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, March 3, 2025

PTAC MEMBERS PRESENT

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

STAFF PRESENT

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

*Present via Zoom

A-G-E-N-D-A

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

9:33 a.m.

*** Welcome and Co-Chair Update - Reducing Barriers to Participation in PB-TCOC Models and Supporting Primary and Specialty Care Transformation Day 1**

CO-CHAIR MILLS: Good morning, and welcome to this meeting of the Physician-Focused Payment Model Technical Advisory Committee, known as PTAC. My name is Lee Mills, and I'm one of the Co-Chairs of PTAC, along with Chinni Pulluru. Since 2020, the PTAC has been exploring themes that have emerged from stakeholder submitted proposals over the years.

Previous PTAC theme-based discussions have included maximizing participation in population-based total cost of care models, addressing the needs of patients with complex health conditions or serious illnesses, developing and implementing performance-based measures, encouraging rural participation, improving management of care transitions, and improving care delivery and

specialty integration, particularly within population-based total cost of care models.

At this public meeting, we've brought together various subject matter experts to gain perspective on reducing barriers to the participation of population-based total cost of care models and in supporting primary and specialty care transformation. How do we effectively reduce the barriers for different kinds of provider organizations and move towards the goal of maximizing participation in total cost of care models?

For today's agenda, we will explore a wide range of topics on reducing those barriers to participation in population-based total cost of care models and supporting primary and specialty care transformation that includes understanding factors that affect different kinds of organizations' business decisions about participating, approaches for streamlined models, improving the predictability of benchmarks, and incentivizing the participation of different kinds of organizations in PB-TCOC models.

And specific incentives for

improving clinical integration and supporting primary and specialty care transformation in different kinds of organizations that are participating in value-based care and enhancing the sustainability and competitiveness of population-based total cost of care models.

The background materials for the public meeting, including the environmental scan, are posted online on the ASPE PTAC website's meeting page. Over the next two days, we will hear from many esteemed experts with a variety of perspectives, including previous PTAC members.

We will begin our day tomorrow with opening remarks from Mr. Abe Sutton, the Director of the Center for Medicare and Medicaid Innovation and Deputy Administrator for the Centers for Medicare & Medicare Services.

I 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, please email

ptacregistration@norc.org. Again, that's ptacregistration@norc.org.

The discussion, materials, and public comments from the March PTAC public meeting will all inform a report to the Secretary of HHS[1] on reducing barriers to participation in population-based total cost of care models and supporting primary and specialty care transformation. Over the next two days, the Committee will discuss and shape our comments that will go to the Secretary.

In February, we posted a Request for Input on the ASPE PTAC website to give stakeholders an opportunity to provide written comments to the Committee on reducing barriers to PB-TCOC models and supporting primary and specialty transformation. To date, we have received two responses that the Committee may consider in their discussion today.

The Request for Input will remain open for public comment following this meeting and is posted on the ASPE PTAC website. Responses received after today's meeting will help to inform future PTAC public meetings.

1 Health and Human Services

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 for flexibility depending on the level of detail of the payment methodology proposed. You can find information about submitting a proposal on the ASPE PTAC website.

*** PTAC Member Introductions**

At this time, I'd like to invite my fellow PTAC members to please introduce themselves, please share your name and organization, and if you like, feel free to describe any experiences you have with our topic. First, we'll go around the table and then I'll ask our members joining remotely to introduce themselves as well. I will start. My name is Lee Mills, I'm a family physician. I am Chief Medical Officer of Aetna Better Health of Oklahoma, one of the contracted Medicaid plans in the state of Oklahoma.

Before that, I was Chief Medical

Officer for a provider-owned health plan in the ACA[2] Advantage, Medicare Advantage, and commercial space, and before that, a medical group and health system leader operating in practice transformation, in which I have helped implement and lead five CMMI[3] models over the years.

I'll turn to my right, Chinni.

CO-CHAIR PULLURU: Good morning, I'm Chinni Pulluru, I'm a family physician by trade. I've spent 20 years in the value-based care implementation space running clinical operations. Currently, I'm Fractional Chief Medical Officer of Stellar Health, a value-based care enablement company, as well as consult with organizations large and small in that transformation space.

Prior to that, was at Walmart Health and scaling health and wellness operations, and prior to that, led a large multi-specialty independent medical group in suburban Chicago. Thank you. Now, I'm going to hand over to Lindsay.

DR. BOTSFORD: Thanks, Chinni. Good

2 Affordable Care Act
3 Center for Medicare and Medicaid Innovation

morning, I'm Lindsay Botsford. I'm a family physician in Houston, Texas, where I also serve as a Regional Medical Director with One Medical.

I'm the chair of our ACO REACH[4] governing body within the organization. Prior to that, came through the Iora Health Network. I currently still see patients, in addition to managing our practices across the Midwest and Texas.

DR. BHANSALI: Hi, good morning, everyone. My name is Henish Bhansali, and I'm a primary care internal medicine doctor by training. I serve as the Chief Medical Officer for Medical Home Network. Medical Home Network works with Federally Qualified Health Centers or community health centers across the country to help transition them into value-based care.

Prior to that, I was Senior Vice President for Value-Based Care, Medicare Advantage, at a multi-specialty group, the same as Dr. Pulluru in Chicago.

Prior to that, I was at Oak Street Health as their VP and National Medical

4 Accountable Care Organization Realizing Equity, Access, and Community Health

Director for Care Navigation, really helping patients across the country find the best specialty and other ancillary services. I was in academics before that. Pleasure to be here.

DR. FELDSTEIN: Good morning, my name is Jay Feldstein. I'm currently the President of Philadelphia College of Osteopathic Medicine. I was originally trained as an emergency medicine physician and practiced that for 10 years, and then I spent 15 years in the health insurance world working in both commercial and government plans with a lot of value-based purchasing, which in those days was called full risk capitation.

MR. RAMACHANDRAN: Good morning, I'm Krishna Ramachandran, Senior Vice President of Health Transformation at Blue Shield of California leading our value-based care efforts. Previously was at Health Care Service Corporation, HCSC, and then prior to that worked for Duly Health and Care as Chief Administrative Officer, a large multi-specialty group. And then before that spent about eight years at Epic, so installing, optimizing EHR[5]

5 Electronic health record

software for health systems across the country. Good to be here.

DR. KOSINSKI: I'm Dr. Larry Kosinski, I'm a retired gastroenterologist. I practiced for 35 years in the Chicagoland area and built one of the largest GI[6] practices in the country. For the last 10 years, I've been involved with value-based care, and it actually started with a project that became the first PTAC-recommended physician-focused payment model, which was Project Sonar, that led to the formation of SonarMD, a value-based care company that's focused on chronic disease in the GI space.

Currently, I'm also Chief Medical Officer of Jona, an AI[7] platform company that is focused on the fecal microbiome. I've been on the Committee for three years.

DR. LIN: Good morning. I'm Walter Lin, Founder of Generation Clinical Partners. We are a small, independent practice based in St. Louis focused on caring for the frail elderly in nursing homes and assisted living buildings.

6 Gastrointestinal
7 Artificial Intelligence

We have been involved with a number of different value-based programs, including institutional special needs plans, PACE[8] programs, home-based medical care for the seriously ill, as well as bundled payments. Most recently I took the position as Clinical Strategy Officer of LTC ACO.

MS. HARDIN: Good morning. I'm Lauren Hardin. I'm a nurse by training and Chief Integration Officer for HC2 Strategies. We work with high-cost, high-needs populations in partnership with states, communities, payers, and multi-state health systems, really focusing on innovation and developing connected communities of care.

I spent multiple years leading care management innovation in all of the ACOs, including everything from Pioneer, all the way to BPCI[9], and then spent eight years at the Camden Coalition as part of the team that started the National Center for Complex Health and Social Needs, where I partnered with projects in more than 30 states, designing innovation for complex, high-cost, high-needs

8 Program for All-Inclusive Care for the Elderly
9 Bundled Payments for Care Improvement

populations.

DR. WALTON: Hi, good morning. My name is Jim Walton. I've been a member of PTAC for two and a half years. I'm a part-time health care consultant, retired physician executive, and internal medicine primary care physician from Dallas, Texas.

Over my career, I practiced primary care first in Ellis County, Texas, and then in Dallas. I led the community medicine and health equity improvement strategy for a large health system before shifting to value-based care development for a physician-led IPA[10] in Dallas.

That IPA contracted with CMS[11] and commercial insurers for practicing independent physicians in and around Dallas-Fort Worth and North Texas for commercial Medicare Advantage, MSSP[12], and Medicaid ACOs.

CO-CHAIR MILLS: Thank you. Let's go to our PTAC members joining us on Zoom. Josh, please go ahead. No, Josh. All right. We will proceed.

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10 Independent physician association
11 Centers for Medicare & Medicaid Services
12 Medicare Shared Savings Program

Let's move to our first presentation. Four PTAC members served on the Preliminary Comments Development Team, or PCDT, which has collaborated closely with staff to prepare for this meeting. Jim Walton was the PCDT lead, with participation from Larry Kosinski, Henish Bhansali, and Walter Lin.

We are very thankful and grateful for the time and effort they put into organizing today's agenda and preparatory information. The PCDT will share some of the findings from their analysis to set the stage and goals for the meeting. PTAC members, you'll have the opportunity to ask follow-up questions afterwards, please. And now we'll turn it over to Dr. Walton.

*** PCDT Presentation - Reducing Barriers to Participation in PB-TCOC Models and Supporting Primary and Specialty Care Transformation**

DR. WALTON: Thanks, Lee. Our title, as already mentioned, Reducing Barriers to Participation and Supporting Primary and Specialty Care Transformation in Population-Based Total Cost of Care Models.

I first want to say thanks to Walter, Larry, and Henish for their great help in producing that presentation. And of course, we couldn't do it without ASPE and NORC's research and support in developing the slides. So thank you all for that.

You know, as I prepared for the presentation, it occurred to me that PTAC, CMS, and many others are following in a long line of visionaries and reformers since Medicare's inception in 1965. Over the last 60 years, we've all been working to continually improve Medicare's social contract with America.

Today and tomorrow, we continue in that tradition as subject matter experts, practicing frontline providers and administrators, and policy experts work to help uncover barriers to participation in APMs[13], Alternative Payment Models, accountable care, and MSSP as we find new ways to support primary and specialty care delivery transformation.

In this, our objectives for our meeting, as Lee identified, first is this discovery of barriers to participation in

13 Alternative Payment Models

population-based total cost of care and other APMs. Second was to discuss the idea of participation pathways and the creation of participation pathways to help reduce key barriers.

Third is to discuss ideas for better supporting primary and specialty care transformation to drive more value and help grow participation in accountable care and Alternative Payment Models. And lastly, discuss opportunities for enhancing both sustainability and competitiveness in the population-based total cost of care models.

Ideas discussed over the next couple of days, as Lee mentioned, will greatly assist PTAC in the work, so we encourage lots of discussion. We would develop a report for the Secretary of this discussion and hopefully will help our colleagues in CMMI as well. So here's kind of an outline of the presentation that we're going to try to go through. So let's go to the next slide.

We start with the first three slides being some basic working definitions. The first one being the accountable care

relationship, which is, in short, a relationship between a provider and patient that establishes the provider as accountable for quality and cost for all of a patient's covered health care services. The next is our population-based total cost of care model working definition as an Alternative Payment Model, or APM, in which participating entities or organizations assume accountability for quality and total cost of care and receive payments for all covered health care costs.

This last working definition is one that we developed for the health care business model, and it follows that a viable health care business model is one that allows a health care entity to provide health care services that meet the patient's needs and delivers value while ensuring a sustainable return to continue so that they would continue in the business of operations over time.

After these definitions, we wanted to review some of the findings of ASPE's research, and you can find this on the ASPE website. There's a number of issue briefs, and one we want to elevate here is a study that was

done between the years 2012 and 2022, effectively the first 10 years of MSSP and CMMI's work.

And we see here in some of the results that CMMI models had gross savings between $7 and $11 billion over that decade. MSSP also had savings of around $23 to $31 billion.

So it illustrates that the CMMI models were successful in reducing spending, and it was noted that it was best in those counties with high penetration and participation, and we'll spend more time looking at those elements for this meeting.

This suggests to me that the likelihood of even greater savings potential in the future if barriers to participation could be identified and mitigated for more participation, especially in low penetration regions where Medicare beneficiaries have not had the access to participating providers.

But beyond the savings, the research also showed both CMMI and MSSP models delivered more care coordination services, more coordination of care, and improved quality to

Medicare beneficiaries. Next, we're going to take a more detailed look at some of the participation data for Alternative Payment Models, both CMMI and MSSP models over the first 10 years.

Here we summarize the data through the lens of a few key trends during the rollout of APMs. First would be that the participation has plateaued, and this is also true for all payers. Hospital and integrated delivery system participation has declined. Physician-led ACOs are growing, and specialty care physicians are less likely to participate in ACOs.

To illustrate these trends, the next few slides were published by one of tomorrow's SMEs[14], and the key point in this particular slide is to illustrate the continuous growth of physician-led ACOs over the first 10 years.

This next slide illustrates the plateauing of covered lives at around 36 million by 2021, and the number of ACOs plateauing around 900 to 1,000 in the same period of time.

From the same study by Muhlestein,

14 Subject matter experts

we see a graphic illustration of ACO growth plateauing across all lines of business a provider holds in their portfolio, commercial, Medicare, and Medicaid between the years 2010 and 2021.

Again, this graph adds to the evidence illustrating the deceleration of new entrants entering Alternative Payment Models, and as well a suggestion of acceleration of exits of participating entities in the ACO market.

Here we see the information differently presented by market potential for growth for both physician and hospital system provider entities. As you can see, the low 6 percent penetration of physicians and 28 percent for hospital and integrated delivery system highlights a remarkable size of opportunity for participation to increase.

The key point of this last graphic from the study assesses the provider adoption of Medicare advanced APMs, revealed that about 50 percent of primary care doctors and 70 percent of specialty care physicians have opportunities to join in participation in the

future.

The trends of participation and the magnitude of the market opportunity for participation of all providers and the entities they are aligned with is noted in this slide and is combined with the benefits.

And when we combine that with the benefits to both quality and cost for both beneficiaries and CMS, has led us to want to take a closer look at the unique barriers hospital and integrated delivery systems confront when considering Alternative Payment Model participation.

This is best emphasized with data showing the increasing number of physicians and hospitals aligned with corporate entities and health care systems. We noted both market share and resource capabilities of integrated delivery systems enables them to provide high-value and well-coordinated care.

So we wanted to know the trends of integrated delivery system participation. So the next few slides try to answer a couple of key questions concerning integrated delivery system participation.

First question was, has there been a decrease in the number of integrated delivery system-led ACOs, and the second question, are physicians and hospitals able to participate in accountable care if the entity they are affiliated with is not participating as the lead organization?

The analysis to answer these two questions tracked ACO participation among large integrated delivery systems for the years 2016, 2018, '20, and '22, and for the Medicare Alternative Payment Models, MSSP, Pioneer, Next Generation, Global and Professional Direct Model, and ACO REACH.

The data suggests the answer to question number one, the Pioneer model had 62 percent integrated delivery system leadership in the ACO in 2016. By the Next Gen model, had a falling percentage of delivery system leadership in the ACO.

It dropped from 56 percent in 2016 to 39 percent in '20. And then finally, the Global and Professional Direct Model had only 23 percent integrated delivery system leadership by 2022. To answer the second

question, the data showed on this slide attempts to answer kind of the second question. Ninety percent of large and 70 percent of small Medicare integrated delivery systems had partially participated in Alternative Payment Models each year of the analysis, 2016 through '22.

In those that participated, however, a relatively small proportion of the integrated delivery systems' hospitals and physicians participated. The graphic highlights the degree of penetration divided by large and small to medium integrated delivery systems.

Other findings were noted that around 25 percent of large integrated delivery systems participated in more than one ACO, and around 50 percent of the large integrated delivery systems participating in Medicare ACOs spanned multiple states.

So, key takeaways. We next turn to addressing the organization's -- let's see, I'm sorry. The key takeaways, the percentage of CMMI ACO models led by IDSs[15] has declined over time. Despite the large integrated delivery

15 Integrated Delivery Systems

systems' high rate of participation in Medicare ACO models, the percent of its providers' participation has been relatively low.

So we're next going to turn to addressing the organization's characteristics that may be factors affecting both organizational participation and profitability in Alternative Payment Models. This slide highlights the first three characteristics that we wanted to discuss during the next couple of days.

The first is the organizational characteristics by type, and you see where we've grouped them together by ownership types over to the left of the slide with physician ownership, hospital ownership, and insurer ownership or payer ownership groupings to illustrate how we might organize this work.

The second table there is organizational characteristics. Examples are management approaches, governance, clinical integration, EHR consolidation, and similar ideas of organization.

And the third is the market characteristics would be urban or rural

geographic locations, the Area Deprivation Index of markets that are served by the organizations that want to participate, the degree of Medicare Advantage penetration could all affect participation and profitability.

When we considered the fourth key organizational characteristic, the business model characteristics, we felt the need to highlight important revenue concepts related to Alternative Payment Model and accountable care. And the first point is the size of total annual revenue has a large contribution to the business model and its participation decisions in accountable care.

The second consideration for revenue would be the mix of revenue sources for a particular entity. And the third item is the revenue of ACO participants compared to the total spending for the assigned beneficiaries dividing into low- versus high-revenue ACO definitions. For example, a large group primary care practice accountable for total cost of care may have high total annual revenues but may control a relatively small share of the total spending for the population.

This would be defined as a low-revenue ACO.

In this slide, the revenue concepts related to ACO participation are represented. We identified business model characteristics as a key fourth organizational characteristic to consider as a factor impacting participation decisions.

The key point of the slide is that ACO revenues as a share of total cost of care may significantly impact participation decisions. For example, as improvements in care delivery and overall health status could shift demand for some organizations who provide these services. Example would be inpatient care for a large integrated delivery system.

When we looked at annual revenues, the size of the revenue for a particular organization may also influence decision, impacting the ability to invest in value-based care infrastructure and or their ability to or willingness to assume financial risk.

And another example would be revenue sources could impact decision-making, as the degree of the diversification of revenue portfolios may impact risk tolerance within an

organization.

In the next section, the subcommittee worked with ASPE staff to create an initial framework for linking the four organizational characteristic areas with participation pathway development for maximizing participation in accountable care and Alternative Payment Models.

Here, we particularly wanted to focus this idea on identifying pathways for increasing population-based total cost of care models.

Our definition for this population-based total cost of care is a pathway may be considered as a grouping of health care delivery organizations treated similarly with regard to benchmarks, two-sided risk, and how performance measures affect payment when choosing to participate. This will evolve over time with this meeting.

So, putting this all together, a picture is worth a thousand words. And here we see the various inputs that we conceptualized entering into the participation pathway creation with provider types and operational characteristics feeding into the organizational

types along with market and business revenue characteristics all feeding into the participation pathway created for like groups of provider entities.

The pathways produced have unique features and incentive structures potentially incorporated into existing Alternative Payment Models with the ultimate outcome of maximizing accountable care mix of entities.

We suspect organizational business model characteristics are useful for pathway development because they help explain why organizations may or may not participate in Alternative Payment Models.

As such, key business model characteristics like revenue, revenue source, management control, could serve as the pathway building blocks for grouping-like entities into pathways that best fit their business characteristics and where it's reasonable to apply similar payment approaches such as benchmarks, two-sided risk, and performance measures in the pathway for those entities.

Additional considerations for discussion around developing participation pathways

include that pathways may take into consideration certain factors that affect outcomes that are not easily modifiable by the organization, like Area Deprivation Index or the geographic location that an organization is operating in.

Conversely, pathways may not recognize factors affecting outcomes that are more modifiable and consistent with accountable care vision, like primary care and specialty care integration and clinical integration.

Importantly, we all agree that the factors incorporated into pathways, future pathways, should avoid increasing complexity of administering contracts by both participants and CMS.

Finally, given the rising influence of value-based care aggregators, for example, it's expected that they might manage 19 million beneficiaries by 2028, we may want to consider a different pathway for this type of entity. In this slide we illustrate some of the complexity connected to Alternative Payment Model and pathways for various types of organizations. This slide attempts to

illustrate this complexity, the total cost of care payment models within the payment ecosystem for all provider types, recognizing the reality of revenue source portfolio management at play.

Moving from left to right, we see an example of moving from fee-for-service, a pure fee-for-service payment system, to a full total cost of care risk-based payments in the brown or reddish boxes. In the blue ovals we illustrate the various CMS, CMMI Alternative Payment Model payment policy options where participation pathways may be applied.

In the green boxes at the bottom, we see illustrated the various entity types that may be attracted to participate in different offerings available based on organizational business characteristics and Alternative Payment Model pathways that have been developed.

To end this part of the presentation, we illustrate how the concept of participation pathways along the Y axis would intersect with pathway payment considerations along the X axis. This is the work ahead

of us, taking the discussion and feedback of this meeting into consideration as we move to fill out the different elements of the different pathways for different groups of entities we desire to have participate.

Next, I wanted to briefly touch on the topic of supporting primary and specialty care transformation to kind of start the conversation for some of our discussions later on today. Specifically focused on primary and specialty care transformation, acknowledging the first decade of accountable care's difficulty with increasing specialty participation.

This slide highlights a couple of ideas previously discussed in earlier PTAC theme-based discussions, and the first point here is the importance of support for sharing patient data as being a key opportunity for improving care transformation.

And the second point is the creation of nested specialty episodes that may be another key opportunity to encourage collaboration between primary care and specialty care physicians.

For emphasis, this slide calls out two different potential approaches for nested specialty episodes. The first recognizes the opportunity for low-cost variation specialty services such as GI, gastroenterology, and the treatment of polyps or gastritis as a nested total cost of care model. The second idea around this, it recognizes the opportunity to nest specialty condition-based payments in total cost of care models as well.

Finally, to conclude this presentation, we want to introduce some ideas around maximizing the competitiveness and sustainability of population-based total cost of care models. The main point here is that regardless of the number of pathways, there are policies that can also help make APMs and accountable care more flexible and competitive.

Policy areas, considerations that might be considered relevant to improving competitiveness would be ideas that address consolidation of the marketplace, the impact of prevailing socioeconomic conditions and low penetration markets, the degree of Medicare Advantage penetration, waiver participation

incentives, beneficiary engagement incentives, and specialty care nested episode incentives.

So now as I finish the presentation, we turn back toward the focus areas for this meeting, reducing organization-level barriers, affecting participation in population-based total cost of care models, supporting primary and specialty care transformation, enhancing the ability of population-based total cost of care models to be competitive, and how to maximize participation of beneficiaries in accountable care and improve the sustainability of effective population-based total cost of care models. So thank you and I look forward to the discussion.

CO-CHAIR MILLS: Jim, thank you and the PCDT for that rich discussion of some important topics. Before we open it up to the full Committee, other PCDT members have any additional comments to add?

DR. KOSINSKI: First of all, great job. It's a very complex subject, and you presented it and organized it quite well. Three points. Number one, I think one of the main issues we wrestled with at the PCDT was

this concept of low-revenue, high-revenue systems. How much of an organization's revenue is at risk from the APM? The more of an entity's revenue that's at risk, the more likely they are going to be to be full participants and maintain their participation over time. What we're seeing is that it's probably not high enough.

Secondly, the data sharing issues are always an issue, especially outside of the integrated delivery systems where you have specialty networks that are not on the same EHR with the primary care base. This is a major challenge.

And the third thing is the inertia built into the system itself in converting entities from fee-for-service to value-based care and maintaining them in that value-based care environment.

The business model of the entity has to be considered in this transition because the, if the transition to value-based care is not good for the business model of the provider entity, you're not going to have sustained adoption over time. So, major challenges. I

hope we learn from our SMEs over the next two days.

CO-CHAIR MILLS: Other PCDT members, comments? Okay. We will open it up to the full Committee. If you have a comment or question, just raise your table tent or your hand online if you're on Zoom. Committee.

Okay. Well, I will take personal privilege to say I was struck by some of your early comments, Jim, about the participation in Medicare APMs have plateaued and backed off in many regards and that we're seeing a trend occurring in Alternative Payment Models across lines of business or across types of payers.

And that strikes me that that is similar from a Gartner change cycle that we're past the innovators and the early adopters, and we're entering the trough before you get mainstream adoption and later adopters.

And what's significant about that to me is it takes different tools, different messaging, different discussion to move through that trough into later mainstream adoption. And I wonder how those concepts apply in this area. Other comments, questions?

Josh, thank you. Go ahead online.

DR. LIAO: Good morning, everyone. Josh Liao, physician and professor at UT Southwestern in Dallas. A really great PCDT presentation. I was struck by two things. I think the first is that last kind of section about competitiveness. And I think really from my perspective, that's important.

I think the idea of maximizing participation is, really, I would kind of maybe just adjust and say, is it maximizing for the organizations and clinicians and patients for whom it makes sense and recognizing there are many different offerings, so to speak, in the market. You know, we want to make it competitive in a way where it's a really nice option for all these groups we're talking about.

But I think kind of like everyone should be, and everyone should not be, you know, loses the nuance, and I think this presentation really gets at. So I just, you know, really encourage us. And I know the PCDT is doing that because I saw all the slides to keep that nuance kind of front and center. So

I think that's just my initial reaction, but great presentation. Thank you.

CO-CHAIR MILLS: Other questions or comments from the Committee? Okay. Well, I will, again, add one more comment, which is I really appreciated the graphic at the end, which is original work and is starting to link the HCP-LAN[16], you know, conceptual pathway towards increasing value on a value-based payment concept, starting to link it to more granular pieces that any business would have to consider of where they start and where they move to. And I think that's really important for operators of many different sizes as they want to get into value-based pathways.

DR. WALTON: Yes. I wanted to comment on this, that particular slide. It struck me when we were discussing this topic, that ultimately led to the slide was the challenges of portfolio management, payer portfolio management for physicians and independent practice or integrated delivery systems and the decision-making process.

And I think that gets -- the graphic

16 Health Care Payment Learning & Action Network

gets at the heart, to the heart of what in this meeting, we wanted to talk deeper about, which is how is it that given the 10 years of experience, the first 10 years of experience, and given this plateauing that we see of providers of all types in all different opportunities around accountable care, there is this kind of, number one, there's a learning that's taking place, right? There are these lessons.

And some of those lessons are very painful, you know, financially painful for physicians and entities. And so one might think that that's kind of a natural -- as you were saying, Lee, a natural sine wave of participation of early adopters and then people kind of consolidating their losses, consolidating their lessons learned.

So the thinking here is around asking folks that have been in the trenches for a while, doing this work, and experiencing these wins and losses, how they would maybe re-envision the next decade or the next couple of decades of this work, recognizing in the sum total of the work, there has been savings,

number one, and there has been improvement in care delivery and the quality of outcomes for Medicare beneficiaries.

And I think that that needs to sit there as the centerpiece of what we're really discussing here in the next couple of days. But appreciating, I think, what Larry was saying, which is this business model portfolio management is kind of the rock and the big boulder in the middle of the stream that needs to be discussed and then incorporated, potentially incorporated, in this kind of participation pathway idea. So I think this is going to be a rich conversation in the next couple of days.

CO-CHAIR PULLURU: Just to add my thoughts, thank you, Jim. That was an excellent presentation. And thank you to the entire PCDT team in putting that together, along with NORC and ASPE.

When we think about participation, what you very rightfully sort of put together are three levers. There's the financial lever, and we'll hear much more from our CFO panel, how the payment mechanism flows down to various

organizations.

There's the operational lever, which is how do these organizations operate? Are they interdependent? Who are they owned by? And are they single specialty versus multiple specialties?

And then I would say the third lever is really how those two things come together in the percentage of participation, and how can we influence that? And I think that that's an important topic that is going to be fleshed out over the next two days.

And I really like how one of the things that was brought up earlier by Larry was the percent of revenue at risk for an organization and that threshold. You know, I would encourage, as we listen to our SMEs over the next couple days, is to think through, you know, is that a lever? And could we potentially use the chassis that we already have in order to affect that to encourage participation?

And so, you know, maybe affect benchmark to affect participation for various people at different, when they have more at

risk. So with that, anyway, thank you. And next, I believe, is Josh and then Walter.

DR. LIAO: Yes. This conversation just kind of made me stimulate another thought I want to just mention. I really like Lee's comment about, you know, phase of adoption, early, you know, adopters and innovators versus others.

I would also think just, you know, what I really like about the slides is it represents all the different approaches that have been thought about, executed, that have not been executed. And I just, I think we have to just be a little bit careful there, right?

It's hard to say people are early adopters or innovators for a model that comes, and then it goes again, and the model changes. So you're kind of re-adopting it, and it's not the same, you know, model. You know, if it was the same model all the way through, then you can say, okay, these people have not been in for five years or eight years.

And that's part of, I think, really the power, so to speak, of MSSP. It's been around for a while. And so we can see it in

its different phases. And I'm sure some of our panel members will kind of elucidate that for us.

But, you know, it's hard to really say early, mid-adoption when the models have changed a lot. So I think there's an overarching kind of pull to more and new approaches. And I think that's very good.

But I think here we don't want to just add, we want to delete and remove as well or avoid certain things so we can have a kind of clear, this is what the offering is. And so we can see who the adopters are and what are the drivers and the barriers as the PCDT just helped us illuminate.

DR. LIN: Jim, a great presentation. And thank you for leading the PCDT in this really important topic of reducing barriers to participation in PB-TCOC models.

Now, as I've worked with you and the rest of the PCDT, ASPE, NORC, over the last six months on this topic, I think if I were to zoom out, the key takeaway that I have about barriers to participation in these total cost of care models is that there is an alternative,

attractive, financially sustainable model that systems who choose not to participate can fall back on, namely fee-for-service, right?

So this is where the business models really come into play because these organizations across the country have built their business models over the last five decades on fee-for-service, six decades or more. And it's easy to fall back on a model that your organization's built to thrive and succeed under. And as long as that alternative is available, then I think that creates a very big barrier to increasing participation.

So I think we've talked about in previous public meetings, the need to make fee-for-service, as our experts put it, increasingly uncomfortable, but as long as it is a comfortable, profitable place to be, I think that's probably, in my mind, the biggest barrier.

CO-CHAIR MILLS: Henish.

DR. BHANSALI: So as we think about fee-for-service versus population-based total cost of care models, there are certain organizations within certain sectors that are

delivering outstanding value within the fee-for-service structure.

And for example, if there are bundle payments with specific components of quality tied to them in addition to that, then we know that there's high-value care that's being delivered, albeit in the fee-for-service structure.

And so as we think about moving population-based total cost of care, value-based care forward, I guess part of the question is where is the lowest value care being delivered, and how do we create models to drive those structures and to create business models that optimize that sector of care delivery into value-based care and make the fee-for-service business model within that sector the least attractive financial model?

With the understanding, based on what Josh said earlier as well, is that not everyone over time will be in the value-based care models, population-based or fee-for-peer, whatever structure it is, but they'll live in the fee-for-service sector and yet deliver very high value.

CO-CHAIR MILLS: Other Committee comments or questions? Once, twice?

CO-CHAIR PULLURU: I just wanted to kind of go back to the point that filling in that table on the slide that Jim had presented is one of the goals that we have at this meeting, is really getting to the point where we could fill in more of that.

CO-CHAIR MILLS: Okay. Well, Jim and whole PCDT, thank you for that wonderful presentation and highlighting some important research and backgrounds. That really sets the stage well to hear from our next panel, which will be CEOs and CFOs, to talk about barriers to entering value-based care and population-based total cost of care models.

At this time, we will have a break until 10:40 Eastern Time. Please join us as we come back and welcome a group of experts for our first roundtable discussion. Thank you very much. We stand in recess for 10 minutes.

(Whereupon, the above-entitled matter went off the record at 10:26 a.m. and resumed at 10:40 a.m.)

*** Roundtable Panel Discussion: Perspectives of Chief Financial Officers (CFOs) / Chief Executive Officers (CEOs) on Reducing Barriers to Participation in PB-TCOC Models**

CO-CHAIR MILLS: Welcome back, the PTAC meeting will resume. Jim and the PCDT team laid the foundation for this public meeting and some of the questions we want to explore and the framework to consider that. I'm excited to welcome our first roundtable panel. At this time, I'll ask our panelists to go ahead and turn on video if they haven't done so already.

In this session, we've invited five esteemed experts to discuss their perspectives on reducing barriers to participating in population-based total cost of care models. After each panelist offers a brief overview of their work and thoughts, I'll facilitate the discussion by asking each panelist questions on that topic to discuss amongst themselves and with the Committee. The full biographies of our panelists can be found online, along with other materials for today's meeting.

I will briefly introduce each of our guests and give them a few minutes each to introduce themselves. After those five introductions, we'll have plenty of time for questions and to engage in what we hope will be a robust discussion. First we have Dr. Christopher Crow, Chief Executive Officer and Co-Founder of Catalyst Health Group. Chris, welcome.

DR. CROW: Thank you. Well, it looks like you have our -- or my background here on the slide, so rather than read it, I'll just kind of give you a quick highlight. Maybe we can even get to the next person quicker, but these are the things we do at Catalyst Health Group. It's a -- I'm a family physician by training. I grew up in a really small town that had three family physicians that really oriented how I think about the world and how I think about how we can take care of our populations across the nation.

And so, I've kind of created an ecosystem of companies along the way over the last 25 years that include, you know, the largest independent primary care group in

probably the whole southwest, maybe the second in the nation that's still privately held by physicians, a services organization that supports that, and then a broader network of primary care physicians that are independent in nature for the last 10 years was -- is how we started across Amarillo area, North Texas, and East Texas.

And really what's been -- what the purpose of what we do is how do we help communities thrive through bringing better primary care access and performance to those communities?

We believe that the three pillars of any community to actually thrive are health care, education, and jobs, and any one of those three pillars being off will make it to where it's very difficult for a community to thrive, so we try to do our part to really push past what I would call the fee-for-service, that I'm very public in how I think that is the devil of primary care, to really do a more of a population or perspective payment, or what all the kids now call their subscriptions, of primary care because uniquely in health care,

that's a longitudinal relationship that can now last years and decades, versus some of the other things in health care where I understand there are reactive point-by-point transactions that need that fee-for-service.

So, we built a constellation of things around that. We have done some things with a not-for-profit that we built in 2020 to get to underserved areas that don't have insurance. We've also done some things around pharmacy with Stellus that is now national that's helping primary care physicians all over the country that are at risk for Medicare better perform as well. So I'll leave it at that and look forward to the conversation.

CO-CHAIR MILLS: Thank you. Next we have Mr. Chase Hammon, who's Chief Financial Officer at Duly Health and Care. Chase, please go ahead.

MR. HAMMON: Yeah, good morning and thanks for having me. Currently I serve as CFO at Duly Health Care, which is -- we've got about a thousand physicians over three geographies, mostly in Chicagoland. A

multi-specialty group, we've got ASCs[17], labs, primary care, and most specialties. Before this I was at Springfield Clinic, which is a very similar group in Central Illinois, about 700 providers. And then I also spent time in a very large health system, Bon Secours Mercy Health in the Richmond office, and before that academic medicine, so I've served the health care ecosystem and patients in what I would consider most of the large and more popular ways of serving patients, academics, large health system, nonprofit, independent, and private equity-owned.

And I'm excited about today's conversation. I think patients' care should be led by providers, physicians, and APPs[18]. I think that's where the cost of care is the best. We showed 20 to 30 percent lower cost of care than most systems, and they're the ones that are really trained to care for our patients.

So when we think about how do we remove barriers to what I'd consider really good care, I think it starts with the economics

17 Ambulatory surgery centers
18 Advanced Practice Providers

associated with it, the burden, and standing up, and then growing those business lines, and it's really difficult to do at that size and scale. And that's I think why a lot of smaller physician groups just simply don't do it, it's too burdensome and too uncertain for most groups to do. So, I look forward to digging into this and spending some more time on it.

CO-CHAIR MILLS: Thank you, Chase. Next we have Ms. Jessica Walradt, who's Vice President of Finance, VBC Contracting and Performance at Northwestern Medicine. Jess, welcome.

MS. WALRADT: Hi, thank you and thanks for the opportunity to participate in today's panel. As you noted, I'm speaking on behalf of Northwestern Medicine, and that's a health system in Northeastern Illinois that employs over 3,500 physicians. We have 11 hospitals, one of which is an academic medical center located in downtown Chicago.

We participate in a number of VBC[19] contracts, commercial, Medicare Advantage, as well as the Medicare Shared Savings Program.

19 Value-based care

And historically have participated in Medicare bundled payment programs, like BPCI Advanced and the Oncology Care Model, and our participation in those programs is what's influencing my comments today. Next slide, please.

So when assessing participation in an Alternative Payment Model, there's a lot of things we consider, and this slide highlights some of the major questions that we contemplate, and which aspects of program design influence our thinking. And I'll just cover a couple of them briefly right now. So, since that we include an academic medical center, education, discovery, innovation are core to our strategy, and we are a destination for patients with advanced, complex conditions.

So we look at very closely a models risk adjustment methodology, the attribution methodology, whether or not there are certain carve-outs, and those factors also influence our thinking about whether we ultimately believe there's a clinically appropriate path to generate savings. And to illustrate that concept, I included this graph on this slide

that shows data from our actual experience and the Oncology Care Model.

So, each of the bar graphs represent average episode payments for a lung cancer episode, and the green reflects the portion of that that is driven by inpatient hospital stays. And then that orange yellow is the range of our target prices across performance periods. And you can see here that if we eliminated every single inpatient stay, meaning all of that green for a lung cancer episode patient, we still would not have been able to come below our target price.

So, we did not see a clinically feasible path to savings in this program, and it's one of the reasons that we're not in the Enhancing Oncology Model today.

And then I think there's a lot of factors that everyone on this call thinks about, like, data, administrative operational lift, if you can meet the implementation demands within the timeline given, things like that. And I'm happy to talk about that in more detail and our other learnings from our participation in these models later in the

conversation today. Thank you.

CO-CHAIR MILLS: Thank you. Next we have Mr. Brock Slabach, who's Chief Operating Officer at the National Rural Health Association. Brock, please go ahead.

MR. SLABACH: Well, thank you, and it's good to be with all of you this morning. I'm joining you from Leawood, Kansas, and I am the chief operations officer of the National Rural Health Association. Prior to my experience having come aboard the NRHA[20] in 2008, was being a rural hospital administrator from 1987 to 2007, about 20 years.

And so, my discussion or my frame of reference for my discussion today will be not only my current role in looking at value-based care initiatives and their impact on rural providers, but also my experience as a rural hospital administrator historically.

I wanted to kind of give a baseline of some of the activities in rural facilities around the United States, and I particularly want to point your attention to the upper left graphic, which shows participation in quality

20 National Rural Health Association

payment models by rural facilities, in this case, Critical Access Hospitals. You'll see here that Medicare ACO, 47 percent currently of rural Critical Access Hospitals are participating in some form of an Accountable Care Organization, 26 percent in a Medicaid styled Accountable Care Organization, 28 percent in commercial ACO, and then about 14 percent in a PCMH, or patient-centered medical home.

I wanted to point this out because I think that sometimes we think that rural providers are not that interested maybe in innovation, but I would say that it's quite the contrary. I think there's a lot of interest in transforming care at the bedside so that it can become more cost-effective with higher quality to the patients that we serve in our facilities.

The other thing I'll point out on this graph is that Critical Access Hospitals, of which there are 1,360 nationwide, about 54 percent are independent, meaning they are not affiliated with a larger system. So we have some real opportunity in terms of networking

and bringing alliances together of facilities, perhaps in terms of aggregation to be able to make these value-based care models more effective. Next slide, please.

I wanted to provide some context because I think it's important when we're looking at total cost of care models that would be applied in a rural context. Forty-three percent of our hospitals in rural areas are currently operating with a negative margin. Right now Medicare Advantage is accounting for 39 percent of all Medicare eligible patients in rural communities, and in many states, seven, the penetration exceeds 50 percent.

So if we're looking at a Medicare only model, for example, more and more patients are being peeled out of the participation cohort that it would make effective utilization of these programs. One hundred eighty-two hospitals have closed or have ended their inpatient care, and we're counting about 432 hospitals in rural areas that are vulnerable to closure.

And during this same time period between 2011 and 2022, we've seen a significant

loss in obstetrical care in rural areas, 293 having dropped this service, which represents over 25 percent of America's rural obstetrical units, so this is another reason. And we look at oftentimes obstetrics as being a precursor to a hospital closure. Next slide.

I wanted to offer some rural considerations in the total cost of care modeling as it applies to rural facilities. I think one of the big factors in rural communities is, and their hospitals and clinics, is the bench strength of leadership to implement transformational programming. Often in rural facilities you have an administrator, a CFO, and then you have a whole line of department directors. And this makes it very difficult to implement innovation.

A lack of clarity around risk and reward analysis, I think Jessica did a tremendous job of giving us an example of how to look at a model that projects what the participation would be in terms of financial impact. Often in rural facilities, it's almost impossible to understand the impact, and so when you're talking to a board of trustees

about putting your assets at risk to participate in a model, that's a very difficult conversation.

We have found a little or no appetite for double-sided risk models, and this is another example of the lack of clarity around risk reward analysis. I already mentioned the thin margins that our hospitals are operating under with no capital to invest in these kinds of value-based care programming.

The other thing that's very present, and I wanted to point this out early, is that the historic turn of VBC or value-based care programming that is either changed or terminated. We have seen a constant stream of programs that have either come into place, rural providers participate, and then the program is ended, leaving them in a lurch with no place else to go.

Lack of alignment across multiple payers on payment incentives and quality metrics. We find that because of this lack of bench strength, the alignment across payers is often different, and it has oftentimes confusing or at cross purposes sorts of impacts

in terms of the program.

And then I already mentioned the increasing diversion of patients from traditional Medicare to Medicare Advantage, which has decreased the population of patients that would participate in a Medicare only program. With that I will turn it back over to our host and thank you very much.

CO-CHAIR MILLS: Thank you, Brock, for those comments. Last we have Mr. Michael Barbati, who's Vice President of Government Programs at Advocate Health. Welcome, Michael.

MR. BARBATI: Thank you, good morning. So my name is Mike Barbati. I'm the vice president of government programs at Advocate Health. I also serve as the president of Advocate Physician Partners Accountable Care, Inc., which is a 200,000-person MS, Medicare Shared Savings Program Enhanced Track ACO, as well as the president for our ACO REACH, which is our -- which is the Accountable Care Organization of Advocate Aurora Health.

So a little bit about Advocate Health. We have a pluralistic physician model that includes over 600 individual

independently-aligned practices, as well as our employed physicians, that serve patients across both rural and urban geographic areas, across Illinois, Wisconsin, North Carolina, Georgia, and some -- well, some service sites in Alabama and South Carolina.

This is a snapshot of our population health platform. We've got 15 ACOs, clinically integrated networks, as well as physician networks. Across our footprint, we manage 2.4 million managed care lives, we've got 110-plus value-based care contracts. My responsibilities do include anything -- any value-based contract that comes out of CMS, CMMI, and Medicaid.

And so, we've generated almost three-quarters of a $1 billion in taxpayer savings across a variety of models dating back to 2015. And then we've paid about $1.4 billion in savings to our participating physicians since 2018. We've got 73 participating hospitals across the footprint. We dabble in all of the variety of payers from Medicare, Medicaid, and commercial capitated risk. We've got quite a large footprint, and then each of these networks is typically

physician governed with equal representation between employed and aligned physicians.

And then, you know, we have invested over the last 10 years significant amounts of dollars into our population health platform infrastructure related to care management, utilization management, other services, and we've spent a lot of time testing and working on specially nested care models to embed within some of our total cost of care dollars, and to give you an idea, we've got about $250, $260,000,000 in budget and revenue across these value-based contracts, and then our largest payer in our VBCs is CMS. Go to the next slide.

So, I just want to talk about some of the participation barriers while we've been in population health and been managing risk since our beginnings in 2009. We still face a lot of the burdens that other health systems across the country face. And I think part of them are typically, you know, assessing new models, or total cost of care across our disparate geographies. We don't have a continuous geography, and so certainly

different insurance regulations by state. Fee schedules look different across states, and so, and we have different levels of readiness, and as we look at tight turnaround times for total cost of care models from CMS and CMMI, that can limit our ability to apply, but as well as our ability to participate. Typically, in most of our value-based contracts, we're taking on quite a risk, and that typically leads to higher financial exposure, meaning that we need a higher level of certainty on the value-based care contract terms and showed it's going to be more profitable than our fee-for-service in order to take that downside risk.

Well, you know, we struggle with some of the data styles and operability issues, lack of standards from, you know, differing standards from CMS, from payers, from our vendors. It certainly creates some data silos, and for an organization like ours, it creates an area where we do need to invest significant resources into the technology and data infrastructure to be successful in these models. And then, I think, just one other area to touch on, fragmented sort of care plan

designs, you know different benefit structures for MA[21] versus, you know, different waivers for some of our value-based contracts with CMS and CMMI, as well as sort of disjointed and unconnected care models in the specialty space.

We firmly believe that nested care models and embedding specialty care within our total cost of care models is a foundation of our future from a population health standpoint, and we've seen in some of our markets difficulty in managing both specialty care models, as well as total cost of care models in the same market where they're not connected or physicians in participating organizations don't have the opportunity to participate in both. But looking forward to the discussion today, and excited to dig in.

CO-CHAIR MILLS: Wonderful, thank you for that, Michael. Great introductions. Now, let's move on to some questions. In the interest of balancing across different perspectives and questions, we'll encourage panelists to keep their response to a few minutes each, but then we will -- and I will

21 Medicare Advantage

have an order to speak in, and then we will pitch each question open to the Committee for follow-up questions and give you a chance for further elucidation.

So question one, we'd like to hear your thoughts on what are the most important factors affecting different kinds of health organizations' decisions about whether and how to participate in a population-based total cost of care model? We'll start first with Chase and then Jess, and then Michael, and then other comments. So, Chase?

MR. HAMMON: Yeah, thanks again. Look, I think organizational structure's a really big deal. Like I said, I've worked in various organizational structures, primarily on the physician's side, and physician-owned versus private equity backed versus nonprofit health system and academics. They all have different views of the world, as it were.

I think Brock said it well, when thinking about rural health health care, or at least health care outside of large metropolitan areas like Dallas and Chicago where I've been, the ability for these organizations to stand up

the infrastructure necessary is really small. And combine that with the uncertainty around the data, around profitability.

Mike mentioned, right, is it -- is the profitability for their fee-for-service side going to go down, right, by participating in the VBC? It's almost always yes for these smaller organizations. So, and then I think, you know, a lot of our physician groups have come together, the independent physician groups have come together, you know, small group becomes a larger group, it becomes a really large group, that's how Duly was created, that's how the Springfield Clinic was created, that's how many of these -- I think Dr. Crow's group was kind of created that way over time, and what that does is you've got these silos of practices, individual practices that kind of operate on a revenue minus expense model or work review model that doesn't really jive with managing a population.

And so, when I say oh, organizational structure's also a cornership structure, it really helps guide whether the physicians doing the work, right, are kind of

team-based players that can play in a population space.

I think, again, one of the other biggest challenges is certainty and timing of cash flow and payments, right? That's a really big deal for independent physician groups coming to do the work now, but not get paid for 12 to 18 months, as compared to fee-for-service where I get paid in two to six weeks, maybe a little bit longer for some payers, right? It's a real struggle for those independent groups to get over that hurdle of, all right, maybe profitability's better, but I won't know that, you know, for three, six, 12, 18 months, and it's a significant barrier.

I'll stop talking and let someone else talk, but these burdens are pretty significant, and the hurdles to get over them are big.

CO-CHAIR MILLS: Yeah, great point about cash flow. Next let's hear from Jess.

MS. WALRADT: Yeah, so there's a lot of things that influence our thinking about whether to participate in total cost of care model, but I'll just give one example that's

unique to Northwestern based on our structure, and that's the fact that we employ two large multi-specialty group practices. So our ACO is 20 percent primary care physicians, 80 percent specialists, and that means that right now, the factor, or a factor that is really going to answer, the long -- like, whether it's long-term sustainable for us to be in an ACO type model is attribution.

And under MSSP right now, attribution is done, just at the TIN[22] level, the full TIN. And so that results in a pretty meaningful amount of our attributed patients not actually being our primary care patients in the traditional way that I think most of us think about primary care. Our academic medical center TIN, for example, we see that over 12 percent of the attributed patients within that TIN are attributed via a visit with a specialty APP, mostly oncology and cancer. So, we would like to see an attribution model that's based on TIN and NPI[23] attribution, and we think that would help us actually get a patient population that is closer to our more kind of, again, the

22 Tax identification number
23 National Provider Identifier

classic quote unquote primary care population, as I think a lot of us think of it.

CO-CHAIR MILLS: Yeah. Great point. Next let's hear from Michael.

MR. BARBATI: Sure. You know, I'd echo both the comments that Jessica and Chase mentioned, and just add a couple things. I think from a health system standpoint, you know, one of the things that we, you know, really have to balance is the multiple revenue streams. And so, one of the things that we try to do, you know, specific to Medicare models, we try to tie in, you know, what's our margin on our Medicare business as a whole? How are those sites performing in the, you know, Medicare Value-Based Purchasing Program?

And then how would reduction admissions and readmissions and subsequent services, you know, impact their bottom line? And what we found is when we can speak that language across our different organizations, we can typically get the health system on board, but because we also have the independent physician groups, you know, where they've struggled particularly on the cash flow side

is, for ACO REACH for instance, we approached about 35 of our practices to participate in the ACO REACH. And they had to give up their guaranteed fee-for-service revenue to take on a capitation and a global form from us.

And while we could lay out our predicted increase in their revenue from participating in the model and their predicted increase in their, you know, shared savings check, they were hesitant to do it and ultimately only signed up about 30 percent of those practices because of the cash flow implications and the challenges around waiting for some of those dollars. And then in addition to that, I think for us it's really key to understand organizational readiness in our different markets.

In some cases, smaller, you know, independent physician groups in more rural communities do actually have -- are a little bit more nimble and flexible with the infrastructure that we can provide from a health systems standpoint, and so we do see them, you know, take on a little bit more risk in some areas, and being a little bit more

nimble and sort of first adopters in some of these spaces. But again, some of that's enabled by, you know, the health system support. And I think without that, that might be even more challenging for some groups.

CO-CHAIR MILLS: Right, thank you for that. Brock and Christopher, other comments?

MR. SLABACH: Yes, thank you. This is an important question, and I think for our rural hospitals and clinics, I think this is central. Obviously, I said in my intro that in those, roughly half of hospitals that are not affiliated with a system, like Mike mentioned a second ago, they are independent and meaning that they have leadership in their organizations that are often a mile wide and an inch deep. And so when you talk about complicated programming such as population-based total costs of care, the level of complexity becomes overwhelming, and then you have just an inertia that occurs in terms of being able to carry off a program or a participation in something like this.

One of the ideas that I think we're

seeing nationwide that is starting to take route is development of networks around the implementation of these kinds of programs through a clinically integrated network that's loosely affiliated between independent hospitals in rural areas.

And this is something that is being experimented with and I think would be the foundation, if you will, for then moving into some of the more complex models that we're talking about here. I think that many rural facilities don't understand, and again, have difficulty assessing the risk, and so that comes back to the discussion in terms of their financial wherewithal to be able to -- I mean, many of them are worried about keeping their doors open, making the next payroll, and making sure that they can stay open into the long-term.

And so, when you're in that kind of operational mode, it's difficult to think long-term about these kinds of programs. And so, I think organizationally this is something that we struggle with at our association when we evaluate programs that would be applicable

for participation by rural providers. It's the complexity, and I think that often we get frustrated because these larger, more sophisticated models are not well suited to the rural environment.

And so, we keep talking about a rural relevant or a rural-centric model that does have an opportunity to take into account low volumes, which are really the factor that creates complication for risk in these rural communities.

DR. CROW: Yeah, I'll just add one to kind of piggyback on that. Catalyst has been URAC[24] accredited for a CIN[25] for seven, eight years, since 2016 or so, one of the six or seven in the country, what we had to do. And we have a combination, while we're in North Texas, which is, you know, evolving to the biggest metro area in the nation, I also have, not only the panhandle but communities in East Texas that ranged from 10,000 people to 30,000 people, and again, I grew up in a town of 7,000.

So, how we talk about this from a

24 Utilization Review Accreditation Commission
25 Clinically Integrated Network

rural setting to your point is completely different to me than how we talk about it in an urban setting. There's just a different solution set that we have to think of there because rural communities, going back to with my point about thriving communities, you have to have the education and the health care and the jobs, well, those smaller communities often struggle in all three of those, and health care being one of the biggest ones right now.

If I take it back to the urban setting though, and say a little bit more about, Chase kind of alluded to it, I think everything starts with incentives and alignment, so the ownership structure and governance kind of is your starting point. And you know, what is a hospital system? You know, Mike talked about the dynamic tension between that, and who I talked to all the hospital CEOs about that around, you know, my area, is it's hard. You know? You got to rob Peter to pay Paul.

That's just -- they're too different, 180-degree different models. If

you're in PE[26], you're in and out, you know? It's not going to be something long-term, and these value-based systems usually need a longer tail, so right there you kind of have different issues just as your start.

Before you even get into, does the financial model even work? Then you get to that, and, you know, Jessica spoke to the difficulties in that and certainly the incentives and the timing of the payment. The investment, do you even have the capabilities, and if you get to where it makes sense, do you have the capabilities, how do you invest in that? And then if you can conquer all three of those, then you get into it.

I think it was Mike was talking about, is like, how do you even get physicians to think about change management in a world where the majority of their pay is still in the, from a primary care setting, I'm going to take off my -- I don't have the specialty hat on here -- from a primary care setting, the Stockholm syndrome of fee-for-service where they think that that's the only way that they

26 Private equity

can work, and I have a very similar situation, I did, to Mike had, is where I can actually show people that their perspective capitative -- I don't want to use the word capitative -- their subscription payments are better than their fee-for-service. I can show them the math, and they will still say, I'd rather keep my fee-for-service. It's very, very, very interesting, even though they want change, they have a hard time changing.

So, you know, there's a lot of hurdles there to get over, and we haven't even talked about data yet, but that's a whole other category.

MR. HAMMON: If I could add one more thing that -- I like the Stockholm syndrome reference, Dr. Crow, but I think, you know, one of the biggest factors in all of health care is the payers, right?

Especially as they relate to small physician groups or even large physician groups, right? They absolutely drive decisions around when to participate and how to participate in these models. The commercial payers in their, you know, semi-legal

monopolies, right, drive physician groups into larger risk-based arrangements that maybe they wouldn't have otherwise been in. And so I think it's hard to talk about what's impacting groups' decisions without talking about how the payers are acting.

CO-CHAIR MILLS: Great points. Christopher, I especially like your point. Change is great as long as someone else goes first and shows how -- points the way, right? Wonderful discussion. Let's raise it to the Committee. What questions do you have on this question of most important factors influencing different types of decisions? Jay?

DR. FELDSTEIN: Thanks, Lee. This is for Brock and anybody else who wants to comment, and this is going to be a sacrilegious question, because I think we need to take into consideration for some rural hospitals, just population-based total cost of care models just don't work, that we need to think, you know, differently, and whether it's, you know, quality-based bonus structure built around fee-for-service, you know, because one size doesn't fit all.

I like the clinical integrated network design, but I think we got to think this through because these hospitals, we're talking about survival. You know, they're not thinking about a capitated payment because their volumes are small, and the irony is most of these hospitals, when they get in a growth mode, they all want to add beds, and they all want to add service lines.

So we've got this dichotomy operating all the time, and I truly don't know how we break it because I've watched it happen in certain markets that we happen to be in, that they all want to grow, add beds, and add service lines, which almost gets contrary to, you know, a population-based, value-based purchasing model. So, you know, how do we balance that to keep them solvent and ease them into the transition?

MR. SLABACH: Well, that's a great question, and if I have the answer to that, if it was easy, I think I probably wouldn't be here talking to you, I would be probably on a beach someplace enjoying my wealth. I think -- I look to models that we've used in the past

that have been successful. Unfortunately, they haven't passed the muster of CMMI's definition of beneficial program, but the Pennsylvania Rural Health Model, which is the global budget, was a model that started in roughly 2017, 2018 and sadly ended December 31st of last year.

And the global budget basically sets forth payment to the hospitals on an average net revenue for the last three years, but the important piece to the model that that employed was the Rural Transformation Plan, which was the requirement that they would enter into a discussion on how they would do exactly the opposite of what you said, Jay, and that is, we're not interested in building more structures, obviously bricks and mortar are no longer where the action is in terms of health care, and we need to start looking at how we reformat our services so that we move into access, care navigation, chronic care management, and the things that rural facilities can excel at and do very well in.

And -- but one of the things that we have discussed ad infinitum in our work is that we have to preserve what we have before we can

move to something different, so we have to make sure that we don't close 30, 40, 50, 100 rural hospitals while we're figuring out this new model and have these casualties along the way.

So I think this Rural Pennsylvania Model, this global budget model, was one that showed a lot of promise, and that goes back to the churn notion that I said a second ago, now that program has ended, out of 18 hospitals in Pennsylvania that participated, I think 16 -- 15 or 16 are continuing, in spite of the fact that the program officially ended, so, and that's for the Medicare-only piece of the program.

So, I think it shows that it was demonstrated to work. It just didn't meet the criteria that CMMI was using in terms of providing savings to the overall system and being able to demonstrate that as part of the requirement.

DR. CROW: Yeah, I might add to that. I would double click on your -- and bold your global budget. I mean, living in these communities growing up and working in them now, and it starts with what I said earlier, it's

really about the ownership structure and who accrues the benefits of the care in the town. And that really is, you know, a pillar of the thriving community.

If we have rural hospitals that are all incentivized to be owned by somebody in Nashville, you know, it's just not going to work, right? These are literally, we call them hospitals, but I like -- they're more like community centers. It needs to be where the physicians, the primary care physicians, the nurse practitioners, the nurses, and those other acumens like you said that are doing care delivery, the people in those towns are highly engaged with each other. You need to leverage that, leverage the power of the engagement in the community.

And again, I agree with you, the service line that you talk about and trying to add things, is all about trying to pull people out of that town to go get more expensive care somewhere else. So you almost have to think about these town -- like if you had to start over, what would you create in a town? You would create a community center of health that

has a few beds in it for sure, and has a global budget. I don't have the answer how to do that. I'm just telling you it's way, way different, and I watch these little towns in Texas die on the vine right now because of their hospital is -- it's either their hospital or their school district is hemorrhaging, or both.

CO-CHAIR MILLS: All right, we're going to go Larry, Jim, and then Lauran.

DR. KOSINSKI: Great discussion. I have so many questions, but for the sake of time and not wanting to dominate, I'm going to start with one for all of you. Some common themes have come out from all five of you that the time between performance and payment has to be reduced, we need to have a feasible path to generate savings, there has to be the right balance and risk and reward.

My question is, what level of reward over risk would move your needle? How big of a benefit has to be there? Is there a hurdle rate? And can you state some successes? We've heard a lot of barriers, but can any of you elucidate success stories? Like, Michael, do

you have a nesting success story? So, I know that's a couple of questions built in the one, but you know, I really want to know is there a hurdle rate when you're making these decisions, and give me a success story.

MR. BARBATI: Yeah, I can start. So, first your comment on the hurdle rate, at least particularly for us, I think, you know, I'm just looking at some stats here, MedPAC[27] found, I think, average margin for hospitals in 2022 was, you know, for Medicare patients, is negative 12 percent. Obviously, that's variable across a variety of markets, but at the end of the day, payments for Medicare services on the inpatient side in particular are not going up, they're going down, right?

And so the hurdle for value-based care within Medicare to put on ACO's side is coming down, and I think where we've been successful in pushing this -- I mentioned, you know, our ACO or, you know, Medicare is our biggest payer in the value-based care space, one, you know, I think the incentives are there where I think large integrated delivery

27 Medicare Payment Advisory Commission

networks struggle is really managing utilization and the complexity of that, and that's where I think, you know, you see a lot of success in the physician outside.

In terms of an example of a nested model, we had a -- we have several aligned nephrology groups within our geographic regions, in particular one larger group in Wisconsin, they have previously participated in MSSP, sort of felt a little bit disconnected, did evaluate the CKCC[28] model, and opted instead to participate in the Medicare Shared Savings Program. They're a participant of us.

Based on other models and other demonstration projects, we created a three-year baseline for their patient panel, they got about 3,000 members, and we carved out their population, you know, from our MSSP, created a baseline, trended those costs forward with our actuarial team, and looked at their performance over time.

A couple stats, that model's been live, it was live in '24 and continues in '25. From our perspective, with the practice, we

28 Comprehensive Kidney Care Contracting

committed a certain amount of shared resources to do care management outreach, et cetera. The results have been 25 percent increase in transplants for kidney care patients; we've seen an increase in efficiency and productivity at the practice just simply by shared problem-solving, both with technology and working together with the group with our quality improvement coordinators; and we've seen about a 10 percent decrease in readmissions across the board.

We're providing some services like transportation and other things through the waivers allowed in the program, and it's really solved an access issue, it's solved some productivity issues, and it's simply just working together with that practice to focus on their CKD[29] Stage 3 through 5 and end-stage patients.

I think there's other areas where, you know, maybe we haven't done as well, you know, you look at sort of complex, you know, long-term care patients, right? You know, we maybe have responsibility for them, but we may

29 Chronic kidney disease

not be the best group to manage them, and so we've evaluated, you know, you've seen a couple, you know, long-term care ACOs, you've seen highly complex ACO REACH entities sort of come aboard.

I think there's an avenue to partner with those folks. You can see some really significant results for folks that maybe are managing care outside of, you know, the four walls of our hospital or the ambulatory settings that we're in.

Those are a couple examples. One last example, we believe in episodes of care, and we are building our own infrastructure and technology. This would be a plug for the group. We think standard episode definitions, such as PACES[30], would really alleviate the burden on organizations to select one of the 160 groupers that are out there for a variety of episodes of care. I think roughly about 75 percent of care can be grouped into an episode; 75 percent of Medicare claims can be grouped into an episode. And we believe that's the future, and so we've invested a lot of time and

30 Patient-Centered Episodes of Services

effort into building that infrastructure capability within our organization.

MS. WALRADT: I can jump in with some thoughts now, and I'll try and be succinct because I know we have a lot to get through. In terms of your question of that hurdle rate, I'm going to be a little annoying and kind of not answer it and say that, you know, these things are not decided in a vacuum, and I think that the greater uncertainty that exists within the health system, the less likely you are to be open to taking on risk. So you know, if you're concerned about, like, if telehealth might go away or what's happening with physician payment, like, you know, those are things that make your overall appetite for taking risk less, and so sometimes the question becomes within a given model, how much is risk limited versus, like, what the game is?

And then an example of where we had a win, I would say, when you start with a model that's kind of answering a key question like, what is this model trying to solve to versus just kind of having the model for a sake of a model that might involve certain specialists,

is where we see a kind of path to success, and so I'd say for joint replacement bundles, you know, I think those came out of 10 years ago now, research showing that there's a ton of variation opposed to acute care spending.

And so with that model we looked at, like, really scrutinized what criteria do we use to recommend where a patient goes post-discharge and we were able to kind of more standardize our process for what type of patients, like, most need to go to a SNF[31] versus an IRF[32], versus home with home health, and so I think we are able to improve the patient experience but also generate some savings within that model.

DR. CROW: And I'll add one more answer to this as the primary care guy that had -- you know, we have several hundred physicians inside of a risk variant doing full risk on about 80,000 Medicare and Medicare Advantage lives. You asked about a hurdle rate. I can tell you by experience I had to throw a lot of things against the wall to try to figure out what the physicians could get to to understand

31 Skilled nursing facility
32 Inpatient rehabilitation facility

how to do a prospective payment and teach them to get out of their Stockholm syndrome as I called it earlier.

And I had to have a you know, pre-pay somewhat I think would be performance, surplus, gain share, what you want to call it, into the realm of around 140, 50 percent of Medicare from their traditional Medicare rates to get them to have their eyes open up enough to go, wait a minute, maybe that math does work. And that's what -- so that's one answer to your question.

Here's maybe a more, or an as important one, is what percentage of their population that they serve can you actually get into that model where ultimately, now the financing model then drives a different clinical model? And we have just kind of crossed that line to where I would say, you know, 40-ish, 50-ish percent of our physicians are now being paid in a prospective payment model with surplus, and it's beginning to change their mind set, so our clinical model, for example, now spends a ton of time asking the question -- so this goes to the success

story -- how do we think about end-of-life care where most of the expenses are?

It is the last thing you think about in fee-for-service. I practiced for 12 years, never thought about palliative, hospice, and that's embarrassing to say, but it's the truth, because the fee-for-service model does nothing but disincentivize you to spend time on those conversations. Now it's the exact opposite, and we're looking at who are our highest risk patients, how can we intervene on them earlier, how do we think about heart failure?

Like, it's a different clinical model, and I will tell you that physicians love it now. I got physicians who say, I want to practice longer because I feel engaged, and I'm less burned out. That burnout word has been around forever, and I'm trying to get rid of it, and this is actually our path to freedom, is what I tell them, is when you get on a subscription model.

But you can't do it at 5 or 10 percent, you got to push all the way, which goes back to Chase's point that I didn't make that I'm glad he did, is unless you have a

multi-payer alignment of these models to some extent, it's going to be really, really hard to get to that. It took me years to get to where we are today.

MR. SLABACH: One of the things I'll just quickly mention, it's not necessarily a hurdle, but in the Pennsylvania Rural Health Model, which featured the global budget, that was a multi-payer program, so it was Medicare, state Medicaid, and then also, two large, you know, three large insurance companies, commercial insurance companies participated. And I think that was a huge benefit to the facilities to align all of their incentives, both financially and in terms of quality reporting, so that they're all aligned along the same pathway in terms of incentives.

And it kind of goes to my motto is that incentives matter, and how providers are incentivized to provide care is exactly how it will be provided. I know as a hospital administrator, going back into the good old days, I call them now, I knew how to titrate a response to my financial situation by exactly what was mentioned earlier by Jay, and that's

increasing service lines, making more profitable services available to members of my community, but that's no longer what our communities need. And I think that this incentive to provide those differences through models like the global budget really provide, I think, the necessary inputs to be able to help make that happen.

MR. HAMMON: Yeah, I think for me, you know, Larry, when you asked what the, you know, some CFOs what the hurdle rate is, it's a dangerous question. But, you know, Dr. Crow throwing out the first number, look, I think Dr. Crow's right, right? The model has to match the incentive, but on this call we're talking a lot about what are the barriers.

And for our physicians, the barriers are the bigger issue as opposed to the risk versus reward. I mean, I'm sure there's a titer point there somewhere, but it's the data, the cash flow, right, the trust in the data. And I think Mike made a great point, you know, when there's five to seven different, you know, VBC plans, each one's looking at, you know, something different, right?

And so now you got to manage several different plans. It's -- the burden's just significant. So I would say just for us it's less about the hurdle, whether it's 150 to 200, it's more about, how do we remove the barriers because again, to Dr. Crow's point, the model's there, we just have to figure out how to operationalize it.

DR. KOSINSKI: Thank you.

CO-CHAIR MILLS: We'll go Jim and then Lauran and then Henish.

DR. WALTON: Thank you. Thank you all for taking the time to talk with us. I want to kind of just take us back a moment and say, part of our conversation over the next couple days is to think through, number one, the barriers that you all are articulating, but also maybe a new pathway that could be created that address some of the key barriers that you're identifying that would incentivize increased participation.

And I was struck by the particular area of interest Chris brings up as being someone who came from a small town. I'm someone who practiced in a small town in Texas, and the

rural health Critical Access Hospital intersection, around our core infrastructure for, you know, a significant portion of the population in the United States, as a way to illustrate the idea of pathways that could attract large systems or large successful organizations like those represented on the call in this discussion here.

So you mention kind of the multi-payer strategy that has had some effect and might actually be able to entice, if you will, successful organizations like yourselves, to move toward collaboration with Critical Access Hospitals that are struggling.

And Chris, I maybe want to have you start with this because I know you, is this idea of if it actually collapses like we think it might, or it already has in parts of Texas or, Lee's from Oklahoma, how would you go in and say, well, what type of incentives in a pathway related to an APM that you're participating in would want you or encourage you, and Northwestern and Duly, you know, and Advocate, same question, to move toward taking your skill set, your energy, your passion, your

knowledge, your experience, and really lifting up in some type of partnership, what would you need in that pathway to reduce the barriers that you already know that are out there because the thing is either on the verge of collapsing or is already collapsed and now we have to go rebuild it?

So, I'm going to -- and I think that you got me started thinking about this multi-payer alignment as kind of, like, a key solution set, but I thought maybe we'd just, I'd open that up, the whole question up and see what y'all -- what your opinions might be.

DR. CROW: I think you asked me to go first. First, I like the beard, Jim. I hadn't seen that. Good add. Secondly, I guess I think your question was, what would attract someone like any of us to go into a rural community that's struggling? Like, what would be some of the characteristics that would have to be present to go in there and help? I think was the question. Am I right or, similar? Am I right?

DR. WALTON: Yeah, you're on it. As an illustration of these pathways we would like

to talk about, yeah.

DR. CROW: The one thing -- like, and we've mentioned it multiple times already, is like, the rural communities have a higher density of Medicare and Medicaid. That actually simplifies, potentially, what you could do. The other thing that I said was they're very engaged, so I actually have very good conversations with, you know, school districts in cities and counties which are generally the largest employers in those smaller communities, so you could actually get some type of alignment through if you had one government kind of connection, plus a little bit inside the big three in the town, you can almost create, again, a single budget.

Now, the other thing you said, like, what else would you need? I would need time. You can't -- this can't be a year to year, this has to be a multi-year, call it five-year investment of what it would take to figure out each community's needs because they're different, they can be different, and what capabilities you would need to bring in terms of acumen.

So there's an alignment of a single, a singular, you know, multi-payer but singular model you have to have, you -- it'd have to meet a global budget, and you'd have to have some time, and then you'd have to agree upon, you know, what are the two or three main metrics we're trying to do to help save that community? And the first thing that comes to my mind is whoever owns that hospital may or may not have the same alignment to what you're ultimately trying to do, and how would you conquer that?

So, those are just my first thoughts. It's something like you said, Jim, you and I are both passionate about, and I find it incredibly difficult to think about how we could do that. That's my first thoughts. I'm sure these other people will have better ones.

MR. BARBATI: Yeah, I would just comment, I think Dr. Crow said it very well. I think there's some elements of this in the AHEAD[33] Model, right, which is, you know, just getting ready to kick off. I think there's

33 States Advancing All-Payer Health Equity Approaches and Development

some elements of it in the Geo[34] Model that came out of CMMI that was ultimately cancelled and -- and is maybe getting steam again. I think it's a combination of probably both of those, plus some acknowledgment or some focus around, you know, the communities that are -- that are struggling and some sort of, you know, benefit or support for them that's a little bit more direct so that organizations that are serving this larger geographic area are focused on, you know, what the intent of the model is, particularly for these rural communities.

CO-CHAIR MILLS: Okay. Next is Lauren.

MS. HARDIN: I'm really appreciating all of your comments. I spent a lot of time in rural environments helping people stand up systems of care for complex populations but also have been involved in implementation of ACOs and multi-state house systems in urban areas. There's a couple of areas I'd love to hear you comment on. They lean more towards rural areas, but I think they apply as well in urban. So I'm curious what policy

34 Geographic Direct Contracting

flexibilities you think are essential around core components like telehealth, mobile health care, virtual care management, and innovations in payment for transportation for success in population-based total cost of care models. And maybe start with, I can't see him right now, the National Rural Health Association and also Chris and then go around the room.

MR. SLABACH: Well, thank you. It's Brock here. Yeah, I think you raise a very good point. I mean I think that these new modalities around connected care are really critical pieces to fit into this puzzle. I think that a lot of our members, a lot of our providers around the country are frustrated with the fee-for-service arrangement around at least telehealth at the moment. Frustrated that the payment isn't on par with their requisite provider type. So if you're a Federally Qualified Health Center, the reimbursement for the telehealth service is less than what you would get under PPS[35] and same with the Rural Health Clinic.

I think that where we would come in

35 Prospective Payment System

on this is that we want to get parity on the services, so that again preserving what's -- what we have now so that we don't endanger it going forward. But I think that as a -- as now putting on my hat as a provider in simplicity, I think that these connected care modalities are going to have to be incorporated into a value-based care model so that this fee-for-service arrangement isn't going to incentivize once again behavior that may not be exactly what we want in this new paradigm.

So we're at this crossroads now where we're kind of inching into now, of course artificial intelligence is a whole other conversation that's going into the space here. And I think that, that's a critical feature. So we need to get parity with the payment, at least in the rural provider context as we start to incorporate those more completely into the value-based care paradigm so that we're not creating another monster that we someday have to have a whole conversation like this group is having on how to fix it.

DR. CROW: Okay, I think you named me next in line. So here's how I think about

this -- these, you know, telehealth go back to even CCM[36] that I helped design years ago. You know, good ideas to kind of move us in, but when it's in a fee-for-service world, all the sudden there's telehealth companies, all the sudden there's CCM companies. You give a code, and you create a company RPM[37] now. So again from the primary care physician standpoint who I believe has a longitudinal relationship with their patients and that is actually where the ROI[38] happens. The relationships compound the same way interest compounds. You make tiny decisions year after year that add up to big decisions on people's health. And you do that across a population and that helps their overall health.

So I go back to, I don't use the word capitation, I go back to we really to be able to have subscription models. How would you do that? You could do it at the government level like I already have with all my Medicare and Medicare Advantage. From a commercial standpoint, if we could unbundle, you know,

36 Chronic care management
37 Remote patient monitoring
38 Return on investment

primary care shouldn't be your insurance. Insurance is when bad stuff happens. Primary care is stuff that happens all the time.

So how do you unbundle that and make primary care something that's tax deductible for the individual the same way it is for the employer? And whether it's their deductible, their FSA[39] or their HSA[40] or whatever it is, the benefit design of the day encourages the patient to actually have a longitudinal relationship with their PCP[41] in a tax-deductible format. And therefore you don't start counting ticks and ties of do they have this RPM? How many times did they use it? And what is this telehealth code? And oh my gosh, I can only get paid if they're in my 10x10 exam room with the crinkly paper and the old magazines. Like it opens up a delivery model, like what do you need to do to take care of them?

And the center of health care moves from that little office into wherever the patient is and you build your delivery around

39 Flexible Spending Account
40 Health Savings Account
41 Primary care provider

that, which is what I've been able to do in Medicare to be successful within the last few years because we got the delivery model that we wanted. But it was -- it's a lagging indicator of a financial model that allows us to actually do that. So that would be what I'd say we need.

MR. HAMMON: I think there's an aspect of kind of this telehealth delivery that we haven't really talked about and it's at least in rural communities. So Springfield is a couple hours south of Chicago. So we deal with it less at Duly than we did in Springfield, but Quincy was just part of Duly as well. Like shortages in clinical care providers. Right? So both physicians absolutely in those communities, but also MAs and nurses. Right? So the ability to get paid for telehealth services, right, to allow our MAs and our nurses to connect with patients when they're at home or in other areas, it's going to be critical moving forward for these smaller communities to be able to connect with their patients. Which to Dr. Crow's point, and this is something we talk about at

Duly all the time, that doctor-patient relationship is sacred, and we have to preserve it. It's not something that, and I don't mean to speak pejoratively of like Amazon Care or whatever, but a patient in rural Springfield isn't going to want to have a relationship with a doctor, you know, 1,000 miles away. That relationship is sacred. So telehealth is important, but it's important within a community.

MS. HARDIN: Great comments. And the longitudinal component too. We've consistently heard how important that is. Would anyone else like to comment? I'll hand it over to you.

CO-CHAIR MILLS: All right, I'll pitch to Henish and then we'll move on to the next question.

DR. BHANSALI: So this is a question for all five of you. We've talked through quite a few meaningful barriers and participation from each one of your organizations. I'm curious, just taking a look at that 2-by-2 grid of high value, low value, high lift, low lift, what are some -- and each

one of you represent a different sector, a different type of organization. So what is that higher value, lower lift more immediate change that can be made in these models to help move your organization more towards population-based total cost of care and improved patient outcomes, et cetera? I mean for example, Jessica, you gave the example of the 10 NPI, like that's a very specific change that can be made to help progress that. What would that sort of an example be, one or two for each one of you?

MS. WALRADT: While people think about that, I'll just add on that's something else that I think is easy for CMS to offer is a longer implementation time frame for models. So I know for us when a new model comes out, I'll take the GUIDE[42] Model for example, we did a kind of quick assessment of it to see where our gaps being able to satisfy all of the requirements and you know, what's the ROI, the lift to fill those gaps in the timeline? And we're basically like oh, we have so many competing priorities right now, like you know,

42 Guiding an Improved Dementia Experience

like we don't really -- we aren't going to be able to devote the resources to that right now.

And I think like a good example, and I know a lot of people have issues with the team model itself, but the fact that unlike past bundle payment models, CMS gave over a year lead time for that model. Like that kind of lead time is very helpful and I think a pretty easy thing to grant now. So not commenting on the team model itself, just the lead time for it.

DR. BHANSALI: So both the lead and the duration?

MS. WALRADT: Not the duration of the model, the lead time up to it. So when you know about it to when you actually like press go and payments start changing and you have to start reporting data and all that.

MR. SLABACH: This is Brock here and thanks for the question at issue. I think that the high value would be, and I would go to the word simplicity, a model that is simple in terms of understanding and is creation a design? That usually tends to be more elegant. I hate to come back to the global budget, which

is a part of the AHEAD Model and to Jessica's point, they did do a 10-year horizon on that model. So they've learned, I think in terms of the duration of the model to make sure that the reporting period upon which success or non-success will be determined has a longer running period to be able to make that judgment.

One of the things that I think that could be done and is being -- and is important in this sense is providing technical assistance for the implementation of these programs would be incredibly powerful to be able to have a lead time in application for consultants, which unfortunately would usually fall to them, to help and guide facilities in their applications to these programs because I think these are very difficult applications to fill out and to complete and think through the entire model. So I think -- I think technical assistance could be very helpful to a rural independent facility looking at some of these models.

DR. BHANSALI: So Brock, before you go on, maybe just to clarify a couple of things. Are you implying that technical

assistance from CMS to the people who are looking to participate in the models or just enough lead time so that the participants can engage with another entity to help figure out whether or not they should participate in the model?

MR. SLABACH: I think both frankly. But I think when I say technical assistance, I'm not necessarily meaning from CMS, but allowing for the engagement and perhaps providing resources to the facility to engage consulting to help them with this. Because again, we're going back to this model where one of the barriers is the facilities are not well resourced, both in terms of leadership and in dollars. And so they don't have an outside or a department for strategic analysis or all of the things that we're talking about here, so it all has to be accomplished with the existing infrastructure of these facilities. And often there's a will, but there may not be of the means. And I think that's what I'm referring to here in terms of the application process. But once you get into the program, I think it's really important.

And then like in the AHEAD Model, it depends upon state participation. So even if you're an individual facility that wants to participate, there has to be a regional or a state entity that organizes the grant application to CMS. So that makes it really out of reach for many. And just using that as an example. And I use that for the 10-year horizon on the demonstration, which I think is really a good period of time to evaluate its effectiveness.

DR. BHANSALI: Is there a model that you found, Brock, that is pretty, I guess simple? I mean not as simple as you would want it to be, but it's getting closer to the type of model you would want to be. And maybe a couple of tweaks that would get it to a place which will substantially increase adoption?

MR. SLABACH: Did you say AHEAD Model, Henish?

DR. BHANSALI: No, just any model, I mean that you found.

MR. SLABACH: Oh.

DR. BHANSALI: Yeah.

MR. SLABACH: I think that -- well,

the AHEAD Model is actually a pretty good one because the problem with it was it wasn't exclusive to rural. And so I think there was some concern from some states about a mixed participation between facilities and different, you know, urban, suburban, and rural, and I think there was some hesitation there if I'm remembering that correctly. But I think that, that incorporated a global budget, a physician compensation piece, and then a total cost of care wraparound. So it had three elements that I think would be important for a rural community to be able to evaluate. But again, I go back to the technical assistance that's needed for it's a rural facility participating, being able to understand the impact and assess its value.

DR. BHANSALI: Thank you.

DR. CROW: I'll go. Actually, I have a hard time with this question, Henish, because a little effort for one might be high effort for another. And I think, you know, what Brock just said, like it's a high effort for a group to be able to create the capabilities. Or if we say hey, we want the

government to provide the technical assistance, and so it's a little effort on the community to do that because it's going to be given to them and it's high effort on the government. Right? So whose effort is something that I'm playing with in my head.

DR. BHANSALI: Just to clarify, Dr. Crow, for your specific type of structure, model, et cetera, what would be the lower lift, higher value thing that can improve the work that you're looking to do to progress into total cost of care?

DR. CROW: Yeah. Yeah, I don't have a -- let me just say this and then I'll shut up because I don't have a great answer for you in this one, but I do have an analog that I think about. If, like we as a government really think that this value-based care thing is important, then we've got to go all in, maybe differently.

And I'll go back to like 2004 when, you know, we decided that everyone was going to have an EMR[43]. Think about that. In 2004, people were fighting it. I don't want it. I

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don't want it. And only 15 percent of the country had it. We decided to create -- David Brailer comes on, we create -- we create the regional extension centers. We go full board. In four years, we get to 80 percent. So I almost say that like this -- you all are talking and Jessica talked about hey, I need to go -- in needs to be slow and we need this 10 years, and I'm like -- I sit there, I tell myself yeah, I agree with that. And then I say, you know what? Until we like really decide and go all in, then it won't -- it will always be this little iterative stuff.

You know, we're here in 2025 talking about value-based care, and I started in value-based care in 2006. You know? And so until we like really say we're all in and create the national infrastructure to do that, that would be what would become simple for all of us to say all right, well I guess we're going to do it. And all of the sudden, we have EMRs, and we can all talk about whether that was good or bad. I think we all can agree that it's better than the paper charts that are taking up, you know, closets. Sorry for that.

MR. BARBATI: No, I agree with that. I mean my comment was going to be sort of right on the quality measures in the Medicare program. You've got eCQMs[44] that are, you know, all payer or multi-payer. You know, multi-payer database and/or model with specialty and primary care models that can expand across payers, I think will move the dial. There are -- even ourselves, we have so much infrastructure tied up in trying to meet the demands of individual contracts for different primary care mechanisms and different quality measures and different things, that if we could rechannel that infrastructure into a singular model where every patient gets -- you know, deserves to get the same science. And the way to deliver that science may differ by locale in that last mile, then I think we're actually to move the dial.

Now I realize that, that's a heavy lift, but it could start with some incremental changes like a multi-payer database, some multi-payer methodologies that expand across the board. You know, one small foray into that

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is sort of shadow bundle reports that are going to ACOs, but that's enough. Right? Like that's a small foray that people who, you know, are sophisticated and can have the time to do that work and build a model around it can do it, but it needs to go a step further. Methodologies, risk adjustments, all that sort of stuff could be standard across payers. And then we could really stop wasting time meeting some of those demands and start focusing on the patients and the improvement efforts.

MR. HAMMON: Sure. I mean something simple, I think that could help some of our groups with aligning, you know, attribution, risk. In models like ours, you know, that first-year patient is significantly more expensive, significantly more a draw on profitability. And so, you know, if we're thinking simple solutions, that would allow groups to consider joining, right, if that first-year cohort, can we do something with the risk for that group? And then, you know, as they move through care management -- a good care management process, right, that profitability gets there. Year one is a draw.

You know, something simple as reducing the risk on that first-year cohort would be a potential solution.

DR. BHANSALI: Thank you so much.

CO-CHAIR MILLS: All right. Walter.

DR. LIN: Thank you, Lee. Great discussion. Thank you everyone for sharing their expertise. My question, I'm going to take it down a level and talk about what I refer to as the last mile problem in diabetes care. And that is kind of what Chris referred to in terms of having enough financial incentives to change clinical behavior. Right? So let's just say you have a value-based organization that has a great care model. You're achieving shared savings. My question is to different organizations represented around the table here, how do you get those shared savings to the frontline clinician to sustain their continued change in behavior? I think probably a lot of the answer might lie in what Chris discussed around the importance of ownership and governance. But I talk to a lot of physicians who say, you know, I'm doing what you asked, but I'm not seeing any of the

benefits. And so, you know, I'd love to hear kind of some more tactical suggestions and recommendations around what best of class organizations are doing to sustain the change in clinical practice patterns under diabetes care.

MS. WALRADT: I'll start. And there's lots of different shared savings distribution methodologies and so I'm sure there's, you know, other panelists could probably speak to those in great detail so you can go that route and of course tie distribution of savings, different quality measures. You can even look at individual physical-level benchmarks that are risk-adjusted if you like. But at Northwestern where, you know, the majority of our physicians are employed, we do have financial incentives tied to specific measures. But one thing we're increasingly looking at is pointing out what we've already invested in that they feel every day. So like an AI scribe for example.

Different things that hopefully enable them to practice at top of license and remove some of those kind of daily like pebble

in the shoe type things. To looking forward to the kind of bigger scale investment that we would like to make that would make both their days easier, but also really help their patients, so social workers, pharmacists dedicated to clinics, things like that, that are frankly a win-win for everyone. Good for the patients, good for the physicians, and also would contribute to the success of our VBC contracts.

So aside from the kind of classic shared savings distribution models, we're looking at those infrastructure investments that hopefully enable our clinicians to just better practice at top of license. And I think we give them direct dollars for some of the things that are like the extra click so to speak that really do not feel like top of license, but we can at least tell you like hey, we recognize this is extra work on your part, so we are recognizing that financially.

MR. HAMMON: I think to one of Brock's earlier points, as models change how we -- how we compensate, you know, the physicians change. Right? How the models iterate every

couple of years, right, really throws a wrench in how compensation to physicians' work and really how we incentivize their activity. You know, one of the things that we're contemplating at Duly is how do we -- you know, there's such a dichotomy, right, between the BBC business and the fee-for-service business and how we operate it. How do we break that? Right? How do we -- how do we look at some of Dr. Crow's points, right, the work that we're doing for VBC patients really would benefit our commercial patients as well. And so can we create standard models that work, right, across there. And you know, we begin our 5 percent, 10 percent of VBC patients five to 12 times a year. Or if we had an approach where we looked at our commercial patients that way and had a series of services that we provided to them, maybe it's on a subscription model. As we think about the clinical care model and operationally through a clinic, right, treating every patient more similarly, I think really helps the physician practice, again, back to payers.

DR. CROW: I'll give you kind of our

perspective and give you a specific. So like 70 percent of dollar that comes in go to the physicians. It's been that way with us for over a decade and that's just the way we operate.

Secondly I would say, and Jessica didn't say it this way, but – by the way, I'm a family physician by training and I haven't seen a patient in over a decade, so I'm really useless in that way, but I still do carry that history, which allows me to say things about my fellow physicians that some people don't want to say if they're in an administer role. But it's constantly a what have you done for me lately? Right? And you have to remind them, to your point, that Jessica said, like of the things you're doing for them, you know, quantitatively and qualitatively because they care about three things in differing order, depending on who they are and the time in their career. But they care about their time, they care about their money, and they care about their ego. Okay? And so even family physicians have ego. Not as much as orthopedists, but it's there.

So how do you address that? Knowing that, how do you address that on a regular basis? And so we have a very consistent intentional educational process that we -- that we use and are always iterating on to be close to that physician to make sure we're educating them. Again, I'm in a different stage now because I've now gotten to where they are ready to change the clinical model because they understand the clinical model drives the financial model for them. Seven years ago, none of my doctors wanted to take Medicare. Now they're asking me, can I stop taking commercial for all the reasons you guys have been saying that it's too hard to manage all these things and now the commercial payers haven't paid me any more in the last five years. Right? And so it's a very different mentality, but it comes with consistent education around that.

And then the second one is there's still the cash flow issues. So as we've been able to perform, we've been able to get contracting in ways that brings more dollars into the forefront so we can connect -- begin

to connect the clinical activities to the financial in what used to be 18 months, I got it down to six to nine. And then if I can bridge the gap a couple more months, it's not as -- you know, physicians still have a hard time in reporting just even though they're paid 30 days later in fee-for-service. When I get them their reports, they're like I'm busy right now. Why is this not more? I'm like because you were on spring break six weeks ago.

So you know, it's hard for physicians to be able to match times and dollars. And you have to constantly -- constantly be able to tie those together. And what we do now is we show them, you know, here are the activities in value-based care that are the most important. It's senior high-risk patients. It's hey, how are we doing on medication management or current disease? Hey, what are we doing in the live care? What about our patients that have, you know, end-stage renal disease? What are we doing? I mean it's getting kind of into the right dialogue around their population, rather than them going around the wheel of their exam rooms -- you know,

every three exam rooms. And that takes time, especially when you're someone like us. One of the few that are really pushing the envelope because the national strategy has not gotten to what I asked for earlier, which is let's go all in all this. And so we're constantly swimming upstream trying to slowly, but surely just take little nicks out of it year by year and survive in advance.

MR. SLABACH: And I'll just quickly add – this is Brock here -- that I don't think it's just the physician. It's also the advanced practice providers, the care teams. All of the way in which we're organizing care now is towards a team-based care going to your last mile analogy. And I think that we need to be adding value to the teams that are assigned around each primary care physician. And then having those rewards, I guess, distributed to everyone within the team for the care of the patients that they have on their panel. And I think – and it may be in this environment moving ahead, it's not really so much about encounters on a daily basis, but your panel size and how you manage a group of patients

versus just them individually in an encounter. And that's a whole other way of thinking going forward.

CO-CHAIR MILLS: Okay. Thank you so much for those hard lessons and pearls for the Committee and such rich conversation. It is now 12:10. I'd like to thank all of you for joining us this morning. We really appreciate and respect your valuable time and wisdom. You've helped us cover a lot of ground this morning. I've got pages and pages of pearls, and I'm sure my fellow Committee members do too. You're certainly welcome to stay the rest of the day and listen to as much as you would like to. But at this time, we're going to have a lunch break until 1:10 Eastern Time. Please join us back at 1:10. We have a great set of experts for our first listening session, which focuses on reducing organizational-level barriers affecting participation. Thank you so much. I appreciate your investment today. We are adjourned until 1:10.

(Whereupon, the above-entitled matter went off the record at 12:12 p.m. and resumed at 1:10 p.m.)

*** Listening Session 1: Reducing Organization-Level Barriers Affecting Participation in PB-TCOC Models**

DR. BHANSALI: Welcome back. I'm Henish Bhansali, one of the PTAC Committee members. At this time, I'm excited to welcome four amazing experts for our listening session who will share various perspectives on reducing organization-level barriers affecting participation in population-based total cost of care models. You can find their full biographies and slides posted on the ASPE PTAC website.

At this time, I ask our presenters to go ahead and turn on your video if you haven't already done so. After all four experts have presented, our Committee members will have plenty of time to ask questions. The full biographies of our presenters can be found on the ASPE PTAC website, along with our other materials for today's meeting.

So I'll briefly introduce our guests. Presenting for us is Dr. Clif Gaus, the Past President and Chief Executive Officer of the National Association of ACOs. Welcome

Clif.

DR. GAUS: Thank you. And I think we're about to begin here, so let me just run through my brief number of slides. I have more slides in the deck than I'm going to use. So I want to first introduce everybody to NAACOS[45]. It is certainly the spokesperson for the majority of the ACOs in the country, over 500 members and serving 9.5 million, 13 million beneficiaries in the ACO Program, both CMMI and the MSSP programs. We like to think of ourselves as three-legged, Thought leadership, education, and advocacy. And I should point out that NAACOS is member-owned and member-governed, and it's a nonprofit association of ACOs.

Next slide. So this is kind of my depiction of where we have been. And over a decade, certainly the ACO model has grown from the beginning to now over 13 million traditional Medicare beneficiaries in the models, over 700,000 clinicians. And a pretty good record, though not as significant a savings record as those of us who were in the

45 National Association of ACOs

early years of creating the program thought would occur. But it is one of the -- it's probably the only Medicare value model that has consistently shown savings over the last 10 or 11 years. And those savings are, like I said, not what all expected, they are not insignificant with gross savings of over $28 billion not counting the 2024 experiences, which are substantial as well. And 100 percent of the ACOs have met the quality standards.

Next slide. I'm going to talk mainly about benchmarks, but I wanted folks to kind of see my perspective on sort of what the adoption challenges have been. And basically there still is significant misaligned incentives sometimes for certain physician groups remaining in the fee-for-service mode can still be the stronger financial option. There's a huge investment required to transition to value and even a bigger investment needed to participate in one of the federal programs just because of the overhead. There's burden associated with the quality reporting in those programs. And the last probably impediment is the whole issue of

benchmarks, which I'm going to devote most of my remaining two minutes here on.

Next slide. The benchmark challenges that have stalled participation include setting -- well first of all, the goals are to set the budget for treating patient populations and getting a historical spending, the start point right has been obviously a big challenge. There's also the accounting for individual patient factors. No ACO, no physician group treats the same kind of patients, and those factors affect the cost tremendously. And therefore, trying to adjust for those has really been an important and significant challenge. And then once the benchmarks are set, accounting for the changes in spending patterns are always a challenge. And we have a whole range of methods that adjust for those, but they're not perfect by any means.

Next slide. This right here, it's a portrayal. I'm not going to go through the details of it. But the two major programs, kind of care are MSSP and ACO REACH. And we put in this chart sort of also MA because there's been a lot of discussion of recent

about -- of how can there be a more level playing field between the value-based care programs of Medicare, MSSP and REACH, and MA. And as you know, from more recent literature, but also literature from as long ago as 10 years, the MA program has prospered -- prospered well. It is the dominant program in Medicare now. And however, it is that program in large part because of the subsidies that are inherent in the MA financial model. I won't go into those in detail, but there is a need over the long term and maybe we can discuss this in our conversations later, about what some of those changes might be implemented to provide a more level playing field for both patients and providers.

Next slide. So in terms of benchmark challenges, the three components of the benchmarking are one, setting the actual start point, and it's not as simple as everyone would think. Traditionally it had in almost every program, it is finding out -- determining that historical spend for that group of patients for whom the ACO is responsible for. And that also includes over the long term, and

I'll mention this a little bit longer, the ratchet effect. And where that has now become a major impediment for new ACO growth and for continuation of some ACOs in the program.

The MSSP program has implemented a variety of adjustments over time in their policies to adjust for changes in spending, regional adjustments, prior saving adjustments, trend factors. And mentioning trend factors, the perspective trends create certainty, but they are also inaccurate. And no one can predict precisely what our costs are going to be next year, nor for the next five years, which the newest of the MSSP models have incorporated a factor in ACPT[46], Accountable Care Perspective Trend that locks in a trend for new contractors, new contractees for five years. And as we found in our recent analyses, this estimate presumably is significantly off -- for 2024. And ACOs are in a position here where they're going to be potentially significantly harmed by just an inaccurate estimate that's getting locked into the five years of spending.

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And then lastly, the risk adjustment component of benchmarking is a -- is probably one of the largest differences between MAs and the Medicare accountable care models. HCC[47] scores are used in both programs, but there are caps that are on the accountable care entities. There are caps on rising scores, and those are not the case in MA. And that has been one of the attributing factors to why MA has become such a big growth -- in a growth pattern and the preferred financial model in Medicare for both -- from physicians and participation.

So I think that wraps up. In conclusion, I do have one more slide. How do we improve the program? Well, we need to make the benchmarks more predictable and stable. We need to allow for adjustments when the predictions fail, and this is debate we're entering into now. My colleagues at NAACOS have before them a major challenge to communicate with the new administration about how to fix this misalignment that occurred in the estimates for the 2024 reconciliations. And certainly to provide the ACOs a more level

47 Hierarchical condition category

playing field with MA. Also improving the business case in general to grow the beneficiaries in traditional Medicare into the accountable care models.

And then lastly, a better way of increasing the inclusion of past savings into new benchmarks to avoid this, I call it the death spiral. It's really -- it's a ratcheting down of benchmarks. As an ACO improves, what it does and what it saves, each benchmark gets harder to meet. And that occurs especially when the contract is renewing. So I'll close here and turn it over to my colleagues.

DR. BHANSALI: Thank you so much, Clif. We're saving all questions from the Committee until the end of all presentations. Next, we're excited to welcome Dr. David Johnson, Assistant Professor of Urology at the University of North Carolina and Clinical Operating Partner at Rubicon Founders. Please go ahead, David.

DR. JOHNSON: Thank you, Dr. Bhansali, and thank you to the PTAC for inviting me to speak. My name is David Johnson. I'm a Clinical Operating Partner at

Rubicon Founders, practicing Urologic Oncologist at UNC Chapel Hill. And prior to joining Rubicon Founders was the Medical Director for Value Transformation at Blue Cross in North Carolina. I'll be speaking today about the role of conveners and increasing participation in population-based total cost of care models. And all views are my own and don't represent my current or past employers.

Next slide please. So in the context of population-based total cost of care models, I refer to a convener as an organization or an entity that engages multiple stakeholders to facilitate the implementation and execution of value-based care models. Conveners engage stakeholders differently based on their specific model, but in general, the convener is the risk-bearing contract holder with the payer. Payers can mean anything from, you know, commercial plans, MA plans, CMMI as previously eluded to in the last talk, or at-risk PCP groups as well. So payer can be a broad term in this context.

Secondly, the conveners engage or partner with a provider organization. They can

partner in terms of care delivery. They can also partner to align financial incentives and work together to deliver on the outcomes of that total cost of care population-based contract. We're going to hear from a couple of, you know, sophisticated and in one case, integrated health care systems coming up here. And so just keeping in mind really what I'm talking about here refers to primarily to independent community physician groups that are interested in participating in these total cost of care models.

And finally in terms of patient engagement, it's also variable based on the type of provider group that the convener is working with, the services that the convener is set up to provide, and then also the contract terms. And again, while many of the principles that I'm speaking about today very much apply to the primary care models, my main focus here is actually on how conveners can enable specialists to participate in these type of risk models as well.

Next slide. So with that in mind, you know, it's worth noting that specialists

like myself, we're trained to deliver reactive, episodic, transactional, face-to-face, and hands-on care. And the systems that we practice in are set up to optimize and facilitate this type of care. And so Clif introduced some of the barriers in the prior talk, but when we think about just, you know, some of the basic requirements that provider organizations need to master or at least have to directly assume financial accountability for both medical costs and outcomes for an entire population of patients, it's not surprising that this feels like a pretty steep mountain climb. In particular with specialists, you know, there's been challenges on adoption because of a lot of these requirements and reasons. So in the next few minutes, I'll discuss how conveners can help play a role in supporting practices to meet these requirements to make participation feasible.

Next slide please. So first, population-based total cost of care model fundamentally requires a sufficiently large population to achieve actuary stability. We just heard a little bit about all the

challenges of benchmarking on a large primary care population. And when we start thinking about smaller populations and more specific populations, all of those issues are further amplified. And so as we move beyond primary accountability -- primary care accountability rather, providers are increasingly taking risk on more narrow populations sometimes defined by an entire specialty service line like cardiology or even a set of clinical conditions like in the GI space with inflammatory bowel disease.

And so conveners are often required to aggregate risk across multiple practices, geographies, lines of business, and payers just so even moderately-sized physician practices can participate in these models. And again, as Clif discussed in great detail, the actuarial exercise to set these benchmarks is extremely challenging. And your typical specialty practice lacks in any actuarial expertise to validate what they're signing up for in these risk models. And so conveners can be helpful in this way by helping identify cost variation, looking at savings opportunities, and helping

project forward future expenditures in order to validate the viability of this type of risk model for specific populations and for specific provider groups.

Next slide please. And from a financial standpoint, in order to meaningfully participate in risk, it requires significant cash reserves and financial capital for care transformation investments. And unfortunately provider groups are not sitting on mountains of cash like insurance companies, so they don't have the financial wherewithal to ride out down years or errors or misses on the benchmark as we just discussed. So conveners can help by shielding provider groups from this downside risk, as well as maintaining adequate cash reserves to meet statutory requirements for taking two-sided risks in the first place.

Additionally, significant up-front investments are required to successfully deliver on population-based outcomes, particularly when being implemented in a traditionally reactive transactional fee-for-service environment. And so conveners are often necessary for that initial outlay and

ongoing outlay of capital for investments in things like clinical infrastructure, additional staff, particularly those that don't generate revenue but are high-value in a fee-for-service world, and technology, including population health management tools, technology to collect and act on patient-reported outcomes and performance dashboards for quality reporting.

Next slide please. So another foundational requirement for managing total cost of care of a population is having a complete and real-time view into what's going on with the patient outside of the clinical walls. So as we know, our fragmented health care delivery system results in an even more fragmented system of information sharing on patients. And so conveners are often able and required to make investments in real-time aggregation of both clinical and claims data, as well as collecting and identifying other barriers to health such as social determinants that are not always top of mind for providers seeing a patient day to day in the clinic.

And finally, specialty providers that want to successfully manage total cost of

care must really make a shift in their clinical focus from a reactive transactional fixing of a problem once it occurs to a more upstream approach and early detection and prevention, and when appropriate, conservative management. And as eluded to previously, specialty care delivery care systems are set up to thrive financially through volume and productivity under the traditional fee-for-service incentives. And so providers must be willing to undergo what's really not a trivial clinical mindset shift. Conveners can support this shift by helping integrate innovative high-value care models into clinical practice, which in my experience can only have a transformative impact if they're evidence-based, both patient- and provider-centered, and done in close collaboration with frontline clinicians. And importantly, they have to coincide with meaningful, attainable outcome space incentives.

Next slide please. So I'll close by calling out the obvious, that all conveners are not the same. So it's important when a provider is evaluating -- partnering with a

convener to understand what are the actual services and functions that are offered by this convener? What is the convener's business model? How are they adding value to the practice? How are they making money in their contract? It's also important to understand how these services and functions integrate into the core clinical operations of that provider care delivery system, especially how it's going to impact the patient's experience. It's also very important to make sure that the care delivery vision of that convener is aligned with the partner practice and that financial incentives are also aligned in the right direction.

Finally, payers must consider why a convener is better suited to provide the services or functions than the practice. It's obviously necessary in a lot of ways to bring additional capabilities to these providers, but it is adding another entity and some call it a third party into the mix, and so there must be a justification for that. The payers should also look at what is the degree of practice integration and provider buy-in that's required

for success? And part of that really relies on how attractive the convener's clinical model and partnership model is for network practices. The payer must also consider whether the convener is willing to take on downside risks, and whether the payer goals actually align with the goals of the convener and the business model.

So thank you very much for your attention and I look forward to the question-and-answer session. Thank you.

DR. BHANSALI: Thank you so much, David. Now we are happy to welcome back our former PTAC Co-Chair, Dr. Angelo Sinopoli, thankfully who is the Executive Vice President of Value-Based Care at Cone Health. It is great to have you here, Angelo.

DR. SINOPOLI: Thank you. It's great to see all my previous PTAC colleagues. I've missed seeing you all and participating in the discussions, so thanks for inviting me back.

As was stated, I'm a Pulmonary Critical Care physician. I spent most of my career as Chief Clinical Officer of large

health systems, although I did spend a two-year stint working in a venture capital of a backed convener organization. So I have a little bit of experience on both sides of the equation. But to the point, I'm going to be spending most of my time today talking about health systems, their clinical integration efforts, and their barriers to clinical integration.

We can go to the next slide. So kind of starting out with what is clinical integration. And obviously there's different levels of clinical integration. I will point out also that I forgot to mention that Cone Health is now a member of Risant, which is an entity that was developed by Kaiser to support health systems across the country who are interested in having strong history of value-based care. Cone is the second health system in that structure, the first being Geisinger. And so we are working together, you know, across Kaiser, Geisinger, and Cone Health to develop clinical integration and value-based care products.

So when you think about clinical integration, it's more than just a group of

docs agreeing on a set of quality measures to measure themselves against. It's really bringing hospitals together, physicians together, care teams together. And to focus on quality efficiency outcomes and affordability, you've got to have great physician leadership. I used to call it, you have to have a mad man present to really drive that sustainability. And certainly care coordination data and aligned financial incentives.

Next slide. So this depicts more of an integrated health care delivery system. So if you think about care from the home, then you think about virtual care community resources, mobile clinics, retail pharmacies, all the way up to the most expensive hospital admissions and then post-hospital for rehab, skilled nursing outpatient, and then back to home. So the real goal for health systems in this arena is to clinically integrate all of those assets to make patient experiences seamless. What that requires is a data and technology system that spans that entire set of assets that drives data and patients across the system seamlessly so that you're not throwing patients

over the wall as I describe it sometimes. You also have to have a horizontal care management care coordination disease management group that's managing those patients across that continuum, along with those technologies.

Next set. So this is what it would look like in a different depiction here. So again, utilizing EMS[48], utilizing mobile clinics, all your community resources. And we've frequently described this as having a medical neighborhood approach with our health care assets reaching out into the community. And also developing an accountable communities approach when we're working with community-based organizations, county and state agencies, et cetera, to integrate care across all of our geographies.

Next slide. So you know, one of the big things that helps us to run into and as do practices is that, you know, there's a foot in both canoes; fee-for-service and in APMs. And it is very difficult to really transform care until you hit about 40 to 50 percent of practices, patient panels under some type of

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significant value-based care. Also until you get to that point, you're not really seeing enough value-based care to cover the start-up cost of entering those kind of products. There was one estimate in 2016 that the start-up cost for this was about $1.8 million, which was much higher than the CMS estimates were when they started these programs. And actually at the time, one of the Health and Human Services Secretaries quoted a Midwestern ACO that start-up cost was actually $30 million. And so it's very hard to think of covering that with a small APM, with a small amount of your practice in APM models.

Next slide please. So you know, part of the answer to that is to extend beyond just MSSP or REACH programs. You've really got to get a point in a health system or a practice where the majority of your patients earned some type of risk arrangements. So reaching beyond Medicare to Medicare Advantage to Medicaid to commercial payers, some organizations have their own provider owned health plan and direct to employer contracting. As you add those up, then the practices and the health system reach

a critical mass, such that they have enough patients under that kind of payment model to really be able to transform care. Up until then, the fee-for-service always outweighs the need to manage care and to keep people out of the hospital. Once you reach 50 to 60 percent of your patients under this kind of arrangement, then all of the sudden, an admission does become an expense. And the investment and all those tools and clinical integration becomes justifiable from a finance standpoint. And I always make the case that the uninsured is 100 percent insured by the health system since we are responsible for those.

Next slide. So again, what enables clinical integration is certainly a critical mass of APM patients, the proper governance and physician engagement, the proper financial incentives. Unfortunately right now the value-based care payment model is emphasized as the financial side of that, but really doesn't pay for clinical integration per se. The technology, care coordination, patient engagement, contractual and legal mechanisms

are all required to create true clinical integration.

Next slide. So luckily -- particularly from a health systems standpoint, the more risk that you are taking -- so if you're only doing contracts that give you pay for quality or you know, very low levels of risk, there's a lot of restrictions in what you can do to support your doctors to create alignment and to create that clinical integration. As you move to where you're having significant amounts of downside risk, global risk arrangements systems where, you know, 30 to 40 percent of their revenues are related to some pre-PMPM[49], then the 2020 OIG[50] file rules actually allow for a lot of flexibility and what you can do for physicians to help pay for care coordination, to help with their technology needs, et cetera. Next slide.

Also with -- this is just another slide to outline some of the restrictions that are -- that OIG covered in that 2020 release.

Next slide. And also being able to provide stronger incentives for specialists to

49 Per-member-per-month
50 Office of Inspector General

participate, we have a lot of embedded bundles within our ACO for our specialists, and we're able to design those and have them gainshare in those things within the ACO model within that shared savings arrangement. We've been able to engage specialists quite well in that model.

Next slide. For small ACOs, you know, they don't necessarily have that opportunity. They have limited risk pools and a lot of statistical variability and, you know, they probably need to stay focused on high-impact interventions, leverage partnerships and new conveners, et cetera, to help them achieve that level of integration they need and the financial risk they need.

Next slide. And so this is just a summary of modernizing the incentives and physician alignment. I think we have to move in a direction where we have to move beyond just the Medicare risk arrangements and get to a point where our practices and systems are more fully involved in Alternative Payment Models to really justify the expense and the care transformations to be able to do well.

Next slide. I'll stop there. Thank

you.

DR. BHANSALI: Thank you so much, Angelo.

Next, we are excited to welcome Mr. Dan Liljenquist, Chief Strategy Officer at Intermountain Health.

Welcome, Dan.

MR. LILJENQUIST: Thank you, good to be here and appreciate the comments from David, Clif, and Angelo, and agree with the sentiments they've expressed.

I'm going to maybe click through just a couple of slides to get to the meat of what I would like to do.

Here's a little bit about me. I don't want to dwell here, but I do want to talk if you'll go to the next slide, a little bit about Intermountain's position.

We are a large integrated delivery system. We have 30-plus hospitals; about 400 clinics.

We operate in six states and have about 48 -- or 68,000 caregivers that work, that work with us every day.

Our mission is to help people live

the healthiest lives possible. This is a pretty unique mission in health care. It's one of the reasons why I love being here at Intermountain.

I've been here coming up on 13 years, and in this role as Chief Strategy Officer, for the last six.

Our mission used to be excellence in the provision of health care services. And about a decade ago, we changed it to this mission statement believing that, that we can do better than just to wait for people to be chronically sick and try to patch them up at the end of their lives.

That we, if we reoriented our delivery system towards helping people live healthier lives, we could create an economic model that makes sense.

Our vision is to be a model health system. This when Intermountain was formed in 1975 by the Church of Jesus Christ of Latter-Day Saints, donating the then 15 hospitals to the community, they stepped out of governance entirely, and gave us, left us this charge to be a model system.

If you go to the next slide, please.

Here is our strategy. This is built right off of that mission statement of helping people live the healthiest lives possible, and our vision to be a model health system.

Our strategy at Intermountain, what we believe the best expression of that mission, is when we take full clinical and financial accountability for the health of more people; partner to keep those people well; and coordinate and provide the best possible care.

That first part of that, taking full clinical and financial accountability. We want to, as Angelo spoke about, we want to align and send it in such a way that every time we keep somebody well, and on their medications, and out of a facility, if we've been pre-paid every dollar of cost reduction is a dollar of value creation, it is way better for the patient.

It's better for us and it creates an economic model that, that we can be proud of as we seek to do our work.

We are focused on two major system initiatives to advance our strategy. The first is simplifying what we do for our caregivers,

patients, and members.

About 62, I think it was roughly 62 percent of people polled believe that health care was deliberately designed to be confusing.

And when you see all of the different avenues of care, all the different options, we hand people essentially an insurance card, and when everything is on the line, wish them the very best to go figure out what they need.

And that's where the lack of coordination of care; lack of awareness about how the systems work has really hurt our ability to meet people where they are and help them find what they need.

And that complexity exists for our caregivers. So everybody who works at Intermountain is a caregiver whether you're involved in direct patient care, or you support those who do that work.

But the level of complexity that we're dealing with inside of our organization is massive.

And it's just as confusing if not more confusing, for the people we aspire to

serve, our patients and our members.

So we are working very, very systematically to identify and remove friction in our system, to be much more situationally aware of where patients are, what they need, what's the next right action they need us to take on their behalf.

So, if they need engagement around and so we're orienting really all of our clinical systems, and our analytics around, around that goal.

To be aware of situationally, we're much more situationally aware than we've ever been about what's happening to patients.

And that requires real-time awareness. It doesn't do you any good if it's, if you're waiting for a claims payment or claims reconciliation two weeks later, to know what's the next right move to make for a patient today.

We're also working on expanding proactive care, and Angelo spoke about this a little bit.

I'm speaking specifically around the need to expand these models. We all live in

with a foot in two canoes of Intermountain's roughly $18 billion to spend, or of revenue. About $5 billion is fully capitated.

So, we are very squarely in both boats.

We believe that doing the right thing doesn't necessarily require you to do materially different things.

But we do know this. That if we collapsed Intermountain's payment levels to the Medicare payment levels in the states we're in, we would go from being one of the healthiest health systems in the country to losing over a billion dollars, if not closer to $2 billion a year.

The gap between commercial payment and where our Medicare benchmarks are in our area, just make it incredibly important to make sure that we have models that work for our commercial business.

And in the commercial world, two-thirds of that commercial business is in ASO[51] models, self-insured models, large employer models.

51 Administrative Services Only

And so, we are really working how do we create proactive care models that work for commercial populations?

And that's meaningful to us. I'm the son of an endocrinologist. I grew up around diabetes. My brother is an endocrinologist as well.

It is, if we are only waiting until somebody turns 65 to engage on a metabolic disease, we will, we miss the real opportunity to change their lives.

We should be engaging effectively in people in their 30s, 40s, 50s, when we can actually avert the complications of Type 2 diabetes.

We are very concerned that the focus on payment models that are only for Medicare, dramatically risk a whole generation of people that if we engage more effectively, we could avert some of the crises.

Add on to that, we're very concerned over the next five years, a full quarter of Intermountain's doctors and nurses are retiring. They are in the baby boom cohort.

If we hired every doctor and every

nurse out of every single program in all of the states we operate in, and retained all of them, we will be thousands of providers short given the massive increase in demand, and the retraction in supply.

So, unless we change how we deliver care, we will be leaving people behind. And unfortunately, we think it will be leaving those patients in their 30s, 40s, and 50s, who could really use proactive interventions to avoid, for example, developing metabolic disease.

That our system will be so focused on caring for the baby boom cohort, who is average age now is 71. They weren't expensive at 65. They're going to be very expensive at 75 and 80.

And we're trying to figure out how to balance out the needs of our broader community with an unprecedented retraction in the supply of providers. We have to do our work.

So, as you look at the bottom here, and I'll finish with maybe just a couple of comments. Our focus investments at

Intermountain, we are adopting cutting edge technology.

We are leaning into AI. We are leaning into ambient listening. We are leaning into those tools that help our providers be as efficient as they can be.

We are working on streamlining the consumer experience process, so we know situationally, how to lower the friction points for people to access the care we do provide.

And then, we're reimagining our work. We are investigating every opportunity we can explore, to decant volume out of doctors' offices to other settings.

For example, we're working on a centralized medication titration refill and preauthorization center so that we don't have to have our doctors taking up time for routine, for routine, you know, prescription refills.

Trying to find that extra three or four slots a day that we can open up in a physician's schedule to handle more patients.

We're working on growing our Atlas Payments, believing that if we do this, we can better align our system around what meeting

patients where they are, when their conditions are less acute.

And helping them along their way in a low-cost model, but in a model that helps us move upstream, but also sustain our economics.

And then, we are on the bottom here, the bottom right here, creating expanded, expanding proactive care models.

We're really working with our clinicians, with our medical, with our clinical programs, on road mapping what is the right standard of care for somebody in their 30s, 40s, 50s.

How often do we need to see them? How do we make sure that we are staying in touch with those communities and at the same time, trying to absorb the largest cohort coming into Medicare in the history of the program?

So, maybe finish with the next slide. How do you do all this? We are working to build trust with our providers. Always communicating.

One of the things we're working on is really getting to the point where we have

daily visibility into how we're performing on our risk-based arrangements.

And not only, just at the program level for Medicare ACO, but also inside our hospitals to be situationally aware of the patients we have in our hospitals that are on at-risk arrangements, so that our hospital administrators can better be aligned with the work we're trying to do to keep people well and out of the hospitals.

If you'll go to the next slide and then I'll wrap up.

How do you do this? We are really going through a lot of change management with our 5,000-plus employee providers here at Intermountain.

And it's maybe the most important thing we've learned is that we've got to listen. We need to act. We need to report back. We need to make sure that we are encouraging this feedback loop.

Because what I've found, what we've found at Intermountain is our clinicians are bought into the vision of what we're trying to do. And that's encouraging.

I think the models that we built across this country are going to be enormously stressed over the next 10 years.

And the only way that we've found to be effective in reducing physician burnout is just being highly engaged with what they're experiencing in their daily lives.

And this is, this process, this simple process has helped us increase our engagement and keep our clinicians here, instead of choosing to opt into concierge models and just throw their hands up on the whole system.

So, with that I'll just turn the time back over to you, Mr. Chair, and appreciate the opportunity to be here.

DR. BHANSALI: Thank you, Dan.

Now we will open up to discussion to our Committee members. So at this time, PTAC members, please flip your name tent tag up or raise your hand and Josh, and if you have questions for our guests.

Yes, Krishna?

MR. RAMACHANDRAN: This is probably more for David, I think.

Just curious on best practices you have around how payments can be made to convenors, particularly for specialty-based models.

DR. JOHNSON: Yes, it's a great question.

I think in general, there really are two issues with sort of the payment flow between convenors and their partner practices.

One is that it takes a long time to change the health of a population. A lot of the interventions take years to actually generate the savings that result in the shared savings payment, or the outcomes-based incentive payment.

The second is that the fact that we have to wait an entire performance year and then six, nine, 10 months for reconciliation.

Once we actually generate the savings, it's challenging for the convenor to sort of keep the providers engaged and interested if they're not really seeing what, the work they're putting in bear fruit in terms of the value-based payment contract.

And so, a lot of what we're trying

to figure out is how do we have a different payment flow that's occurring during the year that we're taking risk and passing that along to the provider partners.

A lot of these convenors are backed by financial institutions, like Rubicon Founders, for example.

And the reason is because it requires so much of that up-front investment to sort of sustain that period of time to get payments flowing back to our partners, which is the ultimate goal, to reallocate those resources.

So, best practice is if there's ways for payers to sort of be understanding about the need to front payments as really cash flow, payers are at this point, wanting all dollars that they're paying out to be at risk for these types of arrangements.

But some lay the front, the flow of funds so that we can keep our providers engaged.

And then also, having a reasonable ramp to two-sided risk even with convenors, understanding the time it takes for shared

savings to actually materialize.

Again, given the sort of uncertainty about benchmarks and how challenging it is to baseline these types of populations.

MR. RAMACHANDRAN: Helpful, thank you.

DR. BOTSFORD: Larry?

DR. KOSINSKI: Thank you. So nice to see some friendly faces here.

I'm going to start with just a follow up for David. David, you know very well that Sonar has been -- it's a convenor.

And you worked with us to ultimately gave us a contract with Blue Cross of North Carolina, so I appreciate all that.

But those prospective payments are really necessary. And the convenor many times has to take risk on that.

Has to take risk on that up-front payment in order to be able to carry this to a point where you can have a reconciliation down the line. The provider certainly can't.

But my question and this can go to all four of you, has to do with the ASO model. It was brought up multiple times.

How do we have a convenor in an ACO model -- in an ASO model where the health plan really doesn't want to go and renegotiate every single contract with each of its self-funded employer clients?

This is a major impediment. The health plans will do it if it's, if they have full risk on that patient population.

But in the ASO model, you have to do other models like develop a friendly PC[52] model where you're billing a CPT[53] code.

Have any of you come up with solutions for a convenor in an ASO model?

DR. JOHNSON: I can give a quick response to that, and then yes, happy to turn it over.

We worked with some convenors in the kidney space in North Carolina and were able to get our ASO customers in that model because there was a broader payer infrastructure for value-based payments, that these additional convenor-based models kind of rolled up into.

The challenge is really getting the employer groups to understand that if they're

52 Primary care
53 Current Procedural Terminology

paying more dollars in their value line item, that that means because it's more than that was saved to get that, that payment.

And that's a sales issue, an education issue. But if there's a way to kind of tuck that in under a broader value program on the payer side, that's sort of how I've done it before.

But interested in other's opinions as well.

MR. LILJENQUIST: Okay, maybe I would just add look, what we're finding here at Intermountain is our large employers are coming to us, and they're saying hey, I've got an insurance card that says I have your network, and I can't get in to see anybody.

And we have 10s of millions of phone calls we take every year and it's basically the elderly population calling every five minutes.

We have massive displacement of people who have been with their doctors for years and years, and their doctor retired right when they have needs.

Doing nothing if we're not deliberate about this, we could be absolutely

overwhelmed by the Medicare population alone.

The needs are so big, and the retraction is so significant, they are already seeing a substantial rationing of care.

And that rationing of care is coming for people with commercial insurance, who can't see a doctor. And can't see a primary care doctor.

We'll do surgeries on them because they pay well, and you can get in for those, but we're talking basic, routine care.

So what we're working on at Intermountain is trying to figure out okay, as we go and work with these large employers, we're exploring sub-capitation models for primary care alone with of course, bonding guarantee for same day access.

And give us a sub-cap for primary care. You're paying a lot of this. You're just paying it through emergency departments, or deferred care, or deferred costs.

And then, with the goal to match that up with newer and less cost-intensive modes of care for those people.

Like for example, we may, we were

exploring moving to a once every three-year primary care visit, but same day access if you have an emergent, if you have a fever or some sort of thing that might require you to see an urgent care.

And even go back and say regardless of this location if we, where we treat you, if it's this certain condition, we'll cover that in a sub-cap.

So, we're doing a lot of that work right now, and frankly, our large employers who have folks in our states are saying hey, that's something I'll pay for.

And it's essentially paying for some access so that they can get their people in to see folks.

So, we're trying to balance that out, but I don't know if that makes sense to you, Larry, but that's some of the stuff we're exploring.

DR. GAUS: Yes, I'll just add one thing that we have looked at that over the years, and toyed with the idea is there a way to create a value network that would make it easier for the payers to on behalf of their ASO

contracts, to contract for certain, certain kinds of services, capitation or otherwise.

It's just a costly, really costly undertaking to do something like that. We were just never able to do it. But it is a serious problem, so, yes, but no easy solution I'm afraid.

DR. SINOPOLI: So, and Larry, our experience have been more like Dan's is that we've not really figured out a broad umbrella ASO type approach.

But we've approached individual employers and offered them a spectrum of services that go all the way from minimal services, same day access, sub-capitations up to total risk with risk quarters.

But we've had to do that large employer by large employer. We've not really had another mechanism for doing that through a payer.

DR. KOSINSKI: I do have a follow-up question for Clif on benchmarking.

One of the things that I see in my day job is that when we have private practices that are being compared against hospital-based

provider groups and we have a risk adjustment that's made between the two.

The private practice always loses out on the risk adjustment to the hospital-based systems, and there's always a negative adjustment back because of the coding.

The systems do a much, much better job at risk-based coding, than the independent practices do.

Do you have any solutions in that regard?

DR. GAUS: Not easy ones, but I, coding underlie. The coding problems and all of the inequities in it underlie so much here of I think the problems in both benchmarking the reconciliations and as I mentioned earlier, the disproportionate difference between MA and accountable care models.

One of the benefits I think of the convenors, and they have now are playing a much bigger role.

I mean when NAACOS was started, when ACO program was started, there literally were less than 5 percent of the ACOs in that first few cohorts. They were part of a multisystem.

Now, there's over 50 percent of the ACOs are part of the -- either the convenors or the multi-hospital systems.

And the convenors do bring, do bring new technology, coding technology. I'm not necessarily endorsing that, but frankly, they do put the individual private physician practices on a more even keel I think, with the capabilities of the hospital systems for coding.

It's a whack-a-mole game though. And somehow I am hoping we can address this fundamental problem soon.

It's driving, of course, the trust funds to a faster liquidation, and it is just not a fair system to providers or frankly, to the taxpayer.

So, it is, but there is no simple solution I'm afraid.

DR. KOSINSKI: There's no financial incentive for a doctor to improve his or her coding. They're going to get paid the same no matter how they code unless they're in a risk-based contract. Thank you.

DR. GAUS: That is correct. That is

correct.

DR. BHANSALI: Lee, and then Jay.

CO-CHAIR MILLS: Thank you.

This question is first for Angelo, but then I would certainly invite everybody's thoughts on it.

And this is I want to ask your insight and wisdom to a piece of the ecology here that I've long been concerned about and asked questions about.

And that's to borrow Dr. Lin's phrase, that's the last mile in value-based payment.

So, we do see increasingly in Medicare Advantage plans and some commercial contracts, you know they're paid as a capitation from payer or some value-based arrangement from the payer to their contracted network.

Yet the contracted network's employers of physicians by and large, still hugely pay their physicians fee-for-service.

And I'm not saying that's absolutely required to see behavior change, but it certainly facilitates behavior change if you're

paid to care for a population and not to produce RVUs[54].

I've thought a lot of this is tied up into the fair market valuation rules, and the facts that systems counsel and compliance staff are very conservative.

And it's just not changing to understand that you can pay on different bases. You mentioned the 2020 OIG final rule and reinterpretation. I just don't think that's really percolated through systems yet.

So, love your comments on what types of physician compensation arrangements you found most effective to change the mind set to caring for a population while still balancing needs for access, and productive career physicians, that sort of thing.

DR. SINOPOLI: Thank you for that question.

And yes, as you know I agree with you 100 percent with that. I think it's multifactorial.

So again, as networks initially enter APMs, and they may be on a value payment

54 Relative value units

only kind of model, their hands are really tied in terms of what you can do for practices.

Because their base salary has to be linked to fair market value. But as you move to more global risk arrangements and you get more and more global risk, then you do get leeway to do other types of support.

And the shared savings is not always predictable. It's not always something that you can rely on to incentivize.

And there's always delays you know as mentioned before, as to when you're going to get that shared savings.

And so, once you reach a certain level of risk, then you do have through the 2020 OIG rules, an ability to pay physicians for things other than their shared savings. And I'm not an attorney, but I know that this is the case.

And so, you can pay for such things as care coordination efforts. You can embed staff in those practices.

You can pay for process improvement projects, things that you need to have done for the network.

So, there's an array of those kinds of things, and you can also supply in-kind services for them like ambient listening.

Like a majority if sometimes not all of their EMR, as long as they're fully integrated, which goes back to some of those coding questions.

If you've got an ambient listening device that actually imbeds the note in an EMR, which there is a handful that will do that, then the EMR can capture those codes and more sure that you're getting accurate coding on those things.

So, there's a lot of leeway in there. I think you have to really judge what, how much risk are you taking does that get you past the thresholds for the OIG regulations, and you certainly have legal input into that.

But that actually drives the clinical integration in the bigger systems that take advantage of that because it's not just a fee-for-service.

And then maybe you'll get some shared savings down the road. They're being paid to produce quality and clinical

integration.

So, does that answer your question?

MR. LILJENQUIST: Maybe I would just add, Angelo, well, well said. You know there is more flexibility in these models than you would have in other ways.

And again, the value goes to the patient. If you're improving that care, there's more leeway.

I would say another big concern that we've had is that there's the unpredictable nature and I think Clif, you got to this, the unpredictable nature of what are the economics going to look like, are a challenge.

And you can be a large sophisticated, integrated delivery system like ours and still be stuck on the wrong side of a contract.

Especially on MA when a plan gooses up your benefits and you're in a full-risk arrangement, they can shift a lot of risk to you, and they do.

And so, over the years we've had significant conversations with our payer partners and had to move away from some of them

because the temptation to shoot for a short-term quarterly earnings at the expense of the broader network, is real.

And I think we're seeing that with version 28. A retrenchment of all of the larger MA players. And they are doing what they can to keep their quarterly earnings, but without the risk adjustment; without the HCC uplift they've had.

They're denying claims, and they're also shifting risk by adding benefits and then using the contracts against their providers.

And what that's done, it's dramatically reduced the willingness of individual providers who have low capitalization as David talked about, and who are terrified of bearing downside risk, it literally could wipe them out.

And we've had our challenges as a large sophisticated system ourselves.

So, there's just if I were a provider and thinking about betting my practice, I would have a hard time betting on value-based care if I were -- like my brother.

He's not doing it. He'll take

upside only contracts. But if the rules change and some contracting mechanism he doesn't understand moves, it could wipe out his practice.

And so, I do think you know the more transparency there is about what particularly the rules will be, the more you can have people invest.

And I served in the Utah state senate, and I ran Utah's Medicaid ACO legislation. And we had tried managed care in the ’90s.

And essentially what happened, the reason why it fell apart in Utah as we learned, was that every time you organized to keep somebody well, middlemen or some extra would come back and say well, the people you were caring for weren't that sick.

And so, you would have the savings taken off the table. And what it was is it was a one-way deal where the state benefitted, and the practices didn't.

And so, you know we tried and the legislation I ran in 2011 tried to address that. But it really comes down to creating

clear rules and being comfortable with what the shared saving is with the government program with the providers.

And I could go on a little bit about what we did in Utah around that, but I do think this is an unpredictable environment for most of our providers.

And unless it becomes more predictable, it's going to be left to large systems like Risant, like Intermountain and others, who are willing to take these steps.

But it's going to be more difficult for individual providers to even participate or know how to do it.

So, just my view but I'm happy to defer to anybody else.

DR. BHANSALI: Jay, to you.

DR. FELDSTEIN: I'd like to thank everybody for participating this afternoon.

I'm going to change, shift gears a little bit and ask each of you how your organization is approaching using AI in terms of your workflows, your processes, whether it's clinical integration, whether it's ambient listening, AI scribes. Whether it's predictive

modeling.

How are you approaching it? Are you early adopters? Are you letting your existing software vendors incorporate into their own products?

I'm just curious how each of your organizations are approaching it.

MR. LILJENQUIST: Jay, I'm happy to hit it fast from Intermountain's side. We have offered to all of our doctors, DAX copilot ambient listening. And in all settings we're rolling that out.

Some of our doctors were really, really good at using macros. I haven't found a big difference in how they do coding.

But for some of our doctors, it's saving them between 90 minutes and two hours of pajama time every day.

We've turned on AI tools around drafting response notes to patient inquiries, and that's saving about half that time.

We have about close to 70 different AI projects under way at Intermountain. Most of those are back office oriented.

For example, we've taken about 30

minutes off of the time it takes us to do a claims denial letter appeal. But we're working systematically to smooth that out.

One of the things we're maybe most excited about is using ambient listening for nursing.

And we're working very closely with Microsoft on a nursing pilot, and we're taking our coding time per patient, per shift, per nurse, down by about half.

And the goal there is to increase our bedside time from about 36 percent to 41 percent for our nurses, which will help them maybe take one more patient or shift, or maybe even two depending on how efficient we can be.

And that is trying to be as proactive as we can with the nursing, dramatic nursing shortage we're facing.

So, we, what we haven't done, and I don't think anybody's figured out, is to really ground these AI tools in truly physician co-pilot-type work where a physician is getting real-time advice from these tools as they're scouring the record.

We hope to get there, but that's

going to require a broader collaboration with other health systems around things like Graphite Health, and some other things we're working on.

But we need leaps forward in productivity. And these tools are the best thing, best option we've seen.

Comes with the risk. But the risk of doing nothing is even higher in our opinion. So with that, I'll defer to others.

DR. SINOPOLI: So Jay, I can tell you from our experience, we've implemented ambient listening in most of our employee practices already and have seen the same kind of response that Dan quoted.

It's just they've loved it. It's decreased their pajama time. It's creating better notes from a documentation standpoint.

Where we're struggling with now is getting that ambient listening into our independent docs' practices.

Because as you can imagine, there's a wide variety of EMRs there, and we're trying to figure out a way to integrate that directly into the EMRs. So we're working with them on

that.

We are beginning to implement some care everywhere kind of things, so that patients from their phone can actually just describe their symptoms and get directed from an AI standpoint, to their best site of care.

Whether that's an emergency room, a virtual visit, or offices, or whatever, and it can from an AI standpoint, determine that.

And we've got some other care guide things for the primary care docs to use, that can help direct them in terms of just guidelines and those kinds of things.

So, we think that's going to be big issues for the future, and we're really betting a lot on AI.

DR. JOHNSON: I'll just quickly add at UNC for clinical purposes, we have Ambient Scribe. Pilots rolling out that are being disbursed across the population, but that's about it.

DR. BHANSALI: Lauran?

MS. HARDIN: You started to address my question, but I'll just add the question and give you an opportunity to add another layer.

Each of you have talked about the importance of proactive prevention of costs from even occurring, or really prevention of risk in the population.

And having worked in hospice and palliative care before, working in complex care and care management, we would call that anticipatory symptom management, anticipatory disease management.

It's a completely different competency than what you function on in a fee-for-service environment when the payment model is structured differently.

So I'd love to hear from each of you what clinician roles, technology, and practices have you found as essential and success in delivering proactive care, or what are you learning about that, that you think will be essential to take forward?

DR. JOHNSON: I can give that one a shot.

So, I think the biggest transition I think is going to have to happen and in terms of what you're talking about, and in a specialty practice that's not integrated and

doesn't have primary care doctors, advanced care planning, palliative care services, kind of integrated or embedded in the practice.

And so first from a clinician role standpoint, it's providers who are experienced in that type of care that you mentioned.

Whether you want to call it the goals of care, advance care planning, anticipatory, symptom, or disease management, just having the thought process of, and the training to have those conversations of what patients are expecting and hoping for down the line.

Definitely not something I ever learned in residency as a urologist. And it's just incredibly important, and having individuals whose clinical focus is really on having those conversations and being able to communicate that well with patients.

And sort of elicit the patient preferences, which is a skill in and of itself.

In terms of technologies, I think one of the things AI may be able to help with is patient stratification and cohorting of your high-risk patients that us as clinicians,

aren't able to predict that very well at all just by looking at the patient in front of us in clinic.

And so, being able to bring together both clinical data, outside records, social determinants, information to determine who are the patients that we need to have these conversations with so that we can dedicate those resources I just mentioned previously, to the right population of patients.

And then, in terms of practices, in my mind at least having the financial incentive be flipped so that there is a reason to do this and it's, there's a business model for hiring these people, for investing in these technologies.

And then, taking time away from doing high-margin procedural things in place doing these types of conversations that are really aligned with patient goals of care.

I think those are the three things that we need to do, speaking specifically from where we are on the polar opposite side, and community specialty practice.

DR. SINOPOLI: So, Lauran, from my

perspective is, you asked that question I think it's a tough question to answer.

And certainly to really do it well, we need sophisticated data analytics and AI. But as I think about that question, I think about two buckets.

So, one is on an individual patient level, what are our predictive capabilities to predict what they're going to be at risk for.

And more broadly, you know related to work you do, is predicting that in our communities. Where are our high-risk patients living, and can we predict based on those demographics, who is going to be at risk for what?

And providing a broader population approach to those individuals by trying to focus individually on individual patients and their specific risk. You know again, working across primary care and specialty care.

MR. LILJENQUIST: And maybe I would add, Lauran, health care drives itself down the road by looking in the rearview mirror.

And that's the biggest challenge is with dealing with population risk, is there's

always a regression to the mean.

Your sickest patients the previous year, regress to the mean almost always. Either they die, or they get better.

And so, we've been trying to figure out how to focus on rising risk. And if you're looking retrospectively in rising risk, you're going to miss a lot of it.

And so, what we've been to Angelo's comment around AI, we've got 138 clinical systems that feed data into Intermountain.

They feed them into 2,500-plus data tables that because there's no standard of what that data represents, we have an army of people that are wrestling with those data tables manually, to try to get what we call a gold-level data.

And it's not gold-level, it's still really difficult to understand what's happening.

Some of the advancements that we're doing through collaborations with Kaiser and others with a company called Graphite Health, which is a nonprofit organization, is focused on creating what we call a semantic and

syntactic data standard.

We donated, Intermountain donated all of its clinical element models for free, into this organization.

We are working with Graphite to actually create a translation engine inside of our firewall, Azure, that goes from 2,500 data tables to three, and does that on a real-time basis.

So, we're able to feed our clinical systems into that data model quickly, which means that instead of having to wait for lab values to show up, or for a blood pressure monitor to show up, we can do that within minutes. And then, run algorithms on that data.

But that is a big hurdle for all of us. We've not come up with a standard as an industry to go back and have all of these clinical systems retrofit to a data standard.

But as we upload our data now into the cloud, the technology is there to translate that data as it comes in, into a cleaner dataset.

And we're working on that. We've

just finished; we're the first group to go live with this. Emory's going to go next, and we have a handful of partners who will move forward.

But that is the most promising thing for us because if we're able to do that, we should be able to identify rising risk in a real-time basis and using AI tools to do that.

And that is the goal to move away again, from looking in the rearview mirror to being able to react more aggressively.

In fact, that engine that we are working to build is -- we are calling it the next right action engine.

It's like what's the next right thing to do, be driven by clean data, and that gives us some hope that we might be able to get on the front end of some of this.

But it's enormously complex and our datapoints right now are so limited as to what is actually happening with our patient base, that largely even the best systems are largely flying blind here.

DR. BHANSALI: Dan, a question for you to follow up on that.

As you're coming up with the next best action, is this a clinical action? Is this a, addressing care management or care coordination? And do you have insight into what is driving that potential risk of negative outcomes?

And then, I have a next question for the entire group.

MR. LILJENQUIST: Yes, great question.

A lot of that next right action is if you're in an episode of care, it's understanding what's the next right thing to do in that episode of care.

It's okay, we're going to get you, we found out you have a carcinoma in your colon, the next step is a CT contrast. And we're going to take that real easy to do.

We're actually pretty good at that stuff now because we have teams of people who are looking at that.

Where we struggle is hey, you're 30 years old. What should you be doing? And the models there have not been developed. What is the right thing to do for a 30-year-old?

So, you know largely we've been focused on Intermountain's known for its quality, but a lot of that quality is episodic-focused. It's not really longitudinally focused.

And we're working with our clinical programs to build that longitudinal view. But we needed to do both. We needed to know where somebody is in a particular pathway so that they can get the next right step done.

And have a broader mechanism wrapping around them to say okay, when we have a touch point with them, let's make sure they're getting their vaccine.

Let's make sure that hey, the colonoscopy guideline moved from 50 to 45. Let's get you scheduled.

It's making that stuff easy and intuitive but it's, but you've got to get really, really good episodically as well.

And so we're trying to figure out how to create an awareness across both of those kinds of in-depth episodes, and the longitudinal pathway for our patients.

So, not easy stuff but we do think

the technology and the awareness, we can build the awareness. We can be a lot better at it than we are today.

DR. BHANSALI: I want to share that was at ViVE maybe about two to three weeks ago, and it was, I mean the theme was AI to solve for some problem or another.

Whether it is figuring out the next best action, how to solve for the workforce, ambient listening, how to call patients and make appointments, et cetera.

And so, as we think about these different solutions for workforce shortages and et cetera, appropriate documentation, risk management, and whatnot.

But I want to switch gears a little bit to the question around benchmarks, right, to have the resources that are necessary to be able to deliver this care and invest in these models.

So to that end, what are best practices for improving the predictability of ACO benchmarks, and to effectively address the ratchet effect?

And whoever wants to go first.

Presume it's going to be Clif though.

DR. GAUS: I'll give it a try.

So, the predictability of, there's various components that are benchmark. And I think we have relatively achieved agreement that the baseline includes it's three years basically, of historical.

Sometimes it's there's debates about it. How much weight would year one, two, three, or even four and five have in that benchmark.

Then, the problem comes with how do you adjust for all the different factors that come to play in the future?

And I don't think we are at a point where everybody is certainly comfortable. I'll address the one element that is kind of the elephant in the room right now for the ACOs, which under the MSSP program, there was an effort to bring predictability to future benchmarks.

And they incorporated a, called the ACPT. And that is a prediction about what the total costs are going to be risk adjusted, over the course of the five-year contract. CMS had projected that at 3.9 percent.

So ACOs signing up in 2024, that was the component of the benchmark. It turns out that 2024 spending is almost nine, between nine and 10 percent.

So, how does CMS adjust for that inaccurate estimate, and why was it even created? And if we don't fix that problem, the result will be that ACOs will achieve -- will not, will lose almost $100 million in potential earnings through the shared savings.

And so, there is -- everybody wants a predictable, stable future-oriented benchmark, but we still don't have the solutions to it that I think everyone's comfortable with.

And we're working on those technology. Whether AI actually will bring a better tool for predictability of trends in spending, whether they're national, local, or even for an ACO, I'm not sure.

It certainly should, but I've not seen any reports of experiments or tests of that yet. But anyway, it's there is no simple solution.

DR. BHANSALI: Jim, if you have a

question or comment on that?

DR. WALTON: No, I want to switch. Can I ask a different question?

DR. BHANSALI: Of course.

DR. WALTON: Yes, thank you for sharing, and I was particularly intrigued by Dan, some of your comments about where you're moving with your data and some analysis.

So, I'm going to just direct this question towards you and then maybe others would respond.

The next right action oftentimes in my experience as a provider, then leading an ACO, were directed toward community-level issues that patients were struggling with in order to achieve their maybe control of their rising risk. I'm going to pick on that one.

And I'm curious about what you might think, what the group might think, about what AI might actually miss or undervalue factors because of a bias in the data toward people who have utilized the system more, disproportionately more than others.

And hence, undervalue or under predict if you will, the actions, the next best

action to take, which is really more of a social determinant at the community level, rather that affects the individual's health-related social needs, that would ultimately produce a lowering of their rising risk.

And I'm just curious about how you're thinking about that as you kind of lean toward AI as a solution, and how do you, how are you thinking about the, mitigating the AI bias risk?

MR. LILJENQUIST: Yes, really great question, and boy, if I, we have not figured this out. We do have some ideas we're working on.

One is think about it this way. There are significant asymmetries of information. And you're going to miss what's happening in relatively healthy people's lives until they understand there's an issue.

I'll give you an example. My daughter was diagnosed with Type 1 diabetes two years ago. She was 13.

Our demand for health care services were fairly elastic, until they were inelastic. And then all of a sudden, she went from being a

relatively healthy 13-year-old, to having tremendous needs and that expectation changed dramatically.

Now, she had diabetes for about six months before her pancreas completely failed. And so, we had that need.

You miss that all the time. You also miss that with somebody who's got hypertension, but they don't realize they have hypertension, and they're in their 30s.

So, you're going to have asymmetries of information. I think the difficulty is how do you engage with somebody who is relatively healthy and has the beginnings of metabolic disease, and yet it takes them six months to see a doctor, and they have to wait for hours to try to get an appointment.

And how do you take that, how do you make the ability to interface with the system far easier and far cheaper to do, because again, somebody with Type 1 diabetes is going to wait to see a doctor no matter what. They need insulin or they die.

Somebody who has got the beginning stages of obesity and where we could really

make a difference, doesn't.

So, what we've been trying to figure out and this is the analogy we've been using. I have a neighbor who's blind, who is a runner.

And so, you would ask how does a blind person run? Well, she runs with a friend who is loosely tethered to her, and they run.

And every morning when they come up to a stop sign is the tether tugging just a little bit to nudge that person to slow down and make a different choice.

We are trying to figure out, Jim, how to build that tether, that ongoing relationship between a health system and a patient, to give them nudges.

And it may be as simple as hey, you're coming up on your 30th birthday. Here's what we recommend you do.

It's so that we can get some data points. So that we can identify hypertension early so that we can get somebody if they ever become affordable, GLP1 as a prophylactic measure against the development of metabolic disease.

It's figuring out those interactions

when the demand is low, that will create additional datasets to how to deal with the population.

Now, to the overall bias that's inherent in the data, we are very, very concerned about that.

And we saw this play out in COVID, that the treatments just were dramatically different, and there were a whole bunch of other factors that came in.

Our Pacific Islander population, for example, died at twice the rate our Caucasian population did here in Utah.

And so, I think what we're mostly focused on is being very hypervigilant about the tools that could drive that bias and systematize that bias.

And they're subject to a higher level of scrutiny, even up to our board, in viewing our assessment of whether or not that we are challenging what the results come out of that, those tools.

But again, we are dealing with imperfect datasets as they are. We're trying to figure out how to expand the datasets into a

broader realm so that we can more effectively engage with people when they're well or developing early stages of diseases.

And then, working to refine around particular populations, our data so that we can again, that next right action hopefully one day is going to be driven off of the best knowledge we have about that particular individual, their genetics, their makeup, their social determinants of health, et cetera, so that we can maybe meet them where they are.

But to say that we figured this out is, would be a gross understatement. We're just at the very beginning of this.

DR. WALTON: All right, just have one follow-up. Is there any of you using any type of analysis for AI bias as you're selecting your -- AI tools?

Is that part of the contract conversation? Are you aware of any AI bias checks and balances within the tools that you're looking at?

MR. LILJENQUIST: It is definitely part of our assessment, Jim. What is tricky about AI is getting replicable answers.

And it's often is the underlying structure of your datasets have more to do with getting replicable answers than maybe the tool itself.

And so, clinically we are having a clinician engage with every point when a result comes out, we require a clinician to be involved.

But it's really hard to tell how much bias is inherent in the system as it is today, and how much is being reinforced by AI, is something that maybe Angelo, David, Clif, you guys have better perspectives.

But this is an area of deep concern for us.

DR. SINOPOLI: No, I don't have anything to add to that. I think it was well said. You probably have more experience with that than we do, but.

DR. BHANSALI: At this time, we have a break until 2:50 Eastern Time. Please join us then as we have a great lineup for our second listening session with experts giving their perspectives on supporting primary and specialty care transformation.

Dan, Angelo, David, and Clif, thank you so much for joining us.

(Whereupon, the above-entitled matter went off the record at 2:39 p.m. and resumed at 2:51 p.m.)

*** Listening Session 2: Supporting Primary and Specialty Care Transformation**

DR. KOSINSKI: Welcome back, everyone. I'm Dr. Larry Kosinski, one of the PTAC Committee members. At this time, I'm excited to welcome four amazing experts for our second listening session on supporting primary and specialty care transformation.

You can find their full biographies and slides posted on the ASPE PTAC website. At this time, I'll ask our presenters to go ahead and turn on their video if you haven't already.

After all four experts have presented, our Committee members will have plenty of time to ask questions.

Our first speaker, we are super excited to welcome back PTAC's first Vice Chair, Ms. Elizabeth Mitchell, President and Chief Executive Officer at the Purchaser's

Business Group on Health. Welcome back to PTAC, Elizabeth.

MS. MITCHELL: Thanks, Larry. I'm really glad to be here. And I know how hard and important your work is. And happy to sort of share some things that are happening in the field that may or may not be of interest.

But we are, you know, I'm now working with jumbo employers and public purchasers, and I can assure you that primary care is a top priority for them, as is changing the payment system to enable it.

So, should I just jump right in?

DR. KOSINSKI: Yes. Please do.

MS. MITCHELL: All right. So who are we? PBGH has been around for about 35 years. We have an average of 40 members, public agencies like CalPERS, as well as private employers like Walmart, Microsoft, Boeing, Apple.

So just very large purchasers who spend about $350 billion a year on health care on behalf of millions of Americans. And we've had the same mission for about, you know, 35 years, which is improving quality,

affordability, and equity. Next slide.

One of the foundational strategies for our members, and this is based on pretty deep experience and obviously research, that investing in primary care is one of the only strategies that achieves all of employers' aims, right.

So better access, better experience, better outcomes, and lower cost. There are not many strategies that can claim to be positively affecting all of those areas. But primary care is one. The other is high-quality specialty care. But that's for another day.

But we know that, you know, even though primary care accounts for only about 35 percent of health care visits, it does influence 90 percent of spending.

And unfortunately despite its value, despite the benefits, despite employer prioritization, we typically spend about 4 percent on primary care.

This is deeply frustrating to employers and purchasers who have been, I think at least in the last several years, very clear that they would like to see greater investment

in primary care.

When we measured on behalf of our members, the average was about seven percent. They are actively putting into their contracts that they would like that amount to increase, their contracts with health plans and their direct contracts.

And I think this is an important piece of context, so bear with me for a second. But I also sit on the Board of the Office of Healthcare Affordability in California.

And one of their, one of our commitments is to increase the percentage of total spend into primary care up to 14 percent in the next several years. So there is growing recognition of the need for this. Unfortunately, we're not seeing the rapid transition we would like to see.

So again, one of the, you know, if you're just even looking at ROI from an employer perspective, which at least my members don't look at it that way.

But, you know, there's a 13 percent savings for every dollar spent. That's, again, it is just a very high-impact investment. And

there is deep recognition of that. Next slide.

You know, conversely there is a pretty significant downside of not investing in primary care. And when you're looking at it again from a large employer perspective, you know, you lose time, and there's additional cost. And there's a higher total cost of care when they aren't treated in primary care initially.

Going way back, about seven or eight years ago PBGH was involved in a CMS program. We worked in California with even small rural practices.

And with the right technical assistance and payment changes, we were able to quantify over 50,000 avoided hospital visits, you know, over 60,000 avoided ED[55] visits. And again, this was all from giving primary care the right tools, the right data, the right staffing, and the right payment.

So we have, I think this has been demonstrated over and over, you know, both in other countries, but also in pilots across the U.S., that this is the right investment.

55 Emergency department

Unfortunately, it just hasn't scaled. Next slide.

So what I'm going to talk about is sort of two things. One is PBGH's sort of national work around advanced primary care, as well as our deeper work in California through our technical assistance team, called the California Quality Collaborative. They work directly with practices.

And so we have sort of two initiatives that have been very high priorities for the members. And they both also are related and coincide.

But we started with sort of one of the key attributes that we're trying to achieve, right. It is, you know, access the way patients prefer. We know we need interdisciplinary care.

One example that I'm going to come back to again and again, integrated behavioral health is a top priority for our members, that requires an interdisciplinary team.

Patient care is beyond the chart. We are absolutely thinking more broadly than what just happens in the primary care visit.

How do we deal with social needs?

And we, you know, I was part, when I worked at Blue Shield of California, I was part of an initiative where there was social needs screening in practices.

But one of the takeaways was that they're doing the screenings, they're finding these needs, and then the clinical team didn't know what to do with them. So there was an expansion to community health workers.

So again, just thinking more broadly than the traditional teams is very important. And then it's obviously got to integrate with the rest of the system.

So again, I don't think any of this is terribly controversial. It's what everybody wants. But it is not typically reflected in most primary care. Next slide.

So we started out with once we had really clearly established the priorities, like what we wanted care to look like from the purchaser and partner point of view, you know, how would we measure it? How would we know that we had it? And how do we translate that into measures that could be integrated into

contracts?

So we came up with a common measure set. Again, this was meant to be not rocket science. These are not terribly controversial measures. But they were meant to be consistent, and parsimonious, and evidence-based obviously.

So again, I'm happy to share this with you. I know this is a very small font. But we looked absolutely at outcomes and prevention. So are they even able to get in, and then get the screenings and the care they need?

We highly value and prioritize patient-reported outcomes. I understand that the methods for measuring patient outcomes have been around for decades. They have not been taken up by the industry for the most part.

In fact, in California recently we went backwards. We stopped doing patient-reported surveys. So we know that this is a critical component, not just for employers but for patients.

And frankly it is one of the best ways to get at equity, because you're actually

asking the patient, and they are giving you their feedback from their perspective.

So, depression screening for adolescents and adults. But then we included depression remission, because it's not enough to do a screening. How, what is the patient's health, and is it sustained?

Patient safety, experience, and high-value care, so emergency department visits, inpatient acute hospital utilization, and total cost of care.

And I appreciate that the total cost of care measure is sometimes controversial. I will say from a purchaser perspective, it is non-negotiable.

Because this, our goal here is not to save money by doing the wrong thing. But it is absolutely to make sure we are doing the right thing.

And we know that investing in primary and preventive care and being willing to pay more for primary and preventive care typically reduces total spend.

So we believe these things are integrally linked. And it's very important

that we are not paying more for worse care. It is about paying for the right care. Next slide.

So one of the things that we did was after we got consensus on measures, we started integrating them into health plan contracts. And we obviously partnered with providers to do this as well.

And the key feedback we heard is that, yes, we would all love to do these things. But the key barrier is payment. We are not paid to do the things you are asking us to do.

So no surprise, we know, you know, fee-for-service and 15-minute visits don't get us there. If you're not paying for, you know, behavioral health screenings or community health workers, or all the things that actually improve health, it's not possible.

So we actually know that payment is the primary barrier. And our members set out to change that. And in their contracts, they are demanding that we have Alternative Payment Models, specifically prospective population-based payment models, so that practices have

the flexibility they need to provide the care that everybody wants.

Our members are also really clear about the fact that advanced primary care, as they define it, includes quality-based specialty referrals.

We know that that is one of the key approaches to both outcomes, experience, but also total cost. And we also know that quality varies wildly, so there has to be a way to ensure that when a referral for specialty care is made, it is done taking into consideration the quality of the provider who is receiving that referral.

I am well aware that that is challenging. I am well aware that most primary care providers don't have that information. I am also well aware that quality-based referrals bump right up against a lot of business arrangements in health systems.

That's why our employers want to do it, because someone has to drive that on behalf of employers -- on behalf of patients, sorry. So we know we want to pay for a team, pay for the data and analytics needed to manage

population health.

We need to hire the community extenders that make this possible, that go into homes and into communities to actually meet patients where they're at, integrate mental health, and pay for physical therapy, particularly for our manufacturer members like Boeing.

They know physical therapy is a key need among their population. They want that integrated into primary care, and they're willing to pay for that. Next slide.

Unfortunately, even though we get a lot of consensus among our employer members about the standards that they would like to see, when this goes through a bunch of health plans to administer, it often gets lost in translation.

So all of these plans have slightly different approaches. And again, no shade on any of the specific plans. But if every health plan has a different measure set, or a different denominator, or a different payment model, that does not make it easy for practices.

There has to be alignment so that they can actually make the change for everyone in their practice across their population. Next slide.

So what our members decided to do when it was really challenging to get that alignment, many of them just decided to direct contract. And that has been, that is not new for our members. They've been direct contracting for decades.

But there was a specific focus on direct contracting for advanced primary care. We have recently launched a very significant initiative in Puget Sound where they're directly contracting using the same measures, using the same contracts, and using the same payment model for primary care.

This is a new initiative, but it's with three jumbo employers. So it was not just one employer asking for this. We know we have to align on our side.

But we've got three very large employers, including Boeing and eBay, and another that I'm not at liberty to name. But it's really big.

And they are saying, these are the things we want. We will pay you more. We will pay you differently. We will make it flexible. But we are going to hold you to the same standards to make it easier. Next slide.

So in California we took a somewhat different approach, because we are trying very hard to align also with our health plan partners. Because we know jumbo employers -- first of all, they're not jumbo everywhere. So they can't drive every market change. They typically have very small benefits teams. They need their health plan partners to do this.

But we had to then do the work in California to sort of get the health plans to align. I want to give a really big shout out to Blue Shield of California, who I know is there, who really helped us drive this work, and helped us enlist plans.

But we had seven health plans step up and say they wanted to do this with us, which was really gratifying. It ended up being three who actually went forward with the aligned payment model. But at the same time, we really have been really appreciative of the

partnership and the readiness to change.

So we started with that measure set that I showed you, and we worked with practices, and then we went the next step in California. And there is hopefully a summary of this initiative that will be shared with you, I sent it along, that showed that by aligning these like, even three health plans, doing the work of aligning can actually really drive change. Next slide.

So we made clear from the outset that there were a few key tenets of this work. Again, we have the measures that we want to achieve. And we have the partners lined up to do it.

But we really wanted to be sure that we have transparency. We've got to be able to see and know the outcomes. We've got to invest and actually pay more for primary care. And we've got to have value-based payment.

And that we have to also provide practice transformation. Because the changes we are asking for at the provider level and the practice level are significant.

So we had the grand signing of a

memorandum of understanding to do this together. Common quality measures, increased investment, shared technical assistance, and clear and aligned performance incentives. So this was I think a real breakthrough, and really quite exciting. Next slide.

So, what is the common value-based payment? Well, payment for direct patient care using a mix of capitation and fee-for-service. We're tentatively calling this fee-for-service plus. That will be one option, or PMPM payment to support population health management. And that's up to a 15 percent increase. And then performance-based payments based on the standard APC[56] measure set, so the measure set that I referenced earlier. And an upside of up to 15 percent.

So again none of this is radical, I don't think. None of this is, you know, it's all evidence-based. And it's been demonstrated in various pilots that this works. But the idea was to try to scale it at least across 30 practices in California. Next slide.

By the way, sorry. Well, I can say

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this here. One of the things that was actually another key enabler of this was a common reporting platform.

And we partnered with IHA in California, the Integrated Healthcare Association, who does collect this data, who does have a common reporting platform.

So when you think about all the basic infrastructure pieces needed for multi-payer payment reform that just don't exist, this was a key example, right.

There's no common reporting platform where, you know, measures are collected in a standard way. And we are fortunate in California to have IHA as a partner who can do this.

So again, just, there are so many missing building blocks, but we are able to sort of overcome those barriers with partners like this.

So one of the things we're asking for, and then I'll wrap up. You know, join. Join this work. Like, align with the payment model. You can, in California, we also have IPAs. You have to sort of enlist. And just

align your incentive programs with the APC measure set.

We've all got consensus that these are the right measures. This is what matters. So how can you, from whatever contracts you have move towards alignment?

Again, those IPAs need to have a challenge. But like, we are asking them to also align their payment model and their P4P[57]incentive programs.

And then what we've asked our purchasers is really engage in a collaborative dialogue with your plans and practice partners. Understand what the barriers are and help overcome them.

Again, I can speak for our members. They would like to see change. But they're also willing to participate in that. If you need a contract change to allow you to do this, tell us. There is a readiness to make these changes.

Identification of multi-payer collaboration as a key aim here. Understanding those operational hurdles, I worked in a health

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plan. Those legacy fee-for-service systems are not designed for this work.

Okay. So there's an operational barrier. How do we get around them? Plans are finding new like start-up partners who are able to or need different types of payment models.

But we've got to overcome these legacy barriers, recognize the time, resources, and adaptations needed. This is not easy. This is sort of no one's day job typically.

And then realistically assess the feasibility for the pace of change. And recognize this might take a two-to-three-year contract, or amendment, something.

We know it's going to take time. But we need to start. And then really incentivize collaboration or at least remove the disincentives to collaboration.

So these are some of our key findings. Happy to answer any questions.

DR. KOSINSKI: Thank you, Elizabeth. It's so nice to hear your voice again. Next we're excited to welcome Dr. Joe Kimura, Chief Medical Officer at Somatus. And we are especially fortunate because he's here in

person. Please go ahead, Joe.

DR. KIMURA: Thank you very much. And thanks to the Committee for inviting me to participate in this panel. And it's a privilege to be here, and I really look forward to the discussion as well.

So I think I've got control of the helm here. Just briefly, I think after Elizabeth's presentation, I'm thinking what my position is, and what my role would be in terms of reflecting and opining to the Committee.

And I think, I think my role is as a provider and a leader who has been working in various levels of delivery systems from highly, highly structured fully integrated systems, towards partially integrated systems, to where I am today, where we are a specialty-based VBC, with however you can call them provider adjacent to provider supportive organization.

Somatus is just an organization that cares for patients with CKD but and takes total cost of care accountability for that particular population.

So I'm a PCP by practice. And all of you know that once patients get over a

certain age, almost everybody has CKD. And so that morbidity of the population is the population Somatus cares for and does that from a vantage point of working alongside providers in the community, as well as health plan resources, to try to drive accountability and outcomes.

So quickly, prior to coming to Somatus in 2022, I was in an organization called Atrius Health/Harvard Vanguard Medical Associates. We were one of the original Pioneer ACOs.

Stuck with it all the way through, through shared savings, as well as one of the original participants in the Blue Cross AQC[58] on the commercial side as well.

And because we were an organization that was fully capitated for over 80 percent of our revenues, 50 percent of our patients, 80 percent of our revenues, managing in this space across 32-plus specialties was one of the things that I experienced firsthand, both as a practicing PCP, as well as an administrator. And so hopefully will bring that perspective

58 Alternative Quality Contract

in.

The other side of my world, and this is sort of a commentary of the prior panel conversation we had. I'm boarded in clinical informatics. So my whole world in value-based care and thinking about how informatics and analytic capabilities can help transform health care has been something that's been dear to my heart for 20-plus years. And again, has serviced me well I believe as we're practicing in all of the different settings that I explained.

So with that let me jump in first and say, thinking about primary care and specialty care collaboration, and how to promote that a little bit more. I always like to think through and say, well, what are we talking about there? What does that really look like?

And fortunately, rather than opine from my own perspective I just brought forth ACP[59]'s 2022 sort of policy paper that said, in order for primary and specialty care to collaborate better, there's four principles

59 American College of Physicians

that they'd submit.

Patient family partnering. Define clinical roles and responsibilities. Timely productive communication between the specialties. And of course, effective data sharing.

Now those of you who are familiar, and I'm assuming many of you on the panel are familiar with this report, there is a 33-page example document that goes along with it that goes into a lot of details that I feel are very appropriate.

I find myself as a clinician saying, yes, these are the challenges we face when we have patients with CKD 4 or 5, lots of behavioral health, as well as obviously nephrology concerns.

And I as a PCP need to manage that. I can't just give it all to the nephrologist. The nephrologist can't punt it all back to me. So how does that work?

I think the ACP document highlights some of the core areas of what generally needs to happen. And a question I believe the panel is asking is, well, how do you make that happen

more robustly, and more reliably, and more effectively?

So I took the liberty of just taking one step back and saying from my experiences this is how generally, and a very, I will apologize, a very rudimentary schematic in terms of my PowerPoint skills.

But thinking about, how do you get multiple people on a team to drive towards achieving a particular performance in an outcome KPI[60]?

And this is not an uncommon structure, right, where you have as you might imagine, on the left-hand side Provider A, driving things maybe on case finding, and sort of initiating that process.

But then multiple specialists or other providers starting to be participatory in terms of closing those gaps. Then ultimately the PCP starting to come back in and saying, how do I wrap it up together and have the communication?

Now all of these folks are involved in driving performance on that end KPI. So how

60 Key performance indicator

do we try to get everyone aligned?

And when I reflected upon our experiences in the various organizations, I would postulate that there's five areas that this panel has probably spoken about ad nauseam. But I'm going to highlight for the group today.

And the first is align clinical culture. I know culture is always a hot button topic. But I do feel like what I mean by align clinical culture is that there needs to be general agreement upon what is the best clinical practice among primary care and all the specialties. And I would actually extend that to say all the care team members involved in that care for the patient.

It's easy to point to evidence-based guidelines that are published and say, of course, we're all following our specialty guidelines. But as many of you know too, sometimes there's discordance.

Particularly I'd call attention to things like mammography screening or Pap screening when the generalist guidelines and

ACOG[61]'s guidelines sort of diverge a little bit. Adds to a little bit of tension in that space.

But in general thinking about how do you align across that clinical culture is kind of a prerequisite because it creates that foundation for everything that starts to follow after it.

And the second one that I think is equally important, and probably more so now, given the stressors that all the clinicians and all the care teams are facing, is an aligned clinical operational system.

And this is where I would point to all the point of care decision support, all the EHR configurations, everything that allows those workflows to go smoothly. That needs to then also be aligned.

Because the last thing that I found that you need is certain configurations firing at one point, driving certain decision support rules, conflicting with what the PCP or the specialists are saying.

When that happens, then you

61 American College of Obstetricians and Gynecologists

automatically place clinicians in conflict with one another. And they're trying to figure out, oops, excuse me, how to actually navigate that.

The third is probably one of the most, I don't know, I would say sort of easiest to understand. But probably one of the most difficult things to try to do today, is to make sure that throughout that entire process chain you have clinical informational continuity.

And we talk about interoperability. We talk about the fact that we are promoting it. But I think everyone in this room knows we are still stuck at higher levels of interoperability, and not at the semantic levels that really are required to make necessary decision points as you're passing from the left towards the right.

Again, timeliness of this is also an important one area. The example that I always give is post-discharge, there are about 30 people jumping in on that patient trying to figure out how to actually make sure that a readmission doesn't happen.

When that happens, that trigger,

whether it's an ADT[62] feed or some other flag, some of that information comes, we have found in various organizations that it doesn't help as much when it comes 14 days post-discharge.

And again, one of those areas that everyone knows what should happen. And yet it still seems challenging for us in today's environment to make happen.

Fourth one is transparent performance management. And this one I'm going to put my manager and administrator hat on a little bit.

And this is where sometimes we tend to blind and work in a space where we say I'm just going to give a particular physician their particular feedback.

And I'm actually going to expand it. It's not just physicians. It's nurses, it's pharmacists, it's everyone on that care team. How do we make sure that those clinicians are getting that information?

Not about their own performance, which is always critical, but overall that entire process and say where is that process

62 Admission, discharge, and transfer

falling down? Who's actually accountable for that?

And this was easier to do in certain settings, harder to do in others. But I would say collective pressure, or collective desire to improve care for the patients leads to some great performance outcomes.

And then finally something that I think is of course the core to this Committee, aligned financial incentives.

And I would say that it's not just around the incentive structures of penalizing or rewarding. I would say that it's very core to the core compensation model of the specialties and primary care that needs to complement that.

Because I have seen in many examples incentives just become completely neutered when that core model is not following suit. So a couple of core concepts.

And if I were to then take two steps back, and I added a little bit here at the bottom. And I apologize, the font got super small.

Not only are the physicians and the

clinicians doing this, there are usually care teams in addition to this, right. Particularly in the world of population health management.

Not only does the primary care clinician have them, in my current role in Somatus, we complement our nephrology specialty colleagues providing that service.

And usually the health plan is also jumping in with a care plan along those lines, all in the services of dropping the readmission rate, improving the HEDIS[63] scores or the Star measures, you name it. All the accountability is there.

How do you actually bundle all of this together? And if I reference back to the five points from before, and I refract them through either a really tightly integrated system like Kaiser Permanente, a partially integrated system like Atrius Health.

In Atrius we just had the outpatient side. We were not connected with inpatient, either hospitals or skilled nursing facilities. Or a provider adjacent or provider supportive model like Somatus.

63 Healthcare Effectiveness Data and Information Set

I put forth sort of the elements that are there mostly because as an executive in an organization like this, you have lots of levers that you could pull.

And you want to pull all of them to try to promote the fastest most efficient way of getting those KPI outcomes. It is much easier to do when you control that entire spectrum of things.

And I think in the prior panel you were hearing from organizations that also had those kinds of controls and abilities, where they controlled the entire informational control stream. They actually had employed and non-employed physicians but also had that system from outpatient to inpatient all the way through.

As you start to drop down, and as the system becomes, if I call more loosely integrated, I do believe the power, even though the core interventions across remain the same, your ability to impact or pull that lever as hard as you wanted to starts to get harder, and harder, and harder.

Whether it's the data side of it,

obviously the compensation side of it, or even the clinical culture side of it, it becomes harder because again that locus of control starts to get looser, and looser, and looser.

That, however, does not mean that it's impossible to do in these settings. I truly believe, and my experiences in Somatus over the past two years have demonstrated you can move the needle tremendously well as long as you're focusing on those five things and trying to provide the level of support.

It is harder, I will say that 100 percent when you don't have these things fully in your control. But that doesn't mean it doesn't work. And if you find creative ways to do it, you can bridge.

So with that, how do you then say, if that's the how, how do you incentivize it? How do you grease the skids? How do you make it work better?

And when I was polling through, most the panel probably goes to where I went originally. There was an article by the late John Eisenberg and Peter Greco in the New England Journal in '93, '94 that talked about

changing physician practices, right.

But that was '93. So looked back in the literature and said, what else is there? What other kinds of reviews have been done, particularly in the age today where there's a lot more informatics capability coming through?

And the folks at McMaster University, Dr. Bhandari and the colleagues in 2015, still a little bit old, but pulled this together. Just sort of looked at the literature and say, what are the elements that start to facilitate better team-based care across primary care and specialty care?

And this list is probably not surprising for anyone on the panel or in the listening audience. But I wanted to highlight some of the things in red that are probably getting a lot more play today.

And perhaps some of the things like printed educational materials may or may not be used as much today, even though they were obviously assessed in that particular review.

I do believe there's a lot of these levers that one can pull. One of the things that came out of this particular paper clearly,

and again lots of face validity.

Multifactorial interventions are clearly superior to any one of these in any particular point in time. And that was something that Dr. Eisenberg and Greco also mentioned almost 20 years ago.

But here's the thing. And as I sort of pull forth and say all that literature is great. It's like going through and saying, polling through John Kotter's stages of change. And you're trying to figure out how to apply it.

In reality, I have found that it's challenging to help bring these changes forward, in particular because I think our clinician workforce in today's world where there are so many competing demands requires something a little bit more than just pure dollars or operational change.

And this is an old paper. I think it's 1983, coming from Andre Delbecq who talked about justice as a prelude for forming teams.

And the concept here for those who have not read this paper is really talking about the fact that, look, physicians and

clinicians truly have the patient's best interest at heart.

And at the end of the day, there's a desire to say, I'm thinking about the best interest of that patient. And it tends to pull apart, rather than pull together when things get really stressful.

But what they have found, and again I still find 30 years later, that this tends to be something that I've found again and again in all the settings that I've worked in.

If you are doing this together and working with the providers in the front lines to say, here is what we're trying to achieve collectively, and that requires transparency. It requires having information across the entire process.

And then visibly processing that, the pros and cons of a particular change with them can start to lead towards more commonality and the decision to be able to say, yes, let's all move forward.

And in a sense, his last line here is, in a sense justice is substituted for cohesion, which as a management person I would

say, I'm going to take that as I'm moving along.

Because I've been held accountable for measures to perform every 12 months. And I don't have five years to help them actually get to the place they need to be.

The applied example of this for me was at Atrius Health. And at Atrius because we were capitated, we had a particular physician compensation committee that brought together all of the physicians and representation of probably 12 to 13 of the specialties across our lab and radiologists, our surgical specialties, med specs, primary care had disproportionate, internal medicine, pediatrics, et cetera, came together with our HR and finance colleagues each year to set the compensation model for our clinicians.

And that conversation was probably one of the most important things that led to the buy-in, particularly when we knew we were actually about to go into a new ACO contract with 25 new accountability measures that no one was going to want to actually change their Epic clicks and all that stuff for.

How do you actually get everyone to that space? And that collective conversation, we always took heat from the community, saying it was kind of like a socialist compact.

But we actually turned around and said, look, radiology knows that primary care for a capitated organization is the driver of revenue for the organization.

Therefore, even though it's hard to recruit radiologists or dermatologists, substitute high-paid specialty on the left-hand side, we had to somehow figure out how to share that pie, given how the economics of the organization worked, and how we needed to split that through to try to make sure all the specialties were supported.

Because it was a team gain. It wasn't that if primary care lost because they couldn't hit all the quality KPIs, orthopedics lost. So how do you actually link everyone together? And that was a brutal conversation at times, particularly around COVID when everyone was hurting.

But at the same time, I think some of those areas allowed the process and that

forming of justice that allowed the organization to push forward and be able to actually drive the changes that we needed.

And I'll conclude with two things. One is something that probably this Committee is, and everyone is very aware of. The burnout problem, if I can call it that way, is ubiquitous, and continues to be a challenge across not just clinicians but all staff members in the health care team.

When we think about that and think about all the challenges and the root causes for that, throwing money at folks is probably not going to be sufficient to actually help overcome some of these things.

And we're seeing it too. I'm sure all the organizations are seeing it, particularly as a newer generation of clinicians are coming through.

There is a tradeoff, right, in terms of time and money. And you can't sometimes pay more or pay enough to be able to overcome that aspect, or trying to figure out how do I balance this.

And lots of folks have jumped in.

The AMIA[64] and the informatics community has actually driven the desire to drive documentation burn down to 25 percent of where it is from current state in five years. I think there's a long way to go in terms of that. But also making things easier for folks to do the right things consistently.

So in that I always want to end with a positive story. And so I pulled three examples on literature. And again, even though the original publication comes from integrated delivery systems, I would say that this, these concepts are expanding and have, I've seen replicated in looser systems and even academic medical centers.

So the complete care program at Kaiser was something where it is a remarkable thing if you've seen this actually in operation. And Mike Kanter used to run quality and published on this back in 2014 I think.

But it is the concept where the entire system leans in to begin to say, when you're actually thinking about getting a mammography, or a colonoscopy, or getting

64 American Medical Informatics Association

someone checked for an A1C, or their retinal eye exam done, you need to leverage every contact in the system, whether it's the PCP, the orthopod, the hospital, the urgent care center, even the skilled nursing facility.

All those touches gets to lean in. And it is all about trying to be sure you're not slowing down that dermatologist, or slowing down that orthopod. But when you create a system where the incentives are aligned, the informatics are supporting it, you lean in, you can start to get tremendous performance.

And that was in 2014. If you look at some of their literature today, it's actually pretty impressive where they've gone.

The second example is SureNet. SureNet is something that Kaiser started. But again in Boston we started to do this. And Brigham and Women's has actually advanced this as well too.

Where you're thinking about using automated systems, right, to be able to screen and create capacity, whether it's AFib[65] or prostate cancer screening, or other areas, you

65 Atrial fibrillation

basically allow the urologists and the specialists to use the same data that primary care is using. And you begin to automate those referrals forward.

Again, because there's an agreement around whether or not if, and again the example in this paper was specifically around PSAs[66], where they were saying, if there is a PSA that's highly elevated, that everyone agrees needs follow-up.

And yet there is no follow-up that is seen in the system in 12 weeks. Then we've all agreed that urology is not going to wait for the PCP to create that referral. We're all agreeing we're going to pull that person into referral.

I have one minute remaining. Last example, Geisinger's Ask-A-Doc. And I think this is an example that all of us have seen, particularly post-COVID.

So e-consultations. What does it do? What does it help? It smooths the aspects of communication between primary care and specialty care, particularly outpatient space

66 Prostate-specific antigens

where it's hard to do, curbsides when everyone's in separate buildings.

But that capability was demonstrated at Geisinger to significantly reduce unnecessary EDs, as well as total cost of care reductions.

So I think there's examples that are out there that show this. And it starts, and it's almost always published in these integrated systems, because they have all the systems, the tools, the capability.

But I would encourage the panel to say many of these examples 10, 15 years later are starting to diffuse out into loosely coupled systems with equal success. And I think it's something that should be promoted and allows all of us to provide better care for our patients.

And I think I'm going to hand it off to Rob.

DR. KOSINSKI: Thank you, Joe. Thank you so much. Next we are happy to welcome back Mr. Rob Mechanic, who is a Senior Fellow at Heller School of Social Policy and Management at Brandeis University. He's also

Executive Director at the Institute for Accountable Care. Great to have you here, Rob. You have two to follow.

MR. MECHANIC: Okay. Well, thank you so much. Thank you to the Committee for inviting me. And it's great to be on a panel with such esteemed colleagues, several of whom are good friends of mine.

Now if we go to the next slide. So the question that I was asked to address was, what are specific approaches for nesting episodes of care in total cost of care models?

And this is something that we've been talking about a fair amount for the last three years, starting with a blog by the folks at CMMI. And the conversations continue.

But the discussion's been mostly conceptual. There's sort of been very little concrete discussion about how would you actually do that. So I'm going to spend a little bit of time talking about how might you actually do that.

I love Dr. Kimura's discussion, because I think the concept of using episode frameworks to look at clinical care and to

redesign clinical care makes a whole ton of sense.

But I'm going to raise some cautions about trying to impose an episode financial structure on top of a financial structure that is already there to manage total cost of care, some of the challenges that would need to be overcome to really do that well. So if we could go to the next slide.

So this is not so dissimilar from the concepts that CMMI raised several years ago, which is well, what are some strategies to do this?

So one is, you could provide data. And you could say, hey ACOs, use this data and develop some protocols and incentives inside your system. So this is sort of the concept of shadow bundles.

And CMMI did provide what they called shadow bundle data to the ACO community. The shadow bundle data was only for the ACO beneficiaries.

So for many ACOs, and I'll show some information as we move along, it wasn't a whole lot of volume or sample size. So it makes it

much harder to draw conclusions from the data that they're looking at.

So second piece would be require ACOs or encourage ACOs and their providers to join bundle payment models. ACOs have always been able to do that.

But participation in the federal bundle payment models has really sort of cut back from a few years ago. Because of the imperative to make it, you know, savings for Medicare. So not a lot of ACOs are in bundle payment models.

We do now have a mandatory model team that's going to start next year. And so about one in five ACOs have a hospital that will be part of team. And I actually think it could be beneficial in driving integration between the ACO and specialists and hospitals.

So another idea raised, set condition-specific benchmarks. Again, this is something that Joe talked about a little bit. Or I shouldn't say, Mike Barbati talked a little bit about this working with one of their renal practices.

So one of my questions here on the

condition-specific benchmarks. You can envision a collaboration between ACOs and hospitals or specialty practices.

But my question is, is it going to be a zero-sum game? So if you nest episodes inside of total cost of care, is, can it be a net win, and not a net loss for somebody? Because if you make it a net loss for somebody, it's not going to go over all that well.

And so where is the balance between the opportunity and the risk when you already have risk? How do you make this into a win-win approach?

Another idea, structure some kind of a medical home type of approach. And we have had primary care medical homes nested inside of ACOs. And that seems to make a fair amount of sense.

But do something more like a specialist medical home with incentives for longitudinal specialty care management.

And that I would envision as something a little bit more like a GUIDE Model where there's not necessarily additional risk, but there are additional resources for programs

that have met a set of criteria to manage a particular population, and sort of jump-start some of that really focused specialty care management.

And then, you know, the last kind of related question is, how do you, how would you reconcile if we're going to nest bundles as a payment model into a total cost of care? How do you reconcile that as shared savings?

And historically that's been a real bugaboo for CMS. It's been very complicated. People don't understand it. It's easy to make mistakes. There are distortions.

And so much so that for the TEAM[67] model they said, we're going to throw that out. We're just going to reconcile the programs separately. We want the ACOs to participate.

We don't want to drive them crazy with some complex reconciliation. So we're going to keep that separate. So that's I think a key question going forward.

If we go to the next slide. I think episodes have a lot of benefits. But they also have a lot of challenges. The first is if you

67 Transforming Episode Accountability Model

are trying to measure episode performance and you don't have a lot of volume, you're going to see a lot of random variation.

And if you have a lot of variation, random variation, what that means is that randomness could affect your gains or losses more than actually clinical performance.

And so some people who are doing nothing could make money. Some people who are doing really good work might not make any money, because of random variation. So you have to focus on bundles where you have big volume.

The second issue is risk adjustment. And risk adjustment is hard to do. I mean, it's hard to do everywhere. But it's hard to do in episodes.

And risk adjustment can be reasonably good in procedural episodes. Acute medical episodes, it's much less, the predictive power is much less. And when you get into the chronic condition episodes, it becomes very hard to do.

Provider attribution is important, the concept of team-based attribution that Joe

was talking about. I think that's really important. But sometimes identifying the right specialist.

Sometimes you have people who, you know, they get specialty care in a hospital, they haven't seen a specialist. They're hospitalized for heart failure. They've never seen a cardiologist. So how do you think about that attribution?

And then finally when we talk about longitudinal episodes, how do we define the episode? Because in Medicare, people with heart failure also have chronic kidney disease, and hypertension, and diabetes.

And so what are we measuring? Is it a capitated payment? Or are we somehow carving out heart failure-related costs? And how do we define those?

So these are all things that make this enterprise a little bit more challenging. If you go to the next slide. And I'm not going to spend much time here. But I think the opportunities for ACOs, one is to help the primary care providers make better referrals.

Second is to get the specialists

engaged in value-based care management, and sort of understanding what the ACO is trying to do. And the third is effective collaboration.

And I think again Joe laid this out very nicely. There are a number of tools for improvement. You need data because, you know, my friend Jared Kaplan used to say, make the invisible visible. And a lot of this stuff is invisible.

So you need to start with data. But then in my mind it's really the culture. You need to start with strategic alignment from leadership. So the senior management and the clinical leaders have to want to do this. And they have to believe in it.

And then, you know, it come down to the organizational culture. You need docs who believe in it, and champions. You need systems to make it easy to do the right thing.

And incentives can be important. But the incentives are probably the last thing that I would worry about. I sort of worry first about the clinical enterprise, and the culture, and the leadership to really make this happen well. So go to the next slide.

So why is it complicated to do this inside of ACOs? And there's really four things that I'll talk about here. One is fragmentation of care. Because I think there's just a lot naturally.

The second is that most of the specialty care received by ACO patients is not provided by ACO specialists. They're outside specialists.

The third is that many ACOs, you know, they range in size from being tiny to huge. Some of the huge ACOs are very geographically disbursed. So in any market they're really not that big.

And many ACOs have not a lot of volume in episodes because they've got healthy people and sick people, as opposed to hospitals that are really treating exclusively sick people.

So, and the last thing I'd raise is that ACOs, many ACOs have a limited power base. The people in the health system who are driving the revenue are the specialty practices and the hospitals.

And so, some health systems have

really embraced value-based care. But there are plenty of them who maybe have sort of embraced it a little bit.

And, you know, they have ACOs, but the ACOs are not the power base. They don't have the resources. And they can't make all of this happen.

So in terms of fragmentation, you know, what's an ACO? It's a lot of different things. And so this is just breaking out in deciles the average number of physician groups per ACO.

And as you can see the average is 34. Sometimes they come in, many of them are on different electronic medical records systems. Many have different culture. And so kind of organizing around specialty care is more complicated in that sense. Go to the next slide.

So here what we did is we looked at the Medicare claims data. And we split ACOs into four groups, what we call PCP-focused, at least half of their providers were primary care providers, primary care oriented, specialist oriented, and specialist-focused.

And the specialist-focused probably between two-thirds up to almost 80 percent of the providers on the ACO list were specialists. And looking at the percentage of primary care provided by ACO practitioners, which is a majority. And now looking at medical specialist care and surgical specialist care.

And so this was our analysis. But Michael Barnett and Mike McWilliams did a very similar study they published in AJMC[68]. And so it's just a lot of the specialty care is outside. And again, it can be very fragmented.

Go to the next slide. In this slide, what we did is we looked at ACOs in 2021. And I think there's roughly 450, 460 ACOs. And we said, how many of those ACOs had patients who would have triggered these different BPCI Advanced episodes?

And so you have, you know, most ACOs would trigger 100 pneumonia, 100 joint replacements, 100 sepsis. Now we're down to less than half, have 100 heart failure episodes. Now we're down to 30 percent, 100 stroke. And the numbers just get smaller.

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So the volumes are relatively low. Now if you said, let's take ACOs and let's look at their hospitals, and how many bundles did their hospitals participate in. The numbers could be higher.

But for the ACO patients, the sample sizes are often low. And if you go to the next slide, what are the implications of this? And here, this is kind of a complicated slide, but I'll try to explain.

What we did is we looked at 90-day Medicare episodes for heart failure, acute heart failure hospitalizations. And we did something called a bootstrap simulation.

So we essentially created this big pool of episodes from a very large market. And then we pulled out 1,000 random draws of 50. And we said, what's the average cost of the 50? And you can see the range here for the groups of 50 was, the average cost was between 34,000 and 23,000.

Now as you go to 100, 150, 200, the range gets more and more narrow. But there's still a fair amount of random variation. And so that's one of the challenges here is, if

you're looking at small numbers, are you getting an accurate sense of what the costs actually have been?

So if you go to the next slide. We've done some surveying of ACOs. And we asked them to report their various specialist alignment. So, you know, the first one is lack of data, and especially lack of quality information.

To evaluate specialist costs, so-so. But quality, they really felt like their bucket was empty. I think that the ACOs were concerned that fee-for-service is really driving the specialist behavior.

That if they were small and lean ACOs, they didn't have bandwidth to go out and do all of the, lack of a better word, academic detailing or engagement activities to start to bring the specialists on board.

That some specialists were interested in value-based care, but others aren't. And finally, sort of an uncertainty about the financial incentives.

And particularly, you know, if you get a high-paying specialist, you want to get

him to pay attention, you have to pay a little bit more in terms of bonuses than for a primary care physician.

And I think there's some concern that if we give, ACOs start to do this and build in big specialist game sharing, they can potentially dilute the share of savings that is available for primary care. And, you know, primary care is still the core of many Accountable Care Organizations.

So I will wrap up here. If we go to one more slide, my conclusions. I think if possible, CMS should share more episode data with ACOs. And ideally all Medicare data, including Medicare Advantage. I know that's probably not reasonable now. But it's a goal to work towards.

The second thing is, I talked about power dynamics. I think that we need to think about incentives for specialists in hospitals to engage with ACOs.

So don't just put the onus on ACOs. You got to go out there and engage the hospitals and specialists. What could we do to make the specialists, and hospitals say, hey,

it would benefit us to work with ACOs?

The third is the mechanics of nesting episode payment models I think haven't been worked out and are probably going to be challenging.

And then finally I do love this idea of nesting a medical home approach with incentives inside of an ACO, using something like a GUIDE Model where you have ACOs who have programs that are reviewed, that are, need some additional support, providing some additional support, and then kind of tracking what the outcomes are.

So I will pause here and pass it over to my esteemed colleague, Dr. Opelka.

DR. KOSINSKI: Thank you, Rob. Next we're excited to have a previous PTAC submitter of the ACS-Brandeis Advanced APM model, Dr. Frank Opelka, who currently is Principal Consultant at Episodes of Care Solutions. Welcome back to PTAC, Frank.

DR. OPELKA: Larry, thank you so much. It really is a pleasure to join this panel. It's been amazing to listen to everybody today. There's been a lot of these

presentations that have talked about the current horizon and what's on the immediate next horizon.

I want to push a little further down toward perhaps the third horizon. But all of these are moving together. And all of these overlap. And I think there's a lot to share. And I look forward to sharing that with you now.

So next slide. These are my disclosures. I continue to work with the American College of Surgeons. And I'm working with KPMG on Medicaid and episodes of care within the state of Colorado. And I've got a lot of grouper experience with the Payson Center grouper, and those are the major disclosures.

Next slide. So as I look at this, and as a specialist throughout all of my career, the best outcomes I ever had as a specialist taking care of patients, are those patients who had outstanding primary care. That those patients came to me, and they were in the best of shape, or had the best opportunity.

And so when I look at this, I really value primary care greatly. And how do we actually take a different approach from the approach that's been emerging over the last several decades to get the best practices within integrating primary care in specialty team-based medicine. For the longest of time, we've grown up in medical schools where all of our education has been extremely siloed, very transactional, and not built all of this together. Yes, there's a lot of holistic conversations that talk about it, but when you get down into the field, and you're doing the work, you don't quite walk the talk.

So I think there's a lot to think about in how these organizations are performing, what we can do. Everyone's already mentioned data sharing and how that becomes an important part of about all of this to getting toward more effective care.

Next slide. It amazes me that we've got, in many hospital settings, 300, 400 measures. And still, I get the same questions all the time from my neighbors coming to me as the surgeon on the block. I've got this

condition; I need a specialist. Or from a primary care friend and colleague who says somebody's going to need this specialist, and they're going to need this care, where do I go to get this operation?

And what does good look like? And what is safe, effective, efficient care? What's going to be my out-of-pocket cost? There's an enormous amount of uncertainty in the way we currently practice.

And it is really just our own personal experience which may only be as good as last week and may not really be reflective of the kind of care that we're looking for that's reproducible and has high fidelity. Because we have gotten so used to a transactional, very silo-fragmented approach. And we don't know quite how to break out of it.

Next slide. So there's been a lot of talk about transparency. And I really think this is the key. We're now just starting to say we should be transparent about the cost of care. It should be a lot more than that. We need to be transparent about clinical outcomes and separately about the patient goal

attainment.

The clinical outcomes are those outcomes I know as a physician. In cancer care, I say that Stage 1 should do this, Stage 2, this, Stage 3, that. Or, in somebody who's undergoing total joint replacement, I would expect a certain outcome to occur.

But patients have goals too. And their goals actually take into account a lot of their social determinants. They know they're living in a certain environment that may not be the mirror image of the Mayo Clinic or the Cleveland Clinic or MD Anderson. And yet they said my goals fit my environment. And this is all I'm looking for.

But we don't lay that out there. We don't spend a lot of time determining what is their specific goal. It is a momentary conversation. And we don't really focus on it.

Now as a back-up to those first two, I look at the IOM STEEEP[69]. Is it safe, is it timely, is it effective, is it efficient, is it equitable, is it patient-centered? And if you put those three together, you've got a very

69 Institute of Medicine Safe, Timely, Effective, Efficient, Equitable, Patient-Centered

powerful expression in transparency.

The other part about all of this is health care is -- patients are complex. Care delivery and care pathways are complicated. A care environment and resources in which we work are --they're chaotic. So if we do not certify and verify that entire care pathway, and the care team, and how it all fits together, it just is by happenstance that it just works out in many instances.

We know from years of trauma data, of cancer data, of having verified programs, not just verified bricks and mortar, but clinical programmatic care, that it makes a huge difference in the outcome of care.

We've seen this effort in maternity care recently as we have the maternity care crisis. We're verifying maternity care, that it meets certain standards. There's an effort of bringing that team together.

And if you don't have that, you really don't necessarily know that they are clinically ready, that they can handle the curve balls that come at them, that they can do a rescue when the rescue's needed where they're

set up with the right transfers.

These are elements, these are the core elements, to me, that then form the linkage between helping a primary care ACO or MA plan determine where to get care and who can establish themselves and saying we think we're good enough to perform in this environment. And we think we're worthy of that referral.

Next slide. Value-based care also, in a sense it's been highjacked by the payer community, as if the payer knows the judgment. Value is a judgment. What you value and what I value may be different. What a patient values in one environment may not be what they value in another.

We look at this as value-based care is the judgment that reaches that patient's goal of care. The goal should be personalized, represent the patient's wishes in their environment, in what they expect the care delivery system to give them with advice and guidance from their PCP and specialties.

And we think this is actually the crux of care coordination. When the PCP and the specialist come together around the

patient's goal of care, this is the communication we want to know where the handoffs are and whose got what role to play in optimizing care.

If it's separate from that, if we push them apart from each other and just say we sent each other notes back and forth, or we shared a common platform with information, we're still fragmenting care. We're not spending enough time focusing on the patient's goal jointly between the PCP and the specialist. And that's really where it comes together.

We spend an awful lot of time on adverse event metrics which, if you look at them on a broad scale, the country in general is pretty safe in its health care. And it's not distinctive looking at adverse event metrics, even though they are rare events, to actually determine one place is good for the outcome of care or the patient goal attainments for.

There is some variability there, but it's not that great. It won't show you a distinction in care, and volumes aren't high

enough to have confidence. So to achieve value, PCP, specialists, and patients have to openly share their goals. The true outcome of care can be transparent about the level of goal attainment. And you can throw costs in there too.

Next slide. So when we look at this within the College of Surgeons, we've got decades of collecting risk-adjusted outcome data and looking at all these adverse events. And you can see from the scoring on the right, I know it's a little tight and hard to read, but everything in red, those are bad outcomes, the yellow, not so great, and the green, pretty decent.

And you can see they are rare events. You're not really measuring did I achieve the patient's goal? Now the patient survived. There were no adverse events. But they came to me for a joint replacement or they came to me for treatment of an aortic valve. And did I restore to them their life, their quality of life that they were seeking even though I didn't have any adverse events?

We don't measure that, and we don't

set it down with an agreement with the patient. It's a verbal action that we share together, but we don't hold each other accountable to that. And that's actually where patients come to us. They don't come to us to say I don't want DVT[70]. They come to us to say I want this problem resolved, and I don't want DVT in the process.

Next slide. So patient goals to care and I'm over-emphasizing that, but it considers really a lot of other factors. There is severity of an illness, there are underlying co-morbidities. Patients have a pretty good sense of this. And of course, they want the best out of the worst circumstances.

But when you go out, and you interview across the state, or across an environment, they understand where they are. They understand where they live. They understand the sources they have. But I look, and I've done a lot of looking into total joint replacement, and I look out into rural or somewhat remote areas.

They can get their knee operation

70 Deep vein thrombosis

somewhere. But they have no physical therapy. And if you have a joint replacement, the only thing that really matters is getting through that physical therapy and restoring your life. So we're missing the key part of completing their care. We're performing a portion of the fragment, but we're not putting the whole thing together.

And part of that gets to certifying that this care team provides the entire system of care, all the processes, it's tracking all the points, looking for the failures. It's programmatic approach to care. It's not measuring a surgeon, measuring an anesthesiologist, measuring cardiologist, measuring another specialist. It's about measuring a patient and saying did we put all the moving parts together and achieve what that which we sought to achieve and hold each other in shared accountability for that?

Next slide. So when we look at this, what we're hearing in the episode environment, and we think it actually is, it resonates with physicians in specialty medicine, is that patients are looking for one

episode price.

Yes, the clinicians and everyone else wants to singly bill for all of these things, but put that aside, understanding one episode price, all the clinical services that are involved, the team, whether that team is integrated or it's built upon a community of available resources, by bringing them together in a team and putting the patient goals, safe, affordable, satisfactory care first.

So define the episode, set the team, verify that the team meets the clinical domain, and has the readiness to perform, be open and transparent about the key performance indicators which to me, in the safety profile, goal attainments for its clinical outcomes, ready access, timely access to care, affordability, and understanding the patient risk profile environment that you treat. Do you have the ability to treat high-risk patients or not?

Next slide. So just a moment, sorry, sports analogy, I apologize. But this helps make the point in a little bit of a thought exercise. Imagine you're the owner of a

sports team, whatever it is, soccer, hockey, baseball, volleyball, in my instance it would be an NFL football team. I get the best quarterback, I've got upper-tier running backs, I've got Hall of Fame tight ends, I've got great lineman. I put together all this raw talent.

But until we sit down and come together, and push ourselves, and hold ourselves accountable, and measure our team outputs, you've also got to have a coach, you've got to set schemes against the opposition. In our case, it's a disease, or a condition, or it's the limitations of the resources in an environment.

Putting that together in a system of care doesn't fit within the fragmented environment in which we practice. But it is how most physicians in their practice prefer to live. And yet they get measured in their individual fragmented areas, and we wonder why is there burnout? Because they're not putting themselves together to say let’s work for the best benefit of our team and put this together.

So that's a missing portion. When

we verify and put a team together, and come into a site and do a trauma verification, or a cancer verification, or a bariatric verification, there is a sense of pride from the nursing staff to the house staff, to the C-suite, to the clinical team in the OR[71], that they've all pulled together, and they know they have a role to play, and they hold each other responsible for that.

Next slide. The other thing, and this is just a brief mention of this, and we can go on forever on this now today, excuse me, the concept of AI, of knowledge management, of shared knowledge management in digital platforms is a current reality. We're still living in the EHR world, we're barely leveraging the HIE[72] world the way we should.

What really needs to come together are digital platforms that have shared knowledge about a program of care. Whether it's chronic care management for a PCP, or it is specialty care management of an acute problem, we now have the capability of generating shared knowledge for all of us,

71 Operating room
72 Health Information Exchange

patient facing, payer facing, PCP facing, specialty facing, so that we create the right shared knowledge environment.

And we're not investing near enough in this. We're seeing this come from outside of health care, people coming in saying, gosh, we do this in every other discipline on Earth. Why aren't we doing this, for God's sake, in health care where this affects every one of our lives?

We're starting to see it happen. But to take the engineers, and the clinical teams, and the patients, and put them together into a knowledge environment means we all have to take time. We have to invest in that. And we have to build it.

And that is the exciting future, but that is the third horizon. We're not quite there yet. We're relying on folks like Epic, and Oracle, and Apple, and Microsoft, and AWS[73] to do this. But they need the clinical engineer marriage, the patient inputs, to determine how we'll pull all this together.

Next slide. So I took some of this,

73 Amazon Web Services

and I read it through my own AI engine, and I said, well, what if I got rid of hospital compare and physician compare, and I did episode compare. So I pulled up cholecystectomy in an artificial environment and put in -- you can draw on a zip code and set the milage distance you wanted a patient to have to travel. And that could come from the patient themselves.

And up pops, in this instance, two hospitals, the Central State Hospital and the Regional Medical Center, all of which are just synthetic, artificial. But it gives you what is their price point for a cholecystectomy. It gives you their safety profile, their infection rate, and the readmission rate. It tells you about their high-risk patient profile, and their overall patient rating. But that's not enough. We want more than that.

Next slide. So we drilled down a little deeper. Now I shifted from cholecystectomy to total knee, just to give another example. But we still get a picture of a hospital. And this one is attained a level of verification that calls it a center of

distinction. It's a high-level, high-verified place. It outlines the common care pathway.

So, a PCP can see this, the ACO can see this: these are the expected events that are going to occur in this particular knee replacement environment. And it is the common event. So now we can also look at volume. We can look at, in using risk-adjusted modeling, expected costs to observed cost, and get a sense of 20 percent of this particular practice deals with high-risk patients. And you can set that bar to deal with particular patients that might not just be high-risk; it could be dependent on social determinants. So there are other ways to look at this and create an environment in which the PCP, the ACO, the MA plan, everyone can look at this and see, this is who I am as a delivery system for this episode of care.

Telling me who I am as a hospital is just -- it's too blunt. It doesn't give you enough. It tends to reflect the culture, it tends to give you a sense of this, but the programmatic approach is what, as a patient, I am looking for. And then, as a

physician, I can go out there and turn to the PCPs: I've received a certain status, and here are my data that show this, and this can be live and tracked and updated on a regular basis. We don't provide this level of information to our teams now, and yet it's not that far away. And we should.

Next slide. So, if I delved in one more little bit further, I could look at the verification. And the minimum standard is Joint Commission. But here there's verification for advanced hip and knee replacement. A higher standard that is existing in this environment.

The quality metrics give you the standard safety profile. The complication rates for 30 days, infection rates, readmissions, one-year joint revision rates, those are the kind of things that give you a sense, but then that real important area of patient outcomes, where the patient goal attainment, was it met, exceeded, or not. The patient overall experience. And then the clinical outcome, which, in this instance, is a score that we can actually achieve. Was there

an initial score and was there a 100 percent improvement in that score? And in this case, there was.

So you can see that we can actually create a very simple dashboard or report card that gets to episode compare rather than individual physician compare or individual hospital compare. It's giving the patient the kind of useful information they need in making a decision. And really the reliance on this is the PCP, because most patients can't translate this. But PCPs, this is native to who and how they operate. And they would have no trouble helping their patients read this.

Next slide. So, I thank you for the opportunity to participate. I hope I gave you a little bit of a glance at the third horizon that's out there, and I look forward to the conversation. Thank you very much.

*** Committee Discussion**

DR. KOSINSKI: Well, we thank all four of you for those great, robust presentations. But it's now time to move into some questions. We have 10 minutes. So I want to make sure that the Committee has a chance to

put up their name plates and get some questions in from the Committee. Krishna?

MR. RAMACHANDRAN: Thanks, all. Great job presenting. You all spoke about data sharing in some form or the other there. I've spent part of the last 10-plus years trying to work through data sharing from the Epic side, and, of course, providers and the payer side as well. I know it's a hard, gnarly problem.

I guess I'm curious to see if you all had just, like, best practices, lessons learned from your time in the field. Like, what are ways we can sort of integrate better data sharing between specialists and primary care, particularly in less integrated settings?

DR. KIMURA: Well, I can start, Krishna. You know, I think in the prior panel, we highlighted the challenge, right, in terms of we don't have unified structures in place, right? So, in my chart I've got things set up in a particular way, I can send the feed over to your chart, but it's not all the same field, it's not going to map the same way, and that leads to confusion, and, unfortunately, probably leads to more medical errors or

re-work at that point in time.

But I think the tools are getting better, right? That starts to clean that up. And the more sophisticated organizations are obviously able to create those filters in that transformation logic as that information is coming in.

At least we've seen, for smaller practices -- and, you know, on average, nephrology practices out there are not big, right, so there's three to seven physicians. And so the capability to be able to provide that middle layer, right, to be able to transform and homogenize, I think starts to become really, really, really important.

Because just sending the information, even if it's as stale as a PDF, or subjected out into, you know, very structured data fields, we are finding that, again, it’s those smaller practices are unable to ingest them, and definitely not ingesting them into the workflow in the right spot to engender the types of behavior changes that we would like for our folks to happen. Even though, as you sit every quarter and collectively look at reports and

dashboards, everyone's nodding their head and saying, yeah, wow, we should be doing something about that.

In my area in particular, right, we always think about crash dialysis starts, right, things that shouldn't be happening and yet happens at a very regular clip. And so I do believe -- hoping that our technical vendors, you know, evolve standards to be able to promote greater interoperability, I think it's sort of waiting for Godot a little bit at that point in time.

I do feel like it's incumbent upon folks that are trying to bridge the specialty primary care gaps for smaller practices, someone needs to make the investment that the standards are not there, and has to start to create those kinds of homogenized reports that are clinically meaningful and relevant. And I'd see vendors jumping in doing that left and right, because the overall industry is not quite there yet.

DR. KOSINSKI: Any others want to comment on that? We have other questions.

Henish?

DR. BHANSALI: So, I've heard quite a few different options on how we can integrate primary and specialty care. If it's a fully integrated system, then it's a closed system. For those that are not fully integrated, having robust primary care, and then using specialists only when really needed, right, so that last mile, and then conveners or partners like Somatus coming in and helping folks out.

The other model that I've seen come into play recently is proactive e-consults. So, instead of relying on the PCPs to send patients out to specialists, the specialists are actively -- the risk-bearing entity is figuring out which patients need specialty care. But then the specialists are actively going into their PCPs' EMR systems and managing the patients concurrently, so that there isn't that, you know, delay, et cetera, of care. And the care is integrated within that PCP's EMR.

I would love to get whoever would want to answer that question or comments on that model and where that fits into this, the fourth bucket of different ways of delivering specialty care.

DR. KOSINSKI: Why don't I push this to Rob first?

MR. MECHANIC: Yeah. So I love the idea of e-consults. I think it's a really sensible way to move forward. There are some companies that do this. There are also some health systems that have essentially set up internal processes where their PCPs can do e-consults or -- I hadn't heard, actually, Henish, what you had talked about, about the specialist kind of walking through the medical records and looking for opportunities. It was more that they were creating a resource for primary care to go and ask questions when specialty-related questions come up.

I think the real issue is being able to have it happen in a very timely way, preferably either when the patient's in the office, or you could do asynchronous stuff as well. But I think it's a good idea.

The question is, then, you know, how is it paid for? I think it has to be something that the organization feels like they're getting value from it. I know that there are some new, for example, in Making Care Primary,

some new e-consult fees. But it's like $50 for a specialist, right? And, you know, I just was at the dermatologist. I was there for 10 minutes, and $500 bill. So, I have to sort of figure out how it's financed or whether it's internally financed. But I think it's a great idea.

DR. KOSINSKI: Other comments?

MS. MITCHELL: I'd like to just add one thing. I agree with everything that was said. We ran a sort of Center of Excellence program for about eight years on behalf of our members. And people totally agree on the e-consults. But one of the things that we really identified that was critical to success, to your point, was the appropriateness of the procedure in the first place.

And most of the time -- well, a shockingly large percentage of the time it wasn't even needed. So, having the referral or really not be attached to any incentive to do the procedure was very important, whether that's a third party, whether it's primary care, but just really separating that incentive from the consult was very important.

DR. KOSINSKI: Frank, any comment?

DR. OPELKA: Yeah, I mean, what I'm seeing is a little bit different. And it gets down to pulling in the data and doing predictive analytics on a population, and helping the PCP understand, here's your population, here's where they stand and what's going on with them, and having the specialist, at the same time, be able to assist and look. And they may be able to say, my gosh, we've fallen behind in mammography screening or we're behind in colonoscopy screening. Then the radiologists and the endoscopists have to step up and help and put incentives in play in that system, that that PCP isn't the one -- the only one looking at the dashboard.

Those flags go out to everybody involved. This is a health issue. We owe it to our population to get this done. Now let's step up and get it done. And then we also have that ability to look at a population and generate the predictive analytics, too, and say, gosh, if all these people have this much care, this is how much we're going to save, or this is how much better we're going to improve

quality of life.

Those predictive analytics through AI engines are going to be here within -- probably within the next year and a half. They're already in play; we just haven't put them in front of the PCP and the specialists. But it's coming, and it's coming fast.

DR. KOSINSKI: Joe?

DR. KIMURA: Yeah, the one thing I'd add, Henish, is I think if you have a loosely integrated system, and you have a PCP that's potentially capitated, thinking about that, and the specialist that’s on fee-for-service, that relationship, I think, can also be challenging when, if you have that transparency through, and you're allowing the specialist to jump in -- particularly because not all PCPs have the same range of things.

If it's something only a specialist can do, a little less friction. They begin to overlap, then you start to say, like, hm, there's some conflict there on who's actually providing that care.

So the proactivity, I love. As a PCP, want to encourage it, but then you've got

to get that information back. If they're proactively doing it, I want to get that information back. As the PCP, I don't want to wait a month or two for whatever you found along those lines. So there's a lot of other pieces together that needs to complement that.

DR. KOSINSKI: I think Lauran has a question, or Jim. Jim?

DR. WALTON: Hi, thank you for your comments. I had a question for Elizabeth, and then maybe if anybody else wanted to comment. I was struck by your comment around 13 percent savings in total cost of care, if I heard it correctly, for every dollar spent in primary care. And I was curious how your members thought through the idea of what inflation rate target were they really interested in achieving in these new initiatives. And are they discussing guardrails to protect from too little care versus too much care? Is there a guardrail discussion? So, it's an inflation rate target. Is that part of the conversation with your members? And what is that? What's it tied to, what's it pegged to? And then guardrails.

MS. MITCHELL: That's a big question, and my answer may sound controversial, but it's not intended to. Most of our members are looking for flat trend, right. They are spending billions and billions of dollars and believe that while they are happy to spend, you know, a large amount for high-quality care, there are savings possible.

So that said, you know, many of them are managing to, like, 1 to 3 percent total cost increases year on year. And I will say, going back to the Office of Healthcare affordability in California, that we have set a 3 percent target. But that is across the system.

And, you know, the idea is that maybe that comes from PBMs[74], pharmacy, health plans, and hospital care. But that is reinvested in primary and mental health care, just as an example. So, I don't know how to exactly translate that to an inflation rate, but I would say that they are looking for, you know, flat to very low trend. And of course, that is in contrast to the double digit

74 Pharmacy benefits managers

increases they're getting now. So there's a long way to go. Does that answer your question?

DR. WALTON: Yes, you answered it. And then just the other protection on downside, you know, the protection of too little care for your, the members.

MS. MITCHELL: Certainly, so that was sort of really going back to the measure set that we talked about. Again, it's not the end-all, be-all measure set, but it's about outcomes.

We have an access metric, actually one of the biggest barriers we're seeing now is, like, not even being able to get an appointment for primary care, or maternity care, or mental health care. So there are major access barriers that aren't even being measured. And so they are asking that those be measured. Those are part of the performance guarantees.

And I know access isn't the singular metric here. But outcomes, experience, clinic -- they're absolutely looking at clinical outcomes. So again, it's not sort of a

restriction on care. You know, on the contrary, it is trying to get more people into better care sooner. And they are measuring that.

DR. KOSINSKI: Krishna?

MR. RAMACHANDRAN: This one is for Elizabeth. Elizabeth, this is about multi-payer alignment, obviously a topic close to your heart and my heart, given our work together in California. I was wondering if you have thoughts on just, like, how do we expose this to other parts of the country?

Like, what do you -- do you have any words of wisdom or lessons learned, or best practices you've seen? Obviously, it just kicked off, but it took, like, multiple years to even get to the kickoff point in California, but any thoughts you'd want to share for us?

MS. MITCHELL: Krishna, I think you should be the national evangelist for this. Ha, ha, ha.

I think it takes a lot of convincing. Because I think currently, and again, I'm just speaking from my own experience, a lot of plans see this as sort of a competitive disadvantage, whereas we think

they should compete on other things.

Because, you know, a slightly different measure set isn't really bringing a ton of value anywhere. And it really took a long time, as you said, two or three years, to get to alignment here, in part because it just, it goes against, sort of, current business, how teams are structured.

And, you know, frankly, the muscle memory of fee-for-service is very strong and really convincing folks that this can work took a lot of time.

There isn't a well-funded infrastructure at the regional level, or community level, or anywhere really, to enable this consensus collaborative work. It is, you know, I know CMMI has tried this, but it sort missed the mark of existing relationships on the ground.

I think California is uniquely advantaged, because we have groups like the California Quality Collaborative, IHA, other sort of tables where this can happen. But I think it just takes a lot of, you know, old fashioned time and relationship building to see

the mutual benefit of this. But I would love to export it, and I'm happy to partner on doing that.

MR. RAMACHANDRAN: Thank you.

DR. KOSINSKI: Lauran?

MS. HARDIN: Just building on that, I loved your presentations. I'm doing a lot of work in California, and see that native organizing that's happening on the ground of all of these new roles with community health workers and others, and new payment sources but also work nationally.

And one of the things that I've seen as a trend that's been interesting is payers are starting to fund that integrator role. So it's different than an MSO[75]. They're funding integrator roles to bring the community together for all payers, look at collaboration to meet the needs of complex populations, and then also work on the gaps in the system of care in the community to actually work on building out resources that are not there.

So I'm curious if you are seeing that as well in the work that you're doing and

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where you think that funding may come from in the future if it's not from CMS.

MS. MITCHELL: Is that directed to me?

MS. HARDIN: I think any of you, it's an interesting trend.

MS. MITCHELL: I'm happy to start, certainly don't need the last word here. I used to run a national organization of regional health improvement collaboratives. And there were various tables, and various states and regions funded somewhat differently.

I do think there is a role for payers to contribute to this and say, okay, maybe it doesn't have to be my model. Maybe we can contribute to a community model. And there have been, you know, real success stories around the country of that working, not just in California. But there is not an obvious funding infrastructure for that which, I think, is a big challenge nationally.

And I think, you know, I had lobbied CMMI many times to sort of contribute to that. But I think we still need to keep looking for the right funding source. Because right now it

is not consistent.

DR. KOSINSKI: Any others with comments? I think we have one last question. Walter?

DR. LIN: I have a quick question for Dr. Opelka. It's something you brought up that I hadn't really heard before which is integrating a patient's goals of care into the measurement of value-based care.

So, you know, just for background, I work in a nursing home, and so do other providers in my group. And we are very focused on value-based care but feel like a lot of the quality metrics, like mammography, for example, are not applicable at all to our patient population, and yet we're asked to subject our patients to them because of the universal measure set.

So, I guess, is there a way to integrate patient goals of care into value-based care measurements of quality in a standardized way that's not gameable, but on the other hand really does take into account patient goals of care?

DR. OPELKA: Thanks very much, and I

share the same challenges and concerns you talk about. I recently went through an operative procedure. In pre-op, I had six different visits. And on six different visits, six different doctors asked me if I'd fallen in the last year.

So I'm going to get a T-shirt that says I have not fallen in the last year.

(Laughter.)

DR. OPELKA: But that's how crazy the measurement system is. It's kind of nuts. And nobody asked me what my goal was until I asked them, does anybody care what my goal is? And it was a knee replacement. And I told them I really don't want to fatigue on the back nine anymore. I want the pain to go away, and that's my goal. So I'm measuring them based on that goal.

The NCQA[76] has just put out a goal of care measure. It's a primary care measure. But it should be changed to also consider specialty care. Because all of us have a goal of care with our patients, and it's relatively simple. It's not one of these 50-question

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surveys. It's a very brief survey.

I think that this survey, and we're looking at this in surgical care, I think there should be a pre-op survey. You know, what are your goals, let's lay it out on the table right now. And then there should be a post-op survey.

And for some of these conditions, there may be a need to update that survey at six months and one year. Because the ongoing events related to the care you received are still evolving, and particularly in things like maternity care where, my gosh, this is 18-month event at least, if not 21 years or more.

So there's a lot of this that is important to all of us in the way we practice, and yet we've never put it into our measurement structure. And it's probably much more eventful and informative than the way we're currently measuring. So I would make a big investment in trying to do this, because we think it'll actually -- it will deal more with burnout than anything.

Measuring the right thing, measuring our ability to achieve the right thing is really what the nurses, housekeeping, the

surgeons, anesthesia, everyone got in the business to do, not just to measure the safety profile in adverse events. I'm not saying get rid of those. I'm saying let's get something that's a little more pragmatic for the purpose that we serve the patients and the community.

DR. KOSINSKI: That's the perfect note to end on. On behalf of the Committee and our audience, I'd like to thank each of our panelists and presenters for their insight and excellent contributions today. We so appreciate your time and expertise.

At this time, we're going to probably take a very shortened break, maybe a couple of minutes, and then the Committee will reflect on the day and discuss some potential comments and recommendations for the report to the Secretary. Thank you. We're on a short break.

(Whereupon, the above-entitled matter went off the record a 4:31 p.m. and resumed at 4:40 p.m.)

DR. LIN: Well, welcome back. I'm Walter Lin, one of the PTAC Committee members. As you may know, PTAC will issue a report to

the Secretary of HHS that will describe our key findings from this public meeting on reducing barriers to participation in population-based total cost of care models and supporting primary and specialty care transformation.

We now have some time for the Committee to reflect on what we have learned from our sessions today. We will hear from more experts tomorrow, but we want to take the time to gather our thoughts before adjourning for the day.

Committee members, I'm going to ask you to find the potential topics for deliberation document. It is tucked in the left-front pocket of your binder. To indicate that you have a comment to make, please flip your name tent or raise your hand in Zoom. Josh? Would anyone like to start?

(Pause.)

DR. LIN: Lauran, thank you.

MS. HARDIN: Since I'm next to you, I'll start, I'll go.

So there were a lot of really interesting themes today. I'm just going to call out a few and see if others want to

comment on that. One of the ones I thought was really interesting from a rural perspective for success, and population-based total cost of care models, is the importance of a convener, a networks approach, community hospitals serving as sort of a community center, and the need to really share resources across sectors to build integrated teams and have a lot of creativity around how care is delivered that really shifts when we move to all payer models.

I thought the comment Chris made about just do it, it's time to move, you know, we've been moving things around the edges, but in order to get to success, especially in rural, we need to have that alignment.

And then also the theme around integration of AI for broader predictive work, the need to have proactive anticipatory disease and symptom management, as well as starting to identify needs, pathways, and road maps for a rising risk populations for success, we really need to be thinking about AI, as well as thinking about the tsunami of older adults, and the declining workforce, that we need to get very efficient and be thinking about

integration of AI in all of that. And then also I just loved the last presentation. I think it's very interesting. If we can't do this proactively in our existing structures, business is going to step forward to make it happen, so a lot of things to consider.

DR. LIN: Thank you, Lauran.

Lindsay?

DR. BOTSFORD: Yes, thanks, Walter. Yes, I mean, I think we saw some similar themes here today from previous meetings. But maybe with some nuance that I think is worth capturing, I think hearing that multi-payer alignment is critical for success was not a new theme.

But hearing some of the specifics around, you know, what is that critical mass of patients, and somewhere between 40 and 60 percent of your patients being in these at-risk arrangements is needed to be able to start to make it more profitable to be in these arrangements and move the needle.

I think similarly, on the multi-payer framework, the idea of how could ECQMS that are multi-payer help to streamline

some of the administrative burden of participation in value-based arrangements was an interesting fact today.

I think we heard challenges that we've heard before. That technical assistance needed to participate in models remains high. And then the burden of first year patients is also high. And how can we overcome that?

I think we also heard about the burden, the ratcheting effect. I think that is also not a new burden that's been pointed out. But how can we find new ways to adjust for that?

I think I'll maybe highlight just a couple, maybe more specific tactical suggestions as we think about payments. Both longer implementation timeline as we think about payment demonstration projects in the future, as well as reducing the time between performance and payment can be helpful.

And then I think the specific tactical one I'll call out from Jessica on our first panel is that attribution could be improved by thinking of it at the level of the TIN and NPI instead of just the level of the

TIN to avoid attribution by specialty care alone. So some real, concrete things that we could do in improving things outside of the blow it all up and head there faster as Dr. Kerwin.

DR. LIN: Thank you, Lindsay. I think Krishna was next.

MR. RAMACHANDRAN: Yes, thank you. Yes, to Lindsay's point too, I think there have been some themes from past discussions and past conversations, certainly the multi-payer alignment was key. And we have time coming up in September for -- that should be fantastic. How do we sort of make that real nationwide? Particularly the comments on keeping it simple, keeping the measures simple, so I think that simplicity, noting the barrier to entry and aligning, I think, seems to be a general theme there.

Sort of the dollars for infrastructure, data, pop-health, clearly seem to be consistent, technical assistance of course. And then, I think, Walter, you brought up too the last mile, how do you make sure there are incentives get to the doctors in a

way that keeps providers engaged in the process, given the reconciliation is so long and delayed as well? I thought those were some interesting sort of insights there as well.

DR. LIN: Thank you, Krishna.

Henish?

DR. BHANSALI: So I think Lindsay summarized some of the key points that I was thinking, literally the points that I stated which, I think, were some of the specifics around getting the lead time for the model to really prepare for being able to participate in it, et cetera.

When it comes so specialty care, I think that what I heard is that more robust investment in primary care, and especially as we think about the ROI for primary care and having that be a part of, sort of, the integral part of care delivery and then aligning some of the outcomes that we have, not to negative outcomes, right.

So someone goes to get a knee replacement or hip replacement. They're not walking out with a with a DVT but actually outcomes that are aligned with what the

positive outcomes are expected to be, such as mobility, or functionality, et cetera.

There's an organization called the International Consortium of Health Outcomes Management that specifically states, what are the positive outcomes that you would want from a lot of these interventions? And that's at least what I heard the clinician document, comment on.

And so as we're thinking about quality metrics, measurable quality metrics, to think of them not as the avoidance of negative things, but really as a promotion of positive things that we hope for our patients.

And then the last piece I heard about was advanced care planning. And so advanced care planning, being a part of any value-based current model, just fundamentally changes how that model is practiced. And this has been demonstrated multiple times. And I think it was shared a couple of times. Having that be a core quality metric can also be a consideration.

DR. LIN: Thank you, Henish.

Lee?

CO-CHAIR MILLS: Very similar, some of these have already been said. But I was really struck by the richness and the intentionality our first panel discussion first thing in the morning brought to this. They had some very concrete, very specific recommendations which is what we asked them to give us.

And some of those have already been mentioned on just the criticality of the new cash flow in the first few months, the timeline being too long of 12 to 18 months, and how you try to shorten that. But then the risk-taking organization might help get you over that, you know, one-quarter hump where you can start operating.

Attribution is mentioned. I thought the concept was interesting that the complexity -- we talked a lot about complexity over the last three or four years. But just the complexity is so overwhelming, and the inertia is so entrenched that you financially have to be far beyond the tip point to actually tip.

You know, we had examples of, you know, very favorable arrangements offered to

physicians to move out of fee-for-service. And they're just so fearful of change and so entrenched with the inertia and systems that you have to be not, you know -- 55, 44 is enough to get you tipped. You've got to be maybe 75 percent before you think about even considering changing how you practice, which was powerful to hear.

I thought the point that rural providers that are, you know, traditionally pretty low-volume, bring a whole new set of standards, and the power of low numbers and risk goes up in that setting. I thought that was powerful.

Several people said different ways that, you know, MSSP is, you know, clearly kind of a winning model in the Medicare space but that it lacks one key thing, which was essentially the ability to do UM[77], to work on demand utilization control upstream or utilization control in the organization as a way to weed out waste and unnecessary costs. I thought that was interesting. I hadn't heard that before.

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I thought it was interesting to hear that, again, back to the risk concepts that people think actually that how the downside risk is mitigated, and control is actually more important that how much gain is possible. That was a more important concept.

Again, really struck by several speakers speaking to that a margin of 40 or 50 percent more is needed before you consider it. And that it takes 40 to 50 percent of your practices into our panel in a multi-payer alignment to think about tipping over and changing the operations. I'll point out, I think that Clif's materials from NAACOS, he's done some really nice thinking about benchmarking issues we've talked about, and challenges with some offered solutions that I appreciated, that about risk adjustment and trend adjustment that are worth consideration.

And then the quote of the day from Dr. Sinopoli that really, in your physician leadership, moving to value-based care, it takes a mad man. So may we all be the mad men in our arenas.

DR. LIN: Thank you, Lee.

I think Jim was next.

DR. WALTON: Yes, just to try to fill in some gaps, you probably would expect me to say something about the rural infrastructure problems in America, so I will.

(Laughter.)

DR. WALTON: So I don't want to really disappoint anybody. You know, the big thing that I took away was it's really, really hard to innovate when your ship's got holes in it.

And we heard pretty load and clear, we continue to hear this over and over again from experts in the field that, you know, there is a pretty large issue out in the United States that we, as we talk about value-based care and expansion of it, and increasing participation, and creating pathways for increasing participation, so that the benefits of value-based care would accrue to people that are really vulnerable.

So if you think about all of that, you know, we say well, let's go for the target. And I think we heard that from Chris, you know, to target this.

And we had an observation of, you know, we had a lot of people here that were really highly engaged in doing this work and very excited about it. And we heard from Elizabeth in California that the purchasers, if you will, want to move this way as well.

So there's kind of this momentum accruing in large environments, but there's a group of people that are probably likely to be left behind. And so I think that, given what we said about market forces and organizational structures, and business models that could affect participation decisions, we see Critical Access Hospitals and rural providers being at somewhat of a disadvantage.

And so I would submit that, like we had talked about having a pathway for value-based care aggregators, we actually might want to think about advising a particular pathway for the rural communities where the infrastructure is – health care infrastructure is kind of falling down, not because of value-based care, but in spite of it. I also thought -- there was one other thing that I wanted to lift up was the idea of a measure

being the patients' goal attainment and being kind of a lining, if you will, performance measures across multiple payers in that particular vein, I thought was really, really strong and something I took away from today.

And then finally, I guess there's this thing with Medicare Advantage that seems to have some kind of advantage. And there's a little bit of a wringing of the hands to some extent around the fact that there's more business moving away from fee-for-service and into Medicare Advantage. And we see that fee-for-service value-based care is saving money and producing increased quality in the MSSP model.

So we're thinking well, could it be cannibalizing value? Well, maybe there are some policy opportunities to recommend to kind of stop some of the that disadvantage that -- or the advantage for Medicare Advantage with regard to risk scoring, for example, and some of the ratcheting effects that are adversely affecting the fee-for-service of value-based care. So I'll leave it at that. And thank you very much.

DR. LIN: Thank you, Jim. Larry?

DR. KOSINSKI: I compiled my notes here, and what I have, number one, there must be a feasible, visualizable path to savings. So it's got to be attainable. You've got to be able to see that you can do it.

The time between performance and payment must be reduced. Up-front payments have to be part of the model. We still don't have enough real participation from specialists. I love the line most specialists participate in ACOs are really not in the ACO.

Fee-for-service still has to be made less desirable for the specialist and more desirable for the PCP. Hybrid fee-for-service capitation models need to be investigated. The 40 percent rule may be the way to get participation. You've got to get the hearts and minds. Enough of their revenue has to be at risk or part of the -- and we heard 40 percent a couple of times. Risk reward analysis has to be realistic and consistent with the business model of the practice. Multi-payer alignment could be a game changer for participation.

And then finally, and something that came out near the end that I thought was cool, nested PCMHs[78] may be a way to create cascading accountability for chronic medical care. I thought that was cool. That's what I wrote down.

DR. LIN: Thank you, Larry.

And Chinni?

CO-CHAIR PULLURU: Great job, everybody. I'm going to try to fill in some of the gaps that I haven't heard yet. And one of them is from the first panel. They spoke about rural hospitals and the global payment and how well that had worked. And perhaps that's the way to sort of salvage and rescue some of the hospitals that are very needed in those areas right now and differentiate that.

One of my favorite quotes was that primary care physicians have a Stockholm syndrome when it comes to --

(Simultaneous speaking.)

CO-CHAIR PULLURU: -- when it comes to fee-for-service. And as a primary care physician who practiced, I can tell you that's

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absolutely true.

But I like the idea, and I haven't heard this in all the time that I've been on PTAC, is making the primary care payment tax deductible for the patient because of the ROI on primary care being $13 to $1. I think that's an excellent idea.

I also love the idea of sort of a carve-out, some people called it a sub-cap for primary care, some people called it subscription payment, but a carve-out payment as a mechanism for potentially a perspective type of payment to help primary care physicians do what they need to do and provide that $13 to one ROI.

And then a few other things, the technical assistance to implement programs, I do think that's really important, particularly in areas, you know, so we don't incentivize consolidation inadvertently to programs, because people just can't have access to data or the technical assistance.

And then I think I have one more. The other thing that I noted was having actuarial stability. So as you look at

benchmarking, and you go through actuarial analysis, retrospectively and prospectively, and you're trying to get into programs, figuring out a way that the provider systems or providers have some level of actuarial stability in benchmarking, and having some sort of reconciliation that's quick so they can actually get access to the money when they fall short.

And then I, you know, of course, Angelo, our favorite person, brought up the 2020 OIG rules around the flexibility in waivers. And I think looking at that program to say, like, hey, that was great, why aren't people using it, and how do people -- how do we make that more a part of the sort of connective tissue of how care is delivered?

DR. LEE: Thank you, Chinni.

Josh?

DR. LIAO: Thanks, Walter. Really great session, and I go with what other Committee members have said. And many things bounce around in my mind. I think, you know, I return to kind of what we started with today around kind of barriers to participation.

I kind of alluded to this idea of maybe thinking about it as optimizing as opposed to maximizing, insomuch as that I think these population-based total costs of care models, I think, can and should be improved in a technical way, like PTAC is supposed to be looking at to be one key offering in the market. But as others have alluded to, there are others that I think are really important.

And as I reflect on many conversations leading up to this session, you know, there is so much good stuff that people have said. And where my mind is, it's kind of, like, do I need 10 other really good things added to the conversation, or are there things you might take away from the conversation, addition by subtraction? They're like things that make sense but, if you really think about it, actually don't serve us as we're trying to achieve these goals with population-based models.

And really, kind of, to me it comes back down to tradeoffs. So while I really appreciate a lot of the kind of concepts mentioned, I think we should really stare

honestly and transparently at some of these tradeoffs.

So for example, you know, multi-payer, I think good for any number of reasons, other people have mentioned it multiple times, but it requires a simplicity, right. And that simplicity though, I think, has come at a tradeoff, historically, right. The simplicity can be achieved with primary care and ambulatory measures which is predominantly what many of these models have been historically, however named.

But we struggle with investment in primary care. How can you bring that simplicity to specialty care when every specialist is a little bit different, and the context is different? And the specialty kind of load, or the dose you would need for different populations is different.

I think we just have to recognize that things that require simplicity, like multi-payer alignment, will struggle when you're trying to integrate sub-specialists. And I think, you know, to the extent that one ounce of data is better than a ton of opinion,

if you look at what we've done, really well intended efforts over a decade in Medicare, you see that with multiple models, what doesn't port over to Medicaid, what doesn't port over to commercial space.

I know some of the Committee members have really focused on advancing specialty models in the commercial space. Those don't really carry over very easily to others as well. I think that's telling us something.

And so the more we say multi-payer, keep it simple but, yes, integrate all specialists, I think that notion doesn't serve us anymore. And I think three or four of these meetings suggest we should do away with some of that thinking to help us, you know, do both things, like some of our SMEs have suggested.

Here's another, I'll just give you one more for time. When we think about scaling up participation, say within a payer such as Medicare, you know, what's the tradeoff between that then and the multi-payer that I just mentioned?

Getting more people into different models and one payer doesn't necessarily get us

wide with multi-payer. Because others have mentioned today this idea of one size won't fit all. So if you scale up, you are accepting complexity. The table we've put forward on the PCDT has got complexity in it, meaning it's got multiple rows and multiple columns.

I think this is a feature, this is not a defect in the system. But if we embrace that complexity, we have to set aside some degree of simplicity, right. So scaling up within a payer, I think, and scaling out wide, there is a tradeoff there.

And so I think they're just, as I've been thinking through this, maybe I'll kind of summarize more tomorrow, but there are three or three or four or five things in my head where I think expunging these ideas from our conversation going forward will help us. Because we heard, over many meetings, including today, really nice things. But how do they fit together? And I worry some don't.

And so I really love the conversation. I think this all really helpful for moving the dialogue forward. I look forward to thinking more about the technical

pieces with the rest of the Committee members and the subject matter experts. But what are those ideas that don't serve us anymore that we need to take off the table? That's where my head is at after a really productive day. Thanks.

DR. LEE: Thank you, Josh. And just in the interest of time, I'll just make a couple of really brief remarks in terms of my thoughts. You know, after Jim's PCDT presentation, that went really well, the plateauing of participation in PB-TCOC models, ACOs.

You know, I had said fee-for-service is the real villain here. And I think that was a theme that ran strongly through the sessions today. Since, I think Chinni quoted Dr. Crow's Stockholm syndrome of fee-for-service, or used the other one, fee-for-service is the devil to the PCP, all the way through, to the very last session where Elizabeth said the muscle memory of fee-for-service is very strong, you know.

And I think the idea that there are viable business models that thrive under fee-for-service, I think, presents a real challenge

to increasing participation in value-based care.

The other thing I just mentioned along those same lines is the comment by Clif Gaus around how ACOs are held to stricter financial performance expectations without approaches like networks or utilization management.

And I think that's also very important to grasp as well. Because, you know, if total cost of care models were entering into a boxing ring with fee-for-service, it's like we're entering into the boxing ring with one arm tied behind our back. We don't have the tools that Medicare Advantage plans have to make these models succeed.

And so I just think there might need to be additional considerations over time about adding tools to the PB-TCOC toolbox to help these models be more successful.

With that, I'm going to turn the time over to Chinni to close us out.

*** Closing Remarks**

CO-CHAIR PULLURU: Before closing, I'd like to check with the staff team to see if

they have any clarifying questions for us.

I want to thank everyone for participating today, our expert panelists, my PTAC colleagues, and those listening in. We will be back tomorrow at 9:00 a.m. Eastern Time. We will be joined by Mr. Abe Sutton, the Director of Center for Medicare and Medicaid Innovation, and Deputy Administrator for the Centers for Medicare & Medicaid Services, who will be providing opening remarks.

Our day 2 agenda features a panel discussion and final listening session. The panel discussion will focus on enhancing the ability of population-based total cost of care models to be competitive.

Then listening Session 3 will focus on how to maximize participation of beneficiaries in accountable care and improve the sustainability of effective population-based total cost of care models.

*** Adjourn**

There will also be an opportunity for public comments tomorrow afternoon before the meeting concludes with the Committee discussion.

We hope you'll join us then. Thank you. This meeting is adjourned for the day.

(Whereupon, the above-entitled matter went off the record at 5:07 p.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Public Meeting

Before: PTAC

Date: 03-03-25

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate complete record of the proceedings.

Neal R Gross

Court Reporter