP of record in our system to the nurse practitioner at some point. But that's not a force function to start getting those enhanced services because many patients are connected and we're able to harness 10, 15 years of PCP knowledge around who the patient is to support them in the next phase of their journey. But I do think policy solutions that help the next step of the bridge would really benefit us as well.

CO-CHAIR SINOPOLI: All right. Matt or Cheryl?

DR. WAYNE: The only thing I will add just very quickly because I think Olivia and Dave's responses were perfect. But what's interesting, I have some incredible -- incredibly talented palliative care colleagues. But again, you distill down what is at the core.

I just want to make this clear to the panel. At the core of palliative care is taking time with the patient, right? So yes, there's specific skills. But it isn't so much the program.

And I come back to this. It's investing in the time and the relationship to understand what's going on with this individual. What potentially has fallen through the cracks, what didn't get followed up on? How do we educate the patient?

So to me, you distill that. It's time. It's creating models that allow our clinicians to spend time with the patient and form those needed relationships. That's the special sauce.

DR. PHILLIPS: And then adding to that time is goal-oriented care. So palliative care works because we're looking with the person, not just about or for, but with the person in their journey of care.

CO-CHAIR SINOPOLI: Okay. I don't see any other name tags. But this is a tremendously robust discussion. We got through one question which led to a lot of great dialogue and discussion.

So we only have a few more minutes. I want to give the panelists time to tell us what did we not ask you that's important for you to message to us today before this ends? And so I'll start with David and we'll work our way around.

DR. GELLIS: Just looking through some of my notes. One area that I hope we maybe could talk more about was just health equity and the extent to which total cost of care models for high-risk patients I think essentially set up the preconditions to pay attention to that.

When I look across my population, it's the underserved and the folks with long held disparities. They're having a bad outcome that I'm on the hook for. So, like, sort of at the base level aligns incentives well to go pay attention to it.

And that's necessary but not sufficient. We've learned in our early model, we hired health coaches from the community, sort of deeply embedded. And we thought that would sort of by nature -- and it did -- increase trust, reduce barriers.

But we've taken a lot more rigor of late and actually measuring disparities, tracking them, and seeing, yes, one of our programs is disproportionately enrolling patients with longstanding disparities in care and starting to see shrinking of those disparities. But another hasn't done enough. It's working for the white wealthier folks among the complex chronic subset.

And that's been a really powerful feedback loop with clinicians and operators who are deeply mission driven and just putting that data in our face and reflecting back what we need to do to do better. I think ACO REACH just as an example, the health equity plans that sort of focus around that, has been useful. But I think you need to sort of more deeply bring that to the fore of what you're doing.

CO-CHAIR SINOPOLI: Okay. Thank you. Olivia?

MS. ROGERS: I would echo that exactly. I had written that down as well, the health equity piece. Unfortunately, in hospice and many other areas of health care as well, you actually are de-incentivized to take care of some of those really complicated patients who don't have a caregiver.

It can adversely impact your star reporting. It can impact a lot of things because the patients are just much harder. The outcomes may not be as good. But for the patient, they may still be better than if you weren't there at all. And so I think making sure that we don't create more problems with audits and oversight and reporting that make it more difficult to take care of really complex patients.

I think that we should incentivize all provider types in some kind of way to take care of patients even though they are more expensive. And they're difficult to take care of and you have to employ much, much more social work and those kind of things. So I think just making sure that we are giving providers some kind of incentive to take care of patients who historically there are reasons, some of which we've created inadvertently for why those disparities exist.

CO-CHAIR SINOPOLI: Thank you, Olivia. Matt?

DR. WAYNE: I just want to thank you for involving me. I think I learned as much as I offered. The one thing, I did mentioned it.

But I think it definitely deserves more time is just the burden around reporting.

And I've actually been in positions where as a Chief Medical Officer I wanted to identify or create quality measures so I could measure and provide. And what I can say is I never not once been humbled by how good intentions go awry very quickly and create burden and inefficiency. So I understand the intentions around reporting and quality measures. I just think we need to be more thoughtful and involve the stakeholders in them. And I think there'd be a tremendous amount of waste reduction if we did that effectively.

CO-CHAIR SINOPOLI: Thank you. And Cheryl?

DR. PHILLIPS: I'll try to wrap it up quickly. So in my 35 years, I've seen a lot of really good models and some of them don't exist anymore. And so I think one of the things that we need to also look at is what doesn't work and why.

And so as I look at some of the models that haven't survived, they tended to be local incentives. They tended to be disease-focused. They required a local champion. Sometimes that was me. And when I moved, the program went away. And they were episodic typically.

So what we are talking about here for success is something that is embedded within the delivery system that is longitudinal, that is whole person-focused, not just a one-off model that's a good idea and then we leave and then we're on to the next thing. So that's my hope for this work. And I remain optimistic.

CO-CHAIR SINOPOLI: Thank you for that. Well, I'll tell you this has been a fascinating session. This is has been a great discussion and obviously we picked the right experts to come talk to us.

And we really appreciate that and appreciate your time. So at this time, we're going to take a short break until 2:40 Eastern time. Those that are listening, please join us then.

We have our first listening session to discuss best practices for measuring quality and outcomes related to caring for patients with complex disease and serious illness in total cost of care models. So again, thank you and I hopefully you'll stay on and listen. See you back in 10 minutes.

(Whereupon, the above-entitled matter went off the record at 2:32 p.m. and resumed at 2:42 p.m.)

*** Listening Session 1: Best Practices for Measuring Quality and Outcomes Related to Caring for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models**

CO-CHAIR SINOPOLI: Welcome back. I'm Angelo Sinopoli, one of the Co-Chairs of PTAC. In planning for this meeting, PTAC wanted to prioritize hearing from those with experience measuring quality of care for patients with complex chronic conditions or serious illness to facilitate value-based transformation for this patient population.

To that end, we invited four experts from across the country for this panel. You can find their full biographies and slides posted on the ASPE PTAC website.

I'll now ask Committee member Lindsay Botsford to introduce and facilitate this listening session.

Lindsay?

DR. BOTSFORD: Thank you, Angelo. I'm looking forward to facilitating this session. At this time, I'll ask our presenters to go ahead and turn on your video if you haven't already.

I'll briefly introduce our guests and then give each presenter time to share their perspectives on this topic. After all four have presented, the Committee members will have time to ask questions.

So, first, we will hear from Ms. Brynn Bowman, who's the Chief Executive Officer at the Center to Advance Palliative Care.

Please go ahead, Brynn.

MS. BOWMAN: Thank you.

Good afternoon. It's a pleasure and a privilege to speak with you today. So I do lead the Center to Advance Palliative Care, or CAPC. And we make the case and provide implementation support for improving access to specialty palliative care services.

We also build tools and training for health care organizations across the country to help them identify patients with serious illness who have unmet needs, evolve care delivery to anticipate and prevent crises, and to provide high-quality care that is aligned with what matters most to patients and families.

So, first, we need to clarify who are

patients with serious illness. And I think we think about serious illnesses as a list of diagnoses -- cancer or advanced heart failure. And the problem here is that a diagnosis alone does not adequately predict costs or utilization or mortality.

Palliative care interventions have been shown to improve quality and, as a result of improving quality, reduce health care costs. So, to that end, in 2018, Amy Kelley and her colleagues analyzed Medicare data sets to characterize the population of patients who would benefit from primary or specialty palliative care services.

And that operational definition of serious illness is, I think, useful when we think about where we need to evolve quality measurement to derive improvements in patient experiences and costs of care. So serious illness is a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their caregivers.

And the first thing you'll note is that we're looking at a population that is not defined, again, solely by a list of diagnoses, but that also integrates evidence of unmet need. And second, you'll notice that caregivers are included in this definition.

Caregivers, as we know, are responsible for care coordination -- so much, really, clinical care for patients with serious illness, when we think about administering medications just as a start. And we ignore, I think, the demands of caregiving and the support needs of caregivers at our peril if we're looking at quality measurement.

Next slide, please.

So, second, I want to examine when in the trajectory of a person's illness we see the most risk for poor-quality care that causes suffering and avoidable costs. And here, again, we have Amy Kelley and her colleague Melissa Aldridge at Mount Sinai to thank for this analysis, of which patients constitute the top 5 percent of spenders category.

This was completed for the 2015 Institute of Medicine report Dying in America. And perhaps surprisingly, these are not, for the most part, dying patients. Eleven percent of the top 5 percent of spenders were in their last year of life, but nearly half were short-term high-cost Medicare beneficiaries, meaning they had a discrete high-cost event, such as an MI[40] or even a car accident, and in the subsequent year, they returned to baseline levels of care utilization and spending.

And the third group, 40 percent of this top 5 percent at the time of analysis had persistent high costs of health care. So this group is made up of the patients with complex chronic conditions and serious illness that we're focused on in this meeting. And again, the important thing to note is that they are not at the end of life.

Next slide, please.

So we have a population of patients with serious health conditions and with unmet needs. What does quality care look like for this population? Palliative care is one of those interventions that improves quality while reducing costs.

When it's provided in the hospital, palliative care improves patient and family satisfaction, reduces symptom burden, and reduces readmissions, ICU and hospital length of stay, and hospital costs per day. When it's provided

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[40] Myocardial infarction

not in the moment of crisis but to patients in their homes and over time, home-based palliative care has been shown to reduce emergency department visits, hospital admissions, and readmissions.

So, on top of saving patients and families a lot of misery, home-based palliative care leads to substantial cost savings from reductions in acute care utilization.

Next slide, please.

So what is it the palliative care teams do to achieve these outcomes? This is the definition of palliative care and how it benefits patients. Palliative care is an interdisciplinary care delivery system designed to anticipate, prevent, and manage physical, psychological, social, and spiritual suffering with a goal of optimizing quality of life for patients and families and caregivers.

And just to note, this definition says that palliative care is available at any stage of a serious illness, and the data do tell us that early palliative care involvement is associated with better outcomes for patients.

Next slide, please.

So, to pull these ideas together,

research has demonstrated for years that while we are not accurate prognosticators, even if we were, focusing quality improvement and quality measurement on the population at the end of life really misses the opportunity to improve quality of life over time and misses that 40 percent of the top 5 percent of spenders who persistently incur the highest health care costs.

So, if we consider high spend to be an indicator of poor-quality care, we need to think about measuring quality for patients with serious illness and unmet needs across the trajectory of that illness. And I think palliative care services and outcomes signal what is important to measure for care quality.

Next slide.

So to get in on the measures, two validated measures for people with serious illness are feeling heard and understood and the patient's experience of receiving desired help for pain. So these measures were developed through collaboration by the American Academy of Hospice and Palliative Medicine, the National Coalition for Hospice and Palliative Care and RAND.

They were validated in the outpatient

palliative care population. These are two patient-reported outcome performance measures that were endorsed by the NQF[41] in 2021 but have not yet been implemented in Medicare programs. And I want to emphasize that the measure development process here really incorporated patient voices about what matters most to patients and families.

So why these measures? Feeling heard and understood is about listening for unmet needs that could be addressed, and it's also about trust-building between a clinician and their patient, the sense that clinicians and patients and caregivers are on the same team.

So does that directly impact costs and utilization? No, but we can consider the range of scenarios by which it can indirectly impact those outcomes, from understanding when procedures are or are not aligned with patients' goals, to treatment adherence, to avoiding a crisis ED visit because patients and families have a game plan for symptom exacerbations.

And most importantly, heard and understood measures an outcome that is of primary importance to patients and families. And

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[41] National Quality Forum

briefly, when we look at the desired help for pain measure, really important to note that pain is a major driver of emergency department visits and that the construction of this measure, too, incorporates the same core concept of being listened to and trusting one's clinician.

So these are NQF-endorsed quality measures that can be applied to beneficiaries across Medicare programs. And a starting place might be to use these measures in demonstration models focused on serious illness like Enhancing Oncology Model.

Next slide, please.

One additional note I want to make about these two measures -- they evaluate quality in two domains where we see race-based inequities for patients with serious illness, and those are communication and pain management. I'm sure that Caroline will dig deeper into this topic.

But Black patients and caregivers consistently report lower-quality clinician communication, and in study after study, we see that Black and Hispanic patients are less likely to be believed when they report pain and less likely to have that pain well managed.

So these are two patient measures that

align with CMS' strategic plan to improve equitable care and are validated in the palliative care population. So I think we can think of them as twofers that get at key quality factors driving utilization and that measure domains of care where there are currently inequities.

Next slide, please.

So additional measures used in a subpopulation of Medicare that we can consider for general use across Medicare programs would be found in the hospice CAHPS[42] quality measures. These are validated measures that, again, speak to the quality of coordination, the timeliness of care, and the quality of clinician communication.

So, back to our patient with the symptom exacerbation in the middle of the night, two things could prevent that person from an emergency department visit that they really want to avoid, which would be education for the patient and caregiver about how to manage symptoms and respond to a crisis, and somebody to call when it's after hours and they're not sure what to do.

So these are two hospice CAHPS

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[42] Consumer Assessment of Healthcare Providers and Systems

measures that address these specific concerns and, to me, also describe the basic infrastructure and support that seriously ill patients who we know are likely to experience crises need in order to navigate those crises safely and limit avoidable hospital care. And these are measures that are relevant regardless of diagnosis.

Next slide, please.

So another program that already lays out a really strong foundation for quality measurement is ACO REACH. So that is a model that focuses on addressing disparities for Medicare beneficiaries from underserved populations. And for patients with complex chronic conditions, this means, in addition to measuring readmissions, using days at home, timely follow-up after acute exacerbations, and CAHPS.

An insight of the ACO REACH CAHPS survey are questions about the timeliness of care received, the quality of communication, and whether patients feel they participated in a shared decision-making process with their clinicians.

So these are the right measures for

patients with complex chronic conditions and serious illness and could be applied beyond the ACO REACH population.

Next slide, please.

Finally, I want to call attention for a moment to the fact that that traditional quality measures leave out an important facet of patient experience that is a major driver of utilization and outcomes, and that is social needs.

With a patient who has an unsafe housing situation or who speaks limited English and isn't sure of the instructions being given to them or who splits medication doses because they can't afford the co-pay or who has a caregiver who is themselves -- or cognitively impaired or has to show up to work, all of our best-laid health care plans can fail in the face of those complex social needs and gaps in the social safety net.

And it's very true that in recent years, we've taken much more seriously the need to ask patients and caregivers about social risk factors, up to and including a new billing code for social determinants of health risk assessment. But it is time to measure not just how reliably we are asking about social needs, but about how well plans and providers are addressing them. And this isn't easy, but if we survey even a sample of patients, I think we'll get very valuable information about care quality.

So I look forward to discussing these thoughts with my co-panelists and the Committee.

DR. BOTSFORD: Thank you, Brynn.

We are saving all questions from the Committee until the end after all experts have presented. So next up we'll have Dr. Paul Mulhausen, who's the Chief Medical Director at Iowa Total Care, a Centene health plan.

Welcome. Go ahead, Paul.

DR. MULHAUSEN: Thank you. Terrific to be here. Really a pleasure. Terrific privilege to share my thoughts with you here today, so thank you for the opportunity.

You should probably know where I come from. I am a geriatrician. My place in the market has been primary care geriatrics, which has essentially spanned the spectrum of health care services/stages of life among older adults, so nursing home care, palliative care, hospice care, hospital care, home care, home-based health primary care.

So my comments here reflect that experience over 30 years of practice as a geriatrician.

Next slide.

I do work for a large payer, and I do want you to know that my reflections here are my own and really reflect my views as a primary care geriatrician with a stake in how we measure quality, as well as and how we hold total cost of care models accountable for the care and value they deliver.

Next slide.

So the first question I always have in my mind is, well, why patient-reported outcomes? Brynn has already touched on this, but just to amplify, they amplify the voice of the patient. If there is one really exciting component of quality measurement over the last 10 to 20 years, it's been the effort to bring the voice of the patient into the value equation.

And I have found that both exciting and uniquely helpful in the area of measuring quality. They help us as stakeholders move beyond process measures, so not only get to outcomes, but actually potentially outcomes that matter to our patients or, in my case, the members we serve in our health plan.

And then, for those of us delivering care, these kinds of patient-reported outcome performance measures have the opportunity to promote patient-centeredness on our side in terms of trying to meet the goals of the quality measures and ensuring that the measurement strategies used actually help us improve our performance in the promotion of patient-centeredness.

Next slide.

I thought I would just try to characterize my talk in two sort of summary slides. One is the language of patient-reported outcomes. I think this language is important.

When I talk to colleagues, they don't really understand what I'm talking about when I start to talk about patient-reported outcome performance measures. So I want to talk to you a little about the language of these measures.

And then the next slide -- don't turn it yet -- will be talking about the language of serious illness, multi-morbid complex patients, and touch on some of the issues that Brynn has already brought up.

So the language of patient-reported

outcomes can be, I think, characterized in three ways. And my examples here are really the common example that you would find in the medical literature and the quality literature around how to actually define and explain patient-reported outcomes and, more importantly for our discussion, patient-reported outcome performance measures.

So first layer of language would be a patient-reported outcome, and this happens every day in the life of a clinician: Doctor, I feel depressed. Doctor, my depression is better.

So there are a series of outcomes and reflections that we use to try to determine, does somebody have a problem, and whether or not what we've done has helped them. You can quantify that.

And so, in this case, the patient-reported outcome measure would be a method by which the reported outcome could be collected into a single measure. And in my world, the PHQ[43]-9 would to be used as a patient-reported outcome measure in the domain of depression. And you can see here how that felt experience, that lived experience of I'm depressed, can be

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[43] Patient health questionnaire

quantified in a tool like a PHQ-9.

And then the last step in this process would be, how do you translate that change in the PHQ-9 into, actually, a performance measure? And so this would be aggregating patient information to a valid and reliable measurement of performance. And here, you can see NQF 0711 attempts to do this.

Now, this is a very important distinction between a patient-reported outcome measure and a patient-reported outcome performance measure. I think many of us conflate the validity and reliability of the two as equal.

Oftentimes, you have very valid patient-reported outcome measures that don't perform as well in terms of performance measures. And that is an important thing, I think, for the Committee to keep in mind.

So next step -- or next slide.

So there's the language of patient-reported outcome performance measures. And then I want to talk a little bit about the language of complexity.

I admit I lifted this from the 5Ms of geriatric or age-friendly care, but I think it illustrates the challenges and the opportunities of applying patient-reported outcome performance measures to this population of people with serious illnesses.

They are complex. They have multicomplexity. I'm 30 years into my practice. When I was a young geriatrician, we framed this as comorbidity. They had comorbidity, multiple diseases, multiple disorders.

This is a really important concept because it means that if you have a patient-reported outcome performance measure that's very disease-specific and very episode-specific, it may not capture the experience or the important outcomes to a patient who has multiple conditions, multiple caregivers, multiple providers, and could be receiving care in a variety of different circumstances.

So, for instance, Brynn has highlighted the palliative care measures in the home. That's in the home, and I don't think those measures have been validated in nursing homes or other settings. So that would be an opportunity to think through how do you translate reliability and validity in one delivery setting into others?

The next point I want to highlight on this slide is mine. So I work primarily with older adults. We all know that the incidence and prevalence of dementia increase as people age. It's a very common problem among my patients, and there are varying degrees of cognitive loss.

So not only are we asking for people to report their outcome who are suffering from cognitive problems, but there are varying degrees of cognitive problems. And how do you build that into the surveys and tools that measure the reporting part on the part of the patient, and how do you incorporate caregivers into that, or proxies for those particular people who no longer have the capacity to actually report the outcomes of interest?

And then Brynn's commented -- I'm deeply appreciative of Brynn's comments regarding what matters most. This is the Holy Grail, in my mind, of patient-reported outcome performance measures. How do we measure what matters most to people, and how do we ensure that performance aligns with what matters most for people?

And yet I think it's in that space that it's often most challenging because most of the patient-reported outcome performance measures for those kinds of experiences on the part of our patients are very disease-specific and episodic-specific and may not translate into that five-year experience that people have when they experience a serious illness.

Next slide.

If you go and do an inventory of all the patient-reported outcome performance measures that I can do an inventory of in my basement with an internet connection, you find that most of them fall into these domains.

So health-related quality of life -- again, very challenging to measure in the clinic setting. Functional status, which I think is an exciting development in the domain of patient-reported outcome performance measures. Symptoms and symptom burden -- Brynn has already touched on those. Health behaviors, which are relatively easy to survey people on but may not be as applicable to our complex serious illness population.

Motivation and activation -- I have reservations and ambivalence around motivation and activation domain. I think they're really important for chronic disease management and may be useful. For instance, they're in one of the end-stage renal disease models. And I think they can be valuable but may not be the priority for the kinds of populations we're talking about here.

And then the usual, the patient experience and satisfaction domain, which I imagine you're all very familiar with the CAHPS surveys and the various domains of the CAHPS surveys. But that's what's captured in those patient experience and satisfaction.

Next slide.

As I said, this is the inventory of patient-reported outcome performance measures that I can find. There is substantial overlap across all of these libraries of patient-reported outcome performance measures. What I find enlightening here, however, is that they are available.

People have been working on this. People have been developing them, and consensus bodies have been endorsing them. So, if a payer is interested in implementing and using these kinds of performance measures, they can be found. They can be further developed and enhanced, and they are available, even though I think they're still pretty limited for the populations we're talking about today.

Next slide.

So here's the opportunity around patient-reported outcome performance measures [PRO-PMs]. If we can develop reliable and valid PRO-PMs that cut across domains and conditions, they may promote accountability.

I've had the privilege of working with one provider on a total cost of care model in my career as a CMO for a health plan. And accountability is really important. And I think these kinds of performance measures can be very helpful in ensuring accountability for those who are accountable for total cost of care payment models.

They need to be crosscutting. I think the kinds of performance measures that Brynn has talked about -- they cut across diseases. They may not cut across domains of living and service delivery. So I think that the models, innovation models, present an opportunity to develop those kinds of crosscutting performance measures.

I think care coordination is super important and those that can capture care coordination. And there are a few PRO-PMs available that are no longer endorsed but have been in the past that are available for care coordination.

And then the total cost of care model demonstrations create great opportunities for development, and I want to highlight one here. Brynn has already talked about the caregiver burden. And the GUIDE demonstration project that starts next month includes in the model itself the development of a PRO-PM around caregiver burden. It's not created. It's not validated, reliable, endorsed.

But it illustrates the opportunity around these total cost of care model demonstrations to recognize the need and use the model demonstrations to develop the performance measures.

Next slide.

There are a lot of barriers. We've touched on many of them, from reporting, cognition, sites of care, health literacy, health equity, sensory changes, cognitive loss. All of these present a serious potential challenge to getting accurate PRO-PMs.

In my own world, we put a lot of energy into CAHPS surveys. And these are also survey-based, and they will likely require a lot of energy on the part of providers to actually get the information from the patients across the spectrum of types of patients that are likely to be served under these kinds of models.

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So, in summary, I think that PRO-PMs present a high-value opportunity for all the reasons we articulated. Unfortunately, most of them are very disease-based or episodic-based and may not be as relevant to an episode of care that extends over years as opposed to days and weeks and that can extend across sites of health care delivery, as well as different providers.

But the exciting part is that the demonstration projects create opportunities for measure developers and payers to develop these kinds of crosscutting PRO-PMs that are more likely to meet the accountability and quality improvement needs of the seriously ill and medically complex populations we're discussing here today. Thank you.

DR. BOTSFORD: Thank you, Paul.

So next we have Dr. Caroline Blaum, who is the Assistant Vice President of the National Committee for Quality Assurance.

Welcome. Please begin, Caroline.

DR. BLAUM: Yes. Hello, everyone. Good afternoon. I'm really honored to be here.

Thank you very much.

I, of course, am from NCQA. My background also is a geriatrician and palliative care physician. And if you listened to Paul and what he said he's done for 35 years -- pretty similar to what I've done for 35 years, with a bit of a dose of academic medicine and now measure development thrown in.

I'm going to be talking about equity, so developing and standardizing health equity measures for patients with complex health status. And I was asked to talk about five things regarding health equity in these patients: best practices, challenges, current use, how measures might work in different populations, and standardization.

And of course, from my point of view as a geriatrician, when I think about people with complex health status, I think about older adults with multimorbidity and frailty. We've heard about that near end of life, some of them. But as you know, there are many other types of complex patients that are around, and I'll touch on that as I go through some of my presentation.

Next slide, please.

Here's what I'm actually going to talk

about, but I think as I go through this agenda, I will be touching on most of the questions that I was asked to consider.

So next slide, please.

So this cartoon just shows, in my world, complex patients experiencing the fragmented care that is burdensome and inequitable, sometimes dangerous, and you can see -- we all know this.

Next slide.

And I want to talk again about some of the problems that the other speakers have talked about, but again, in the world of measure development, we depend on evidence. But for seniors, for people with complex health status, we really don't have evidence. We are in the evidence-free zone most of the time.

I will say, for palliative care, there is some evidence. But in many other arenas, evidence is poor. Most trials are disease-specific. People with multimorbidity, disability, and frailty are not in the trials. Behavioral health and substance use are poorly covered.

So we need new and different evidence. And we need to think about trade-offs, uncertainty, complexity, and of course, we need to infuse equity throughout, thinking about community engagement and best practices, as Cheryl Phillips was sort of pointing out in the last session.

Next slide, please.

Therefore, our current measures for complex patients -- they're often not relevant, or they exclude -- they just flat-out exclude complex patients. Sometimes they do cover important activities, but a lot of times, they feel like checking the box. They don't clearly foster integration of personal medical care.

Our future measures need to address equity and what matters most. And you've heard that over and over again, and I'm going to actually get into our what-matters-most measure at the end of this talk.

They need to improve communication between providers and the people and their families. They need to be flexible and usable in different clinical settings, with different and diverse populations, and with different people.

Next slide, please.

So I'm going to start a little bit with talking about chronic conditions and serious illness. So, from my point of view, as I think about it as a measure developer, there are many patient populations who have complex health status.

Of course, it's worth thinking about people with multiple chronic conditions and frail, but people who struggle with behavioral health problems, substance use disorder, people with disability -- even lifelong disability -- people who have sexual orientation and gender identity issues -- some of the other speakers have emphasized socioeconomic challenges and disparities and, of course, end of life.

And as some of the other speakers have mentioned -- and I'm talking the usual suspect, are process structure measures, of which in my view we have too many. Some of them are useful and good. Some of them, maybe, are just a burden. Some of them do what we want them to do, and some of them don't. But most of them don't necessarily address issues with complex patients, and most of them are not addressing equity.

We do have some measures that we're working on at NCQA, and other measure developers are working on addressing social needs and social connection. I'm going to talk about the social needs one in a few minutes. But then let's look at outcome measures, which are going to be very important and crosscutting for our complex patients.

A lot of times, we do look at intermediate outcome measures, and those -- like, for example, blood pressure targets or hemoglobin A1C targets for diabetes patients. These are not necessarily relevant for many complex patients, but for some they are. I mean, a lot of times, the reason they're complex patients is they had diabetes their whole life, and it wasn't dealt with well enough. So sometimes they are, sometimes they're not.

But as Paul so comprehensively pointed out, it's really the patient information, patient-reported information, that probably will help us get a true quality signal for good care for complex patients, and here are the various different types of patient-reported information that we can use to make measures. And I'll be talking in detail about one of them in the future.

But -- next slide.

But I'm going to start talking about NCQA's approach. We believe that quality care is equitable care, and I'm sure most people in this room do, too.

So what NCQA is doing -- and we're not the only measure developers doing this, but what we do is we are starting to stratify our measures by race, ethnicity, and sociodemographic issues and including sexual orientation and gender identity when relevant.

We're also looking at new measures that generate -- both patient-generated information and measures that incorporate the patient voice, particularly social needs screening and social connection, patient experience, and patient goals. So a lot of talk about patient goals.

So we care about both current care planning and advanced care planning and measuring the delivery of goal-directed care in complex patients.

Another big thing NCQA does -- and again, we're not the only measure developers doing this. We work with patient partners, and we care about patients and their care partner also. We're working with caregivers throughout our measure development.

We're also looking at community engagement, looking at groups with lived experience, looking at our experts to help us to assure that we have a trusting relationship as we try to make some of these measures. And I'll talk a little bit more about that.

We're also very interested in learning communities, even if it's the health plan, learning communities and collaboratives so we can all work together and try to begin to infuse equity into better measures for complex patients.

Next slide, please.

So I'm going to talk a little bit about race and ethnicity stratification and the goals that NCQA has as we're starting to do this. We want to bring transparency to inequities in health care by race and ethnicity and incentivize equity with benchmarks and performance scoring.

Now, we're working on this. As you can see, 22 measures have been stratified, and I have an appendix of the measures that we're working with. And we've also developed a learning network with health plans about collecting and reporting race and ethnicity data, how we access the data, how we work to gain the trust so we can work with members to get this type of data.

And back to the measures that are

stratified, some of them are not necessarily targeted to people with complex health status, but some of them are, especially measures of utilization, because most utilization, as pointed out by our first speaker, are people with complex health status. So some of our measures of utilization or risk-adjusted measures are also going to be stratified.

I'll just go really quickly. Next slide, please.

We have been fortunate. Again, we often develop learning networks and collaboratives, and we've worked with 13 health care plans. Eleven have given us quantitative data as they look at their measures, at their HEDIS measures, and how can they be stratified? What will this tell us? They’ve also given us some qualitative data so we can get an understanding of how the plans are figuring out how to do this and learn about challenges and successes.

So we think this is a very important activity to try to infuse equity into every measure.

Next slide.

Another thing that we're doing -- and

we actually now have a new HEDIS measure, social needs screening and intervention. And I'll talk a bit about this. This measure is in HEDIS now. It just passed.

It's what we call an ECDS[44] measure. So it's not a chart review measure. It's completely electronic, completely digitalized. And it looks at food, housing, and transportation needs. And because it's a digital measure, we have to use pre-specified screening instruments.

And the other important part of this measure -- it has a second part. If a person screens positive, there has to be a corresponding intervention. So it's not just an assessment. The measure will also look for an intervention.

Again, this is what we call a first-year measure. It's only been out in the wild in health plans, in HEDIS, for one year. We will be getting data from that first year in about a month, and we'll be looking at how it's been done, if plans are able to do it, what kind of performance we're getting. And so stay tuned as more information comes out about this measure.

Another thing I want to say -- that there are also social needs screening and

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[44] Electronic Clinical Data System

intervention measures that are coming out from other measure developers on the ambulatory care side and the hospital side. And NCQA is working with other measure developers and with CMS, so eventually these measures can be harmonized so don't have multiple competing measures for the same thing.

Okay. Next slide, please. Oops. I'm going to skip this one. Next slide.

Just for the interest with social connection -- we actually tried to do a measure of loneliness because we think that's very important in this population. And I'm happy to address that in the questions. It just wasn't -- the world sort of wasn't ready for it, but we're still waiting for the evidence to accumulate.

Okay. Next slide.

Now I'm going to switch to what matters most. You've heard several people, several speakers in the last session and this session, talk about patient-generated information, the care that matters most to people. I call it current care planning because people are getting so much care. What do they want it to do for them? What do they want out of their care? What's their goal?

So the next slide, please.

So we think that promoting health equity will come through measuring what matters most to people and that our health care system should be organized about what matters to people, their families, and their community.

Specifically, for people with complex care needs, care should align with their health outcome goals, and what do they want out of all this health care that they're going to get?

Now, we think measurement can be used to drive care that matters and also not just encourage clinicians but to reward the clinicians that are really trying to do this. And many people are trying to do this. Many clinicians do want to develop goal-directed care.

But if you're going to make a quality measure to incentivize that type of care or to make people accountable, outcome goals must be measured and standardized and tracked in a standardized way.

So next slide.

So we have three measures, the person-centered outcome measures. And you can read this. You'll have your information. You'll get the slides. But the idea is relatively simple.

The first measure is to identify the goal, and then make sure there's a care plan that addresses the goal. But this requires some conversation and training between the clinician and the person who has complex health status.

The second measure is just follow-up. Track this. Is it working? Is the care plan working? Is the care plan helping the person achieve their goal?

The third measure is actually an outcome measure of goal achievement. How many of these people actually achieve their goal or make progress?

Next slide, please.

Now, we have been testing this -- actually, the title is wrong. We've been testing it since 2018 all over the place. And this sort of addresses, can we do a measure of goal-directed care, or what matters, in different types of people? Well, we have done it in everybody from people who are at the end of life to frail and multi-morbid geriatric patients to people with substance use diseases to younger people with disability.

We have done it with all types of clinician types who are working with the patients and trying to deliver goal-directed care, and as you can see, many, many places all over the country.

So this has been well tested. It's been funded by the John A. Hartford Foundation, the SCAN Foundation, and I will say NCQA certainly has some skin in the game, too. And we are working to make this a digital and ECDS measure, and I'm happy to take questions about that going forward.

Next slide, please.

So -- but we have tried to infuse this from the get-go. All the time we've been working, we've had health equity in mind. So, in other words, our analysis of the measured data compares race and ethnicity, language, social needs of all the people that are part of it. So we understand how the measures work in different populations.

When we recruit delivery systems to work with, or special needs plans to work with, we want organizations that serve diverse populations. And we’ve succeeded. At least 50 percent of the people that have been part of this measure are from diverse populations. We also have many patient-facing materials in multiple languages.

And finally, that we try to use measures/we try to do training and data and stories that resonate with diverse populations and people. And most important, from the very beginning of this, even before I came to NCQA, there have been patient partners and expert panels of people with lived experience. They have been with us all along. They have been helping to train the clinicians. They've presented it at national meetings. So our patient partners have been a huge help and highly involved.

So next slide.

Just to -- this is the next to the last slide, but here's what we've learned from testing for qualitative results both from patients, caregivers, and the clinicians. Get better communication, better awareness, builds trust.

For our quantitative results, we did have one group where we were able to get some claims, and it was nonrandomized, but it was controlled. And we did see a significant decrease in hospitalizations and some decrease in ED use and improved patient experiences regarding care planning and activation.

The other thing I'll say about this -- this is a type of PRO-PM or PROM that doesn't have -- we don't have any trouble with response rate because this is a conversation during care with the clinician and the patient, and everybody responds. So it's a real PROM.

So the last thing I want to talk about is some best practices.

Next slide.

This comes from our Equity group at NCQA. We sort of talked about, what do we think would work? What do we strive for at NCQA? In other words, consider all areas of risk – sociodemographic risk, location -- to target inequities.

Race and ethnicity stratification is important, but it's only part. Link equity to the whole person, person-centered care. Identify barriers. Take perspectives not just from the health care industry -- from patients, families and communities. And think differently about our process of measurement, like first, do no harm.

So thank you, and happy to have questions and discussion later.

DR. BOTSFORD: Thank you, Caroline.

So our last expert for this discussion

is Dr. David Kendrick, who is the Chief Executive Officer of MyHealth Access Network.

Go ahead, David.

DR. KENDRICK: Great, thank you. And thank you for the repeat invitation. I really enjoyed getting to present to you a couple years ago on a somewhat similar topic. And I'm going to try to draw that thread of conversation through what I'm presenting today.

Next slide please. These are my disclosures. Note, I am on the Board of NCQA. Immediate past chair there since we have one of my colleagues there presenting. It's obviously a non-paid position.

Next slide please. So first of all, I'm an enormous fan of CMMI. We've used participation in models from the network I operate, MyHealth Access Network, to really be the nidus ~~NIDIS~~ of innovation.

It’s really created the burning platform on which, so to speak, that we've gone about practically implementing solutions for each of these initiatives across the community. And we achieved some pretty remarkable results along the way which we're very proud of.

But moreover we've created real and

lasting innovation in our community that persists to this day. Which I'll tell you more about.

Next slide. So I'll start where I ended last time. This was my last slide in our last get-together. And my point in showing it was that, you know, just because, I'll use an analogy, just because you want to start a trucking company doesn't mean you can do that everywhere.

You really have to make sure that there is not only a system of streets and roadways, but probably an interstate highway system as well. And that means that there’s infrastructure, there are utilities, there's a supply of petroleum along the way and so on.

And so moving data and innovating on data in health care is no different. And so this pyramid shows kind of how we built our network in Oklahoma. The MyHealth Network. And there are others, many others around the country as well.

But I just want to point this out, that to get to that pinnacle of actionable results you really need this infrastructure. And let's dive into that now.

Next slide. All right, so you gave me three questions. Let's start with standardized patient data. And I bet you can't guess where I'm going to go on that one.

Next slide. So this is a picture of data for four real patients in Oklahoma, or anywhere in this country. And what we see there is that claims data is a mile wide but only an inch deep. That is, it doesn't have actual biomarkers or lab results but it does have diagnoses and procedures.

On the other hand, each given clinic signified there by their EHR 1, EHR 2, et cetera, is a mile deep but only an inch wide because patients, and unfortunately the sicker the patient is, the more places their data will be scattered and fragmented.

And so, in this particular population we're talking about today probably has the maximum data fragmentation that's possible in health care. And includes a lot of entities not even on this screen that are important for their care.

Next slide. And of course, even claims data, administrative claims data, is fragmented with 20 percent of people changing insurance every year.

Next slide. So this is real data from

Oklahoma pulled, I don't know, whenever I finished this slides. And what this chart shows are the five largest health systems in Oklahoma. And it shows the fragmentation of their data.

Meaning, what percent of patients have data and in how many places. So that's the X axis there, is how many different locations their patients have data, for each of those health systems.

And you just need to focus on the red box first which shows essentially, what's the percent chance that if somebody walks in my emergency room or my clinic that I have all the data I need in my system today because this patient is loyal to my health system a hundred percent. And you can see that that number ranges from as high as, or as low as a 92 percent chance there with 8 percent there on Health System D, that data will be needed from outside to as low or as high as a 99 percent chance that there is data from outside with Health System C.

I'll let you guess which one is the Academic Medical Center.

So the point here is, there is essentially no patient that it's not appropriate to check for outside data, have the complete picture for to truly do appropriate care coordination. Mai Pham had showed in 2007, from Medicare data, that the average primary care doctor is expected to coordinate care with 225 other providers and 117 other organizations.

I think we can probably double that if we're dealing entirely with palliative care. Although I'm not a palliative care provider myself, I do see the data moving and it is quite fragmented.

And I'll also say that the average Medicare patient, also from that same article, was seeing seven different providers a year.

Next slide. On the other hand, we are finding as time passes, and with meaningful use out there, that most health care providers at least are on an electronic system, electronic medical record system.

And I think that a big, you know, a large percentage of the large health centers, billion dollar, let's say, health centers, are using a common EHR. Some, most are on Epic, some are still on Cerner and a few still on Meditech. But those are the big three really in large health centers.

And so I'm often told, well, we use

Epic or we use Cerner and therefore we have all the data from outside. But I'm here to tell you that is not the case.

You can see here, again, look at the red box and you can see that in fact that Epic is only 92, is 92 percent of patients don't, have some of their records that are not in Epic. Does that make sense?

So Epic only has a hundred percent of the data in Oklahoma on 8 percent of people. Which means there's a very good chance you need outside information.

Next slide. So I took this same data and I sliced it, or grouped it by age. And as you can see, no surprise I'm sure, but we do have obviously a significant rise in the number of data sources per patient as age, passes age being a proxy for complexity of care I suppose.

Next slide. And so, I'm back to my original point which is, we must have networks that connect hospitals and health systems and clinics.

And importantly, they can't be electronic health record networks because medicine is not the only player at the table here. We’ve got community services, we’ve got lots of other, we’ve got agencies, federal, both federal and the state, and even many local.

And we have to have a piece of community infrastructure that supports that. MyHealth has grown substantially since we last met two years ago. More than 130,000 patient visits a day.

Next day. And we have rich data across lots of types of organizations, including community services and including health plans and others that have a role to play in delivering services to this population.

Next slide. And available to all members of the team, whether they're in the clinic seeing the patient, on the floor doing a procedure on the patient or in the home rendering care or services based on a set of goals, they all have the same view, this same view, of the patient’s record which is comprehensive of all those other places.

And I’ve had people tell me, this sounds like a fantasy, but it is not. This is real today and happening all day, every day.

Next slide. So I want to bring your attention to a new term. When we last met, I used the term health information exchange to describe what we're doing. We decided that's a little bit confusing because everybody does it. It's both a noun and a verb and everybody exchanges health information when they need to.

So we've put a different term to label what it is we do as nonprofit organizations making connections in communities. And that is, we serve as the health data utility.

So you need a power grid, right? You need a clean water supply. You also need a health data utility to deliver comprehensive care and services, especially for complex populations.

So like an HIE, it has governance, trust of stakeholders committed generally to a specific geography. And it generally has most connectivity among health care providers and health plans.

But a health data utility adds to that in that we deal with social needs data, we deal with government agencies, we deal with education data, we deal with lots of kinds of information that needs to be protected and secured. And we have a broad range of stakeholders, up to and including tribal governments and sovereign entities such as that participate.

Next slide please. So this concept

for the health data utility better helps us describe what roles we have played in the past, continue to play and will play in the future in helping to understand the real cost of health care, the quality, improving the patient's experience, we'll tell you more about that in a moment, and then of course being prepared for the next thing that comes along.

The health data utilities in this country did a lot of important work during the pandemic.

Next slide. Second question is one that I'm not quite as much of an expert in, so I was glad to see the previous presenters talk about specific measures.

Next slide please. But I'll tell you about some that I've come across in just general from my experience with measurements.

Really, really like numeric continuous variables and those assessed with patient input and their family in these situations especially. So this is data that we move all day, every day through the health data utility. PHQ-9s, GAD[45]7s, SBIRTs[46], the AHC[47] social determinants of health screening,

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[45] General Anxiety Disorder

[46] Screening, brief intervention, and referral to treatment

[47] Accountable Health Communities

Edmonton, as well as goals of care. And those are all replete within the system already and in the central record.

But I also think there are important system-centric measures here because we have to continuously improve this complex system. You know, we're posting most out there and being tracked and available to the next provider in line immediately, including emergency providers.

Caregiver support and funding where available. Those caregivers are covering a lot of gaps for us in the home and in other places. And I'm proud to say Oklahoma now has a model for that. We're probably last in line to get it done but we've now got it.

Family supports, cultural sensitivity, including communication in the patient's preferred language. And I'll talk more about that in a moment. And then things like drug diversion protection.

Next slide please. So I knew that our first presenter today was from a policy organization well versed in this, and so I consulted with a colleague in palliative care and got pointed to another organization to show as well.

I think both have incredible content. I was blown away by these guidelines for excellence of palliative care. The eight domains here with lots of practical materials.

I'm not going to go into those because I think they're self-evident, but I just wanted to call them out if this group has not considered this body of work as well in your planning. You definitely should because it's really valuable.

Next slide. So what strategies can we use? And again, I am, you know, coming at this from a practical implementation perspective.

Next slide. So here are six strategies. I'll go through them as quickly as I can.

First, next slide. Next slide. So, these health data utilities are not rare. There are 75 of them across the country.

And I would submit that testing models anywhere but a location covered by one of these entities will force that model to invent its own methods of data exchange, its own methods of collaboration. And that's not really what you're wanting to test I don't think. I think you want to start with a highly functional community.

Next slide. Next slide. Next slide

is recognizing that patients move beyond boundaries of the community they're in, although perhaps less so in these complex situations they still might, and they certain deserve to.

Next slide. So these networks, these health data utilities are connected to one another in something called the patient-centered data home, which is obviously a play on the term patient-centered medical home.

We developed this network in 2015 and have connected 40 of the 75 networks and are on track to connect the rest into a live data network. Meaning, you don't have to go get the data, it's actively pushed to the next place in line that needs it to take care of the patient, which is a rare, a rare commodity in our health care system today.

Next slide please. Okay, next item is, now that we have that infrastructure, use it. Be alerted.

Next slide. Use that structure. We do alerting to unplanned critical events like admissions, discharges, transfers. We call them care fragmentation alerts.

As this slide shows, patients over the last 24 hours that have had an event, and what kind of event it was in various locations so that we can coordinate that care and let everybody in the care team know that something has occurred.

Next slide. Things like impending 30-day readmissions based on utilization events can be alerted to and so forth.

Next slide. The next one is to deal with expected and planned events. So the first one was the unexpected that I just talked about, now what about the ones we expect and plan, how can we make that go better?

In a prior life I've developed and rolled out systems that do this, next slide, to coordinate care and actually actively manage the referral of services. So, pretty easy to make referrals within a health system. It's very difficult to make them beyond. And in fact, health care is the last bastion of the fax machine for that reason.

And so I think it's important to embrace electronic systems for referrals between primary care and specialty care, but also health care providers and social services, as well as all members of the team. And that can be done in a very discrete way.

In fact, our network in Oklahoma was

the test site for the closed looped referral system based on the existence of this.

Next slide. And so we were able to show, as you can see, a dramatic improvement in the so called loop closure rate between two clinics, one using the technology and the other not.

Next slide. And so we also layered in e-consultations to this.

And next slide. We were able to allow providers, essentially anytime there was a differential of knowledge or experience to allow two people to collaborate asynchronously to arrive at the best plan and the best approach for the patient. And we were able to demonstrate that that saves, produced significant savings in the Medicaid population.

Next slide. Next slide. So the next item is, how do we get these patient-reported outcomes? How do we get feedback from patients when it's not me, the person who they're judging asking, don't you like that, didn't I do a good job for you, right?

How do we get independent feedback? And so, we at MyHealth have recognized, and this is our accountable health community small intervention, the same picture you see for fragmentation and health care data we see, if not more so, for social services information and social services that are being delivered to the patients here called clients.

Next slide. So we developed a mechanism using mobile devices. We found that more than 90 percent of patients registering in clinical settings for care had a mobile device that could receive text messages, and so we were able to leverage that to provide a lightweight interaction that any clinic or hospital or provider could ask us to turn on for their patients and deliver that screening to patients.

And if they, in this case it was for social needs. And if they reported a social need, we're able to immediately return to their mobile device, a tailored referral to services that met their needs that were close by. And also to share that information with the provider so they could account for it into their plan.

Next slide please. It’s very lightweight, it's the AHC screeners. Should be well known to CMMI as the originator of it. And you can see that it takes patients about three minutes to complete it whereas it takes a facilitator, or the provider, between 12 and 15 minutes to get the patient through it.

Next slide. And so speaking of reducing provider burden, this has been a tremendous benefit there.

On this screen you can see the immediately delivered set of referrals to these patients who completed the screening. And they can click any of those links and be talking to the service. They can see eligibility and other things.

Next slide. And so, I'm happy to say that model, which we kicked off in 2018 as part of the AHC, continues to this day. And we just hit 4.6 million offers to screen and a million patients who completed the screening over time. It turned out to be COVID-proof because even when patients were using telemedicine or at home, the screener worked.

And that's part of the reason that I think this is a good approach to use potentially with this complex care population. Especially for the homebound portions of their care so they and their caregiver can have an opportunity to give feedback independently and without fear of retribution from somebody who is providing them care and control for their pain to give, you know, even anonymous if you set it up that way, feedback, but in real time and in context with their care.

Next slide please. And so you can see we get real credible numbers from this. The uninsured have the highest need rate across the board, then Medicaid, then Medicare. And then shockingly the commercial insurance population. Commercial insurance population still has a significantly higher rate of social needs.

Next slide. And this is by age grouping. And you can see it really peaks in the 19-to-59-year-old group. But these social needs persist throughout.

So I believe that this workflow, this process, could be leveraged for lots of other kinds of screenings and questions to patients that should not only ask them for information, but that should return some value to that. And it can contribute greatly to reducing provider burden while giving us a more measurable return on our intervention.

Next slide. I'll keep going but this shows sites of care. ER being the highest rates of needs, and primary care being the lowest rates of needs reported.

Next slide. And then need rates by insurance type.

Next slide. And then finally we'll get off sort of into the frontier land of artificial intelligence, which we used to just call machine learning when I was doing it.

Next slide. I think there is sort of the basic and advanced here. I use it personally in clinical settings actively today. And I do it, I teach in a free clinic. I teach medical students.

And most of our patients speak in language other than my primary language. And things like Chat GPT 4.0, the latest one with the audio, are fantastic at translating almost anything to almost any language.

And I think that's such a critically important show of respect. The language lines are kind of a disaster to be quite honest. At least the ones we use. And we've had patients hung up on in the middle of their statements.

And so this has empowered me and my team of students to really have great interactions with patients from completely different cultures and learn a lot about them.

And then if we move into the advanced space. And I think this applies obviously to the written materials and other things that we can put into their languages as well.

In the advanced space, with the health data utilities we've aggregated not just one hospital set of data or one clinic, we've aggregated entire lifetimes worth of health care data into one system, including their, you know, from birth to death in some cases today that we have in the system, in many cases.

And when you add to that, the social determinants of health data that we're gathering in real time as well. We really got an opportunity to train AI models on something that is free from the fake information, it's just objective data, and get new insights on how these systems can be developed. And I'll stop there.

DR. BOTSFORD: Thank you, David. Lots to digest. Now we'll open the discussion to our Committee members.

So at this time PTAC members, please go ahead and flip your name tent up. If you are on Zoom, Lauran and Josh, feel free to raise your hand in Zoom if you have questions for our guests.

All right. We'll go with Lauran.

CO-CHAIR HARDIN: All of you were fantastic. I could spend an hour asking you all questions, but I'm going to start with David.

So I work deeply in the space of complex populations, and closed loop referrals are really essential in stabilization and integration. I'm curious what evolution you're seeing with some of the existing structure that's out there like Unite Us and Findhelp and Aunt Bertha, and what you are talking about in an integrated structure, how are they playing together or not, and what do you see as the future of that?

DR. KENDRICK: So I worked in this space even as a, like a senior medical student. So when the, which is many, many, years ago. And so when the Unite Us and the Aunt Berthas came along and the closed loop referral, the word closed loop referral began to be used, my ears perked up because I had been doing for a decade and a half at that point.

And what I was struck by is, similar to the way we, I would say mistreated behavioral health and medical care, we took, we were, again, separating, creating an artificial separation between social services and health care.

And I only see Point A and Point B, regardless of what it is in a referral. And so had always built systems, the one that I was showing you that we studied, is agnostic to whether it's a referral to a cardiologist or from a primary care doctor to a cardiologist or to a food pantry.

All of the same levels of control. The maintenance of statuses for example. I know that's kind of wonky, but we discovered there to be 24, in some cases 25 unique states that a referral could be.

It doesn't have to go through all of them, but it's going to be in one of them. Once you include the payer and other types of utilization that might need to be reviewed and so on into that process.

And I think, and then we tuned it to run through HL[48]7 using standard message types as well so that it didn't have to be built custom for every electronic health record vendor but could be deployed. So that's my short answer.

I will tell you in general that the Unite Us and the Aunt Berthas I think of as sort of the last mile in social needs, and that the

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[48] Health level

first mile is that piece where we screen everybody, right? Because the screening tool we developed, we realized that was really the provider burden point was, who's going to sit down. We got, I've got GAD7s and PHQ-9s and a whole list of other things I got to ask a patient when they get there.

I'd really like for all of that to be done, and then get to have a conversation with a patient. And so, by thinking of the way we approach social needs screening and sort of expanding that to other, these other areas so that the patient arrives with that information in hand, or in my hand so I can act on it, then I think that's a better spot to be. So, I hope that helps.

DR. BOTSFORD: Any other thoughts in response to Lauran's questions from our other panelists?

DR. MULHAUSEN: I guess I actually do a lot of work with Findhelp. I really like it.

(Laughter.)

DR. MULHAUSEN: Admittedly I'm not in the data management, data transmission world, but I do find Findhelp useful. I find the closed loop component of it very helpful.

And in Iowa, which is where I live, we've been trying to stand up a community hub that helps with some of that data flow that David has been talking about. So terrific enterprise. And I agree that the data flow ends up being a challenge and very important.

And then the last thing is, I do a lot of HRAs[49], I guess I would call them. And I find that it's helpful for me to do them as a clinician because it then becomes part of my understanding of the patient. And I find when the data are presented in a form I find somehow I have a little more challenge integrating it into my day-to-day work or in my thinking about the patient.

So from that perspective, once that health risk assessment has been done and we identify the social, and people have changed the language from determinants to some other term, but I'll use social determinants because that's what I've grown up with.

So I have found Findhelp as a referral source and the ability to give me information back about when that referral was completed to be useful.

DR. BOTSFORD: Thanks, Paul. I think

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[49] Health risk assessments

we have Larry next, followed by Lee, then Jen.

DR. KOSINSKI: Again, what a great panel. You guys all spoke from experience, which is what we needed.

I want to address my question to Paul, but I think any of you can also pipe in if you want. On your PROMs, are you using any of them proactively?

Do you send them out to patients proactively to monitor their activity, and if so, are you using any technology for that?

DR. MULHAUSEN: So in my very tangible world where I am using, I would have to say it's mostly PREMs, so patient-reported experience measures, we use everything we can. We will send surveys out in hard copy; we will use text messaging to engage people. We will send a person to their house to try to get it done.

But the energy that goes into getting that information I think is important for the Committee to understand. I think David's approach is very exciting.

And I really loved what Caroline had to say about a patient-reported outcome performance measure that happens at the point of care. That's really quite exciting. And it sounds like it's relatively easy to do.

Most of these are relatively complicated surveys. Some of them are, you know, three-point questionnaires. But most of them that are available to us are really extensive surveys. And so they're a little bit difficult to do.

I, myself, have a spouse for who I'm the primary caregiver because of her disability. And, you know, when you're sitting there filling out all of these forms, it is a challenge. And when they send her forms on the internet, she can't do them. So A, I have to find them, and then do them. And then I don't even know that they know that I'm doing them.

So a lot of effort goes into it. It takes a variety of strategies to actually achieve engagement with our patients. So a variety of strategies, for the most part in my mind have to be used because most of these are not done at the point of care.

DR. BLAUM: Yes, I'm going to pop in on there too. And the first, you know, at NCQA I have always been very interested in how do we make PRO-PMs, and you talked about that. Because if you go for the prime you have to see if the score changes so you can get a measure.

But it does, it is, unfortunately, somewhat burdensome. And not just to the provider to the person. The person trying to do it, you know.

And, you know, I had advanced health care system, advanced primary care where there is all kinds of things in the, you know, automatic check-in, and people don't do them. So I think one of the challenges is to make sure that what we use is meaningful to people.

That's why at the point of care, as I say with our PCO[50] measures, everybody answers because people want to tell you what their goals are. And whether they want to tell you what the --

(Laughter.)

DR. BLAUM: So we don't have a problem with that. But, you know, if I want to, as a geriatrician I often might want to know someone's function. So okay, they'll tell me the first time but they're not going to tell me constantly. You know, they get tired of answering the questions.

So it is an issue that we have to

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[50] Person-centered outcome

address. And I think, and that gets to the idea of burden. You know, for people and for the providers. We have to do stuff that's meaningful and we have to restrict ourself to what we really want to know.

If we like, for example, close the loop on referrals. That seems to be something that people really want to know, and you don't have a response rate problem. So, anyway, it's going to be a trick.

One of the things that we did notice in the behavioral health world is that people were not necessarily responding sometimes. And I don't know, David, how much you work in the behavioral health world with your systems.

We felt that was a trust problem. Like when one of the clinicians were talking with the behavioral, with people who have behavioral health problems, substance use problems, they may be just as involved. Definitely complex populations. Complex health status.

And we didn't get much response regarding their social, social need. And we think it's a trust problem in that particular population. So again, not all people with complex health status are the same in different populations.

DR. KENDRICK: Yes, I might just respond on that. I agree. We thought a lot about that as we developed what we were doing. And it really, it came down to the numbers. I mean, we were building primary prevention first, right?

And once we got a need then we hand it off to community health workers and others to take it over. But we needed something that we could afford to deliver to everybody.

Just during the AHC model we saved 250,000 hours of provider time doing the screening, right? I mean, that's a real quantifiable difference.

And we were able to identify the several hundred thousand people with a need and get them met. But we don't have any delusions about who we might be missing.

We really pay attention to response rates; can we even deliver the message? Because that tells us something too, right? That mobile number that used to be good is no longer good. The communication pathway is no longer good, right? And something is going on here and that all warrants more intervention.

I just think that in many cases we see

the opposite. We've seen, I think, more trust because it's not an old white guy in a white coat in front of them asking if they're being hurt at home, right? So we see a bit higher response than I think we would expect on safety reports.

And particularly this younger generation tend to commune more with their phones than almost anything else. And I think we'll see more comfort in that response.

DR. BOTSFORD: All right, thank you. Let's go with Lee, followed by Jen.

DR. MILLS: Thanks, Lindsay. I want to pick up this thread of burden again, dive into that a little bit more. Primarily for Dr. Kendrick, but for the rest of the panelists as well.

Which is, you know, given the context that we're in a measurement metrics-driven world, that bus has left the barn, it's not going back. We're working, all of us, hard on finding better measures to ensure we're measuring the right thing to reduce burden of measurement.

And burden and practice burnout, administrative burnout is very significant, but yet simultaneously. You know, us physicians we have a dirty little secret, which is we're both data hounds, a bit obsessive, and we don't trust giving up control of our data to report on me and my care to anybody else, right? So we're stuck between a rock and a hard place.

Question. How could, and why, this health data utility function kind of thread the parsimonious path between those two incompatible extremes to dramatically relieve reporting burden and give true cross community reporting at the patient-physician practice level?

And does CMS have a role to play in pushing that forward perhaps?

DR. KENDRICK: Great question. I'll start, I guess, it was directed at me.

So, this was really considered heavily early on in the development of, not only our network but other networks around the country. And that was, you know, how are we going to engage with one another, how do we deal with trust?

We always say that interoperability is powered by trust, it's fueled by trust to start with. And how do we develop that trust.

And so we had to build the policies and procedures that made everybody comfortable. You know, obviously HIPAA[51] and then 21st Century

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[51] Health Insurance Portability and Accountability Act

Cures came along, and others that we adhere to.

But we also had to deal with things like competitive business pressures, right? One health system to another, one health plan to another, one university to another. And so we established governance very carefully to include competitors in the governance of the nonprofit.

We choose a nonprofit model to start with because we didn't want to put profit motive in the exchange of health data. And that enabled us to get the data moving.

And then in general we found ourselves playing a role, sort of a role of compromise in-between the payer side of the world and the provider side of the world. I've actually got a slide on this I can show you, but it basically says, look, we received a clinical data in real time, we received the administrative claims data on a monthly basis.

And when we do things like help with quality measurement, it's inevitable that a provider is going to have information that we can include in the measure for them that they had no idea existed because the colonoscopy happened somewhere across town or the required screening to meet the measure required in some other location.

And so, in that sense we've had to both, you know, sort of lay the groundwork, build the trust and the policies and then really deliver.

We helped one large health system in Oklahoma improve from the bottom quartile to the top quartile in their performance on colon cancer screening simply because of data they had no idea existed. And I have no doubt that this is in the same place.

Now in terms of CMS' role, CMS' role is critical here. And, you know, as the largest payer and the tone and trendsetter for the rest of the nation, this infrastructure can only persist and grow and exist if CMS is supportive of it.

CMMI can, you know, as I have been advocating for, could use these nodes to deploy its innovations and test them and not have to do all the rework of building data and interoperability but can start with it as an assumed existence. But furthermore, you know, CMS, and not just CMS, as I'll come back to in just one second, the role of, the promoting interoperability metric, for example, under meaningful use and under MACRA/MIPS[52] for the providers.

Simply by connecting the provider meets that fully in our community. Unfortunately, there are lots of sort of vendor-centric competing efforts.

And there are even some situations where it doesn't cost anything to share this data through your EHR vendor, but it costs something to send it to anyone else. And so there are these, I would say anti-competitive forces in play to make it complex for health data utilities to navigate and persist.

If I had a nickel for every time somebody told me, oh, we’re on Epic, we don’t need anything else, or we use the Epic payer platform we don't need anything else, and then I show them, look how many care gaps you're missing that are not there. That's really what we need CMS to see is that this is not, you know.

And I would say as a physician professional myself who wants to be able to practice anywhere and use any system that I think is best for my patients, I really don't want the world to be a solo vendor engagement platform,

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[52] Medicare Access and CHIP Reauthorization Act of 2015 / Merit-Based Incentive Payment System

so.

But now to the point --

DR. BOTSFORD: Thanks, David.

DR. KENDRICK: -- of other agencies, just real quickly, we've done projects for the Food and Drug Administration, for the Sentinel program. We've done projects for the CDC during COVID. And it's all the same infrastructure that supports that kind of thing.

DR. BOTSFORD: Thanks, David. We're in our final five minutes so I'm going to let Jen go with the next question as we get close to ending. And keep in mind with your answers we're in rapid fire mode after she introduces it.

DR. WILER: Thanks for a fabulous discussion. I'm going to actually riff a little bit off of the question that Lee asked. And, David, this one is for you.

You made a brief comment that I want to give you a chance to expand on related to the opportunity from the last time you presented to our panel to now around the infrastructure that's been created around both the patient center data home and the health data utility network.

And your comment was around CMMI leveraging this network in its models as a deliberate strategy for testing. Can you talk a little bit more around what your ideas are to leverage this network?

What that might look like either from a payment or care delivery or model perspective for CMMI, CMS, or other regulatory bodies?

How would you incent leveraging this in a way to encourage participation in care delivery?

DR. KENDRICK: So there are a few steps in CMMI’s process, and I'm not intimately familiar with it, but from being around it I observed them. One is choosing regions that are eligible.

And it could be possible to emphasize some of the regions that have good coverage, good governance, and good data interoperability. And we can even provide some metrics on that that might help to guide those regions.

I can tell you that when we started the Comprehensive Primary Care Initiative, we were just starting our network and spent the first four years, first three and a half years just getting data moving. So that's one opportunity is to choose regions that are connected as well.

The second is to prefer provider groups that are already in these data exchange agreements. It's not the same to say I'm on TEFCA[53] or Carequality or we have Epic, and therefore the other Epic in our community can use Care Everywhere, right?

Because those are federated. Meaning, I have to go get a piece of information. And by the time I have to go get a piece of information, this patient survived the hospitalization and they've come to see me and they're sitting in my clinic. I need to know when that patient registers for care in a hospital or clinic so that we cannot repeat everything so that we can get the plan in front of the new ER doc or the new admitting physician or the new place they're getting discharged to, to coordinate that.

So I think it actively, a network that's actively pushing data where it needs to go is critically important. And I think the incentives I would create there are just, ask for providers who are engaged in those now.

DR. BOTSFORD: Okay. We're in our, just our final few minutes, but I'd like to end with the question for all of our panelists for

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[53] Trusted Exchange Framework and Common Agreement

any additional, final insights or things you didn't get to share about measuring quality outcomes for patients with complex chronic conditions or serious illnesses.

And I'd like to first start with Brynn, followed by Paul, Caroline, and then David.

MS. BOWMAN: Thanks for the opportunity. And I'd like to pull together a couple of threads that I think were reflected in most or all of the talks that you heard today.

The first is the reality that we do not have any validated quality measures that we've said is so important that are crosscutting in the cross-care settings across disease conditions. But that it is worth the investment in difficult data collection and in measure developments to get there.

And I'd love to emphasize Paul's point that CMMI demonstrations are an excellent opportunity for measure development and for measure testing, for patient-reported outcome performance measures.

And then second, again, I'd like to just put a fine point on the importance of including caregivers in this equation. Whether caregivers are being identified, whether their needs are being identified and addressed, whether their level of distress is being identified.

And so just put a plug that we include caregivers in the unit of care and in the unit of quality measurement as we think about how to move forward.

DR. BOTSFORD: Thanks, Brynn. Paul, any final comments?

DR. MULHAUSEN: Yes, I have two. So one is this, that the reality is that the process measures that are available out there and present a burden for people like me to have to be measured on are not uniquely helpful to the care of this complex population.

And I think the kinds of measures that Caroline and Brynn and David have talked about here could focus what we're doing actually on what matters to the patient. And if that could be where the energy goes, it might reduce the burden in the other spaces of quality reporting that take place.

And then my second is, there is a lovely example. So Brynn talked about caregivers. The Guiding an Improved Dementia Experience Model has a goal to develop the caregiver burden PRO-PM.

And I find that very exciting, and a lovely example of what could be done. I'm going to assume it succeeds, what could be done with an innovation model to address some of the meaningful areas of quality that we need to be promoting for this population of care. So those are my two reflections. Thanks.

DR. BOTSFORD: Thanks, Paul. And let's close with Caroline.

DR. BLAUM: Well I just want to get us back to equity because there weren't, and I'm sure David has -- deals with this in his health data utility because, you know, the providers that take care of some people, diverse populations are not necessarily as digitally connected. We certainly have a digital divide with our patients.

And especially complex patients and people with older adults. People with disabilities can't really access some of the digital tools that we want to use. And the providers that take care of them can't always access, you know, the digital capabilities to access our ECDS and our digital measures.

So I think equity is a big, although

we have the capability of addressing equity through technological measures, we also have the capability of making it worse if we're not careful. So we have to look at the digital divide from all, from the point of view of all stakeholders.

From the people and the caregivers and the providers, and people like David that are trying to promote interoperability and string it all together. So let's not forget equity is my comment.

DR. BOTSFORD: Thanks, Caroline. And David, we've put you in the hot seat enough already so we'll spare you the last one.

But I think on behalf of the Committee, we'd like to thank all four of you for joining this afternoon. And you're welcome to stay and listen to as much of the rest of the meeting as you can tomorrow or for the closing remarks to come.

I'm going to turn it over to Angelo.

CO-CHAIR SINOPOLI: Well thank you. And on behalf of the Committee and our audience I'd like to thank each of our presenters for their insights and excellent presentations in this group, and all day today, it's been a fantastic day.

We so appreciate your time and expertise. And at this time we're going take a short 10-minute break until 4:20 Eastern time. And then we'll come back to reflect on the day-to-day and discuss some of the potential comments and recommendations that we'll make to the Secretary.

So thank you. We'll see you again in 10 minutes.

(Whereupon, the above-entitled matter went off the record at 4:13 p.m. and resumed at 4:24 p.m.)

*** Committee Discussion**

CO-CHAIR SINOPOLI: Welcome back. As you may know, PTAC will issue a report to the Secretary of Health and Human Services that will describe our key findings from this public meeting on addressing the needs of patients with chronic complex chronic conditions or serious illness in population-based total cost of care models.

We now have time for the Committee to reflect on what we've learned in our sessions today. We'll hear from more experts tomorrow, but want to take a few minutes today to gather our thoughts before adjourning for the day.

Committee members, I'm going to ask you to find the potential topics for deliberation in your folder. It's tucked in the left front pocket of your binder. To indicate you have a comment, just flip your name tent over, or raise your hand if you're on Zoom, Lauran or Josh.

And I will ask, who would like to start?

DR. LIN: Sure, I'll start. So, you know, I think it was a really good day of learning for me. And really appreciate all the insights and expertise from our subject matter experts.

You know, just a few kind of big picture takeaways for myself. It was gratifying to hear our experts confirm that this is kind of the population to focus on in terms of cost savings to Medicare. Not that that's what, not that that's everything, but that is a big focus of PTAC is payment models that will improve quality or keep quality the same while lowering costs. And so it was gratifying to hear that.

And kind of the secret ingredient I heard to these care models that have actually worked to save costs, and improve quality at the same time is, I think it was Dr. Smith who said, an activated primary care physician, you know.

And Dr. Wayne mentioned this idea of being available 24/7. Having an infrastructure in place where, when a patient needs you, you're there. Or a provider is there to take care of issues. And so, that seems to be a common theme that I heard throughout the day today.

And lastly, I really appreciated another theme which was that we aren't measuring what matters for this population of patients. And that's because what we're measuring are patient diagnoses and basing payment off of those diagnoses. But that's not adequate is what I heard from Dr. Phillips and many others on different panels throughout the day.

CO-CHAIR SINOPOLI: Jen?

DR. WILER: I agree with all of Walter's comments. And want to thank the PCDT team for really putting together a phenomenal day.

What I heard was that in terms of care delivery, one of our speakers said we know what to do, this is an implementation issue. Which I thought was interesting.

And what I heard from the delivery perspective, the best practices for many of our speakers including being holistic and not disease-focused, developing effective communication with patients and developing strong relationships that are culturally tailored.

We've talked about this in the past, but we heard again today that close monitoring or high touch, one speaker talked about a daily huddle to evaluate their patient panel, and respond promptly to acute episodic care concerns is necessary. We heard that the patient and the family must participate in order to be successful. And that by adding patients and caregivers to governance models was a best practice.

We also heard that primary management should be the strategy versus co-management. And I was compelled by hearing that we need more care than care management, which I think is really true. And we heard a number of speakers talk about that.

We also heard that making equity an explicit goal is necessary. And that we should be thinking about stratifying our programs and our data by patient characteristics versus disease or diagnostic only.

Then what I heard, with regards to

performance of the system was that we, again, need to create compelling incentives for participation or to get action. And structure incentives that ensure revenue flow.

We also heard that we need to create incentives to scale beyond pilots. And one of the suggestions was to ensure that there is a focus on aligning Medicare and Medicaid strategies together for those patient populations.

We also heard that we need to drive attribution to primary care. It had lots of pie conversations. But what it made me think about was, what about the appetizers and what about the entree. How are we thinking beyond just Part B strategies.

And we also heard that there needs to be a prospective patient to primary care. And to have real dollars available to create those kinds of compelling incentives.

And then I heard three last things. Providing protection for downside risk while developing or implementing a program or participation is necessary. And I think that's, we've heard those themes over many of our sessions.

And we also heard, loud and clear, for this specific patient population that incenting partnerships with local and community-based safety net programs is very important. And one of our last speakers used the word, create knitting, among those programs. And I think that's really germane.

And then last we heard about being more efficient in eliminating friction. One classic example was prior authorization. But I also heard that eliminating the reporting of data that doesn't matter or doesn't impact outcomes should be a focus.

And there should be consideration for measures that may be of high-value from a risk adjustment perspective. And we heard a couple of different speakers talk about frailty, and this patient population being an important metric to track, not only from an outcome’s perspective but also a consideration and risk adjustment.

CO-CHAIR SINOPOLI: Great, thank you, Jen. I think Lauran was up next.

CO-CHAIR HARDIN: I'll just add a couple layers to that because, Jen, you covered so many of the points that I was going to say too.

So definitely really interesting themes around deep drivers of cost in the population and related to behavioral health, also the impact of house-related social needs and poverty and cost and access.

The importance of developing a reactive system. So 24/7 access to health with disease management, symptom management, but also the competency skill set and systems for anticipatory management of symptoms, disease, but also proactively addressing social needs in the population.

And interdisciplinary teams thinking wisely about who is on that team. The concept of operating to top of license but also looking at, are we using the right efficiency with the number of people at the table and their roles and how they're organized.

Having a lane. So primary care definitely is the center of this work, but what if the reason for complexity and cost is that primary care is failing? So what is the other center of that care or how can that capacity be invested in intentionally as part of this?

And then the importance of running risk stratification frequently as much as monthly. So we're really looking at real data about what is occurring for clients and their families.

And then the importance of integration of data. So health data utility and data interoperability, to really have a holistic view if we're really going to seriously address health equity and take into consideration health related social needs? We need to have a holistic picture of what's happening with the clients.

And then one point, we didn't get to go into deeply, but Caroline on her slides brought up the correlation with social connection measures and loneliness. And I see that as a really emerging area in this population that I see in practice and in hearing more about. So I think that's also worth looking more deeply into.

So really, really rich day. Great job, PCDT, in planning this.

CO-CHAIR SINOPOLI: Thank you, Lauran. I'm not sure if Chinni or Lee was next, but --

DR. PULLURU: Lee's being a gentleman. Thank you.

Excellent day. I thought the PCDT did a phenomenal job bringing this group of people together.

So not to repeat too much of what's already been said, I'll go into larger themes. The first thing that struck me is that multiple speakers spoke almost about a personalization. Are we asking the right questions, are the questions leading to functionality, how are we asking questions? That came up multiple times.

And so, I think it lends itself to really looking at our patient outcome measures, our quality measures to saying, what exactly are we asking and what does it lead to? So that to me was a larger theme of a personalization as to patient outcomes.

The second thing that struck me as a larger theme was a patient connection and trust. Multiple speakers spoke about outside care management organizations that are outside the primary care not being effective. Virtual care management not being as effective. Vendor-related.

And I'm not sure I necessarily completely agree, but I do think that the concept that the patient has to trust the care provider is fundamental in getting the patient to sort of "say yes" to things. And that came up multiple times. So the concept of trust connection in saying yes.

Other things that multiple people have said, but caregivers, not just governance but actually attaching dollars to compensate caregivers. Then obviously interoperability.

But one thing that struck me about that was the fact that not all data is contained in the EMR or in what we think it's contained in, but there is so much data out there. The transdisciplinary versus multidisciplinary.

And what I loved also about this day was the emphasis on palliative care. I mean, you look at some of the cost measures that were shown in the slides on palliative care and you wonder why like everybody doesn't get palliative care, right, it's the right thing to do. Patients are happier, families are happier. It's a soft landing.

And then you think about it and it actually saves the health system money so like why don't a hundred percent of the people get it? And so it's just one of those things that struck me as an aha thing that everyone seemed to kind of speak to it a little bit about why we need palliative care.

And so I'll stop here. And I did like

the CFO panel idea.

CO-CHAIR SINOPOLI: Yes, I like that panel too. Lee?

DR. MILLS: Thank you. I certainly agree with those things other members have already spoken too. Reiterate some of those, and perhaps bring in a few other threads.

Things that stuck to me were really going deep into just, for this population, especially it's all about relationship, and it's that relationship that drives engagement. And this bigger theme of engagement that perhaps paying, that it is critical for having patients, the caregivers, and families be engaged because sometimes for this complex chronically ill population, they're the source of the more information insight then the patients at times. Especially in facilities like, where Walter's group practices.

But also that even sometimes paying patients or caregivers to participate, to get them over the barrier of just saying yes, I want your services, is maybe a very effective and cost-`effective strategy. So I think that was pretty bold.

This issue of the centrality of

engaged primary care practice. The other side of the engagement coin. And that outside that, you know, engaged only longitude in primary care practice, both care coordination and virtual telephonic care, while valuable from a pure access perspective may actually just be fragmenting care and not actually delivering any returns.

That made me resonate with something Dr. Wayne said that never been, he was talking about metrics, but never been more humble than seeing good intentions go awry. And virtual care, you know, care coordination, we need more of it. Well, maybe it's not always good if it's just thrown out of a vacuum. And so I thought those were really valuable points.

I think Erik really hit the nail on the head and talked about, so what's the glide path? What's the template to try to get to 2030 vision? And he talked about just a tectonic shift in prospective payment for primary care if or when those practices have the capability to step up to the plate.

And that pools a theme we've had from multiple meetings over multiple years now, and my term on PTAC, of just continually making fee-for-service an increasingly uncomfortable place to practice because it's not delivering, as others said, the pie is not feeding the right people at this time. And so we need to not, you know, legislate or mandate more pie, we need to do something entirely different.

And finally the similar conversations. I loved the comment that, you know, trainings, we talked about primary care, we talked about bringing in specialty metrics and how to engage specialists and what's their relationship with the risk bearing entity. And there's lots of rich details there, but this idea that transspecialty care is larger than the physician’s specialty.

You know, we are the PTAC, and we're focusing on physician payment, and yet we got to remember that especially for complex chronic disease patients it often, even more often than not perhaps, it may be other community caregivers and organizations, not the physicians in specialties that are making very important and critical contributions to the care.

And then lastly this idea about the health data utility. Again, just very poignant. Having labored trying to implement, you know, new pilots, new measures, MACRA, same measures measured different ways for different payers. It's just a massive burden that we think is impacting patients and providers all the time.

And so the health data utility, as an option to essentially revolutionize both the burden and the accuracy of measurements on a community-wide basis is really powerful. And CMS can empower that, partly just as they think about how to, how to place to stand up new pilots.

So those were my coordinated thoughts.

CO-CHAIR SINOPOLI: Thank you, Lee. Larry?

DR. KOSINSKI: Well I don't want to repeat what everybody else said, but I'm going to frame, reframe. Last year we had a session and I walked away with the thought in my mind, we have to make fee-for-service less desirable. I think Mark McClellan said that. And I built my comments around that.

But that's really a negative statement. I'm coming away from today with a positive statement. We need to make being a PCP a more desirable thing to do with your medical career. Because I don't think the system succeeds unless they succeed.

And this hurts me because I'm a specialist, right? So I'm supposed to be saying, you know, we're really important and everything, but I'm listening to everybody, they're all biting around the same thing. And that is that we need to make primary care doctors have more power over their decisions. They have to be compensated for their outcomes, not their volume.

Taking a PCP and making them click, or her, click off CPT[54] codes and visits and see five or six people an hour, we're never going to get to where we have to be with that. They have to have more control over their decision-making. And they have to have more control over their specialists, which means we've got to think of a way so that specialists are more reliant on the primary care base they're receiving patients from. So they can't make any primary care doctor really unimportant and not focus on the needs of their patients.

So they have to have more control over their decisions. Their income has to be based on their outcomes. They have to have control over the specialists. They got to be paid differently. We need a different pie.

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[54] Current Procedural Terminology

And Chinni brought up a good point, and I think it was affirmed by several of our speakers, there is money in the system. We don't have to be saying that the physician fee schedule is the pie, and if we want to pay PCPs more, it's got to come out of specialists. Probably. Some does. But there is waste in the system elsewhere that we should be able to find to be able to compensate the primary care doctors better.

I heard we have to have a longitude, and we can't have a transactional focus on patients, we have to have more of a longitudinal focus with them because these outcomes are longitudinal. Meaningful prospective trans-disciplinary team-based payments.

So the second thing that hurt me, I'm being funny here, but, you know, I spent the last 10 years of my life with care coordination with Sonar. Heard very clearly that care coordination cannot exist on its own, it has to be linked with responsibility for the patient population’s outcome.

So, I think the positive take from today is we got to make primary care more appealing. A lot more appealing. Not tweaking on the edges, got to make it a lot more appealing.

CO-CHAIR SINOPOLI: Thank you, Larry. Jay?

DR. FELDSTEIN: I'm just going to reemphasize what Larry just said. We've been talking about pay primary care providers more for the last 15 to 20 years.

DR. KOSINSKI: Right.

(Laughter.)

DR. FELDSTEIN: Okay? So it's enough already. The money is there in the system, and we have to pay them accordingly. And then we'll get the results we want. And then we'll have less of this fragmented care and more holistic care. That's number one.

Number two. In terms of virtual versus hybrid and care coordination, health care is about trust. End of story. That is the foundation of health care.

If it's coming from the primary care provider that has the relationship with the patient, virtual is going to work at times. If it's coming from an outside entity, building a plan that the patient has no relationship with, it's not going to work.

So I think if you made primary care the focus and you make the care coordination come out of it, it will follow, and it will work.

And the other point I want to make, because everybody else has made every other point, is I think we've got to get the major EMR companies to the table, okay? Whether it's through CMS or CMMI or us.

Because when we talk about data performance measures, they're part of the solution. Right now they're part of the problem. But we've got to make them part of the solution. And we got to make them see that they're part of the solution.

And again, Walter and the PCDT team, great job today. Thank you.

CO-CHAIR SINOPOLI: Great, thanks everybody for all that. The only thing, lots of folks -- Lindsay, you got, I didn't see your card up, did you need -- go ahead.

DR. BOTSFORD: No problem. Hard to follow Larry or Jay after that because I don't know what else is more important than paying primary care appropriately.

But a couple, I think, things that did get called out today that I think we've heard in previous sessions that I wanted to punctuate here around payments, specifically for people in, you know, as we think about new models. So I think raise the idea that as we think about models and total cost of care models, we can't think about reducing baseline payment after one or two years.

And we heard about people planning for, especially patients with complex chronic illness and serious illness, that is a big investment. An up-front investment that has to be done in advance.

And when the payment gets changed, that's just when the overhead costs have started to dive in. So getting a finance team member or a colleague to buy in on some of the real investment that's needed on this population to change outcomes, it has to be, it has to be more stable baseline payments.

Another way to kind of get at that same thing is the idea of protecting people who are maybe not in a large organization from downside risk in the first few years if they're going after caring for a patient with complex chronic illness. This is an important thing to do.

And I heard something interesting that I hadn't heard before, or maybe didn't listen well enough before, but the idea that it could be helpful to think of a readiness template of what it takes to manage risk if you want to get into what that downside risk is going to look like. But incremental adjustments are not enough.

So, I think the, most of the other points were mentioned by my faster to the draw colleagues here. I think the last one I'll make is, maybe a theme that I heard throughout many of the sessions, which is, the voice of the patients is important.

We heard this theme in the what matters most comments that were already emphasized. We heard it in thinking about what incentives we can offer to patients and caregivers to potentially participate. And we heard it in thinking about creating the right measures that take into account what matters to patients and to caregivers.

With that I'm going to cede to Angelo.

## * Closing Remarks

CO-CHAIR SINOPOLI: Thank you. Thanks to everybody for those great comments. So I want to thank everybody for participating today. Had great presenters and panelists today. Very engaging. I thank my PTAC colleagues and those listening in.

We'll be back tomorrow morning at 9 o'clock Eastern time. Our Day 2 agenda will feature a listening session with experts on optimizing the mix of palliative care and end-of-life care and total cost of care models. A special panel discussion with CMS staff. A listening session on best practices for incentivizing improved outcomes for patients with complex chronic conditions or serious illnesses in total cost of care models, as well as an opportunity for public comments tomorrow toward the end of the day.

*** Adjourn**

We hope you will join us tomorrow. Thank you for all your contributions. And we'll end the meeting today and see you tomorrow. Thank you.

(Whereupon, the above-entitled matter went off the record at 4:50 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: 06-10-24

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

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Court Reporter