

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

**March 8, 2022
11:03 a.m. – 3:46 p.m. EST
Virtual Meeting**

Attendance*

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

Paul N. Casale, MD, MPH, PTAC Chair (Vice President, Population Health, NewYork-Presbyterian, Weill Cornell Medicine and Columbia University)

Lauran Hardin, MSN, FAAN, PTAC Vice Chair (Senior Advisor, Illumination Foundation and National Healthcare and Housing Advisors)

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

Lawrence R. Kosinski, MD, MBA (Founder and Chief Medical Officer, SonarMD, Inc.)

Joshua M. Liao, MD, MSc (Associate Professor, Medicine and Director, Value and Systems Science Lab, University of Washington School of Medicine)

Walter Lin, MD, MBA (Chief Executive Officer, Generation Clinical Partners)

Terry L. Mills Jr., MD, MMM (Senior Vice President and Chief Medical Officer, CommunityCare)

Soujanya Pulluru, MD (Senior Director II of Clinical Transformation, National Health and Wellness, Walmart, Inc.)

Angelo Sinopoli, MD (Chief Network Officer, UpStream)

Bruce Steinwald, MBA (President, Bruce Steinwald Consulting)

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

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

Lisa Shats, PTAC Designated Federal Officer

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

List of Speakers, Public Commenters, and Handouts

1. Listening Session on Issues Related to Population-Based Total Cost of Care (PB TCOC) Models Day 2

Sherry Glied, PhD, Dean, Robert F. Wagner Graduate School of Public Service, New York University

Karen E. Holt, Vice President, South Region, Collaborative Health Systems

Valinda Rutledge, MBA, MSN, Chief Corporate Affairs Officer, UpStream

Christina Severin, MPH, President and CEO, Community Care Cooperative

Jon Broyles, MSc, Chief Executive Officer, Coalition to Transform Advanced Care (C-TAC)

(Advanced Care Model [ACM] Service Delivery and Advanced Alternative Payment Model)

Gary Bacher, JD, MPA, Chief of Strategy, Policy and Legal Affairs, Capital Caring Health

(Advanced Care Model [ACM] Service Delivery and Advanced Alternative Payment Model)

Torrie Fields, MPH, Chief Executive Officer, Votive Health *(Advanced Care Model [ACM] Service*

Delivery and Advanced Alternative Payment Model)

Handouts

- Listening Session on PB TCOC Models Day 2 Slides
- Listening Session Day 2 Presenters' Biographies
- Listening Session Day 2 Facilitation Questions

2. Panel Discussion on Definitional Issues Related to PB TCOC

Jennifer L. Kowalski, MS, Vice President, Public Policy Institute, Anthem, Inc. (Payer Perspective)

Emily Maxson, MD, Chief Medical Officer, Aledade, Inc. (Provider Perspective)

Judith A. Stein, JD, Executive Director/Attorney, Center for Medicare Advocacy (Patient Advocacy Perspective)

Gail R. Wilensky, PhD, Senior Fellow, Project HOPE (Academic/Policy Research Perspective)

Handouts

- Roundtable Panelists' Biographies
- RFI (Request for Input)

3. Public Commenter

Sandy Marks (Senior Assistant Director, Federal Affairs, American Medical Association [AMA])

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

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

The [ASPE PTAC website](#) also includes copies of the presentation slides and other handouts, and a video recording of the March 8 PTAC public meeting.

Welcome and Overview

Paul Casale, PTAC Chair, welcomed members of the public to the March 8 virtual public meeting. He noted that the March 7 public meeting began with Centers for Medicare & Medicaid Services (CMS)

leadership presentations. He stated that leadership from CMS and the Center for Medicare and Medicaid Innovation (CMMI) shared information about the Innovation Center’s Strategy Refresh, which includes the goal for all Medicare beneficiaries with Parts A and B to be in a care relationship with accountability for quality and TCOC by 2030. Chair Casale indicated that this is one reason PTAC chose to explore population-based TCOC models during a series of three theme-based discussions. He noted that the March 7 public meeting featured a variety of experts who discussed current research on the impact of population-based TCOC models and episode-based models, and areas where further information is needed; how population-level efforts can address health equity; best practices for improving affordability; options for defining TCOC; state-level innovations; opportunities to align multiple payers and include specialist participation. Additionally, presented information about how previous PTAC proposals incorporated elements related to TCOC.

Chair Casale invited Committee members to introduce themselves and their experience with population-based TCOC.

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

Lauran Hardin, PTAC Vice Chair, moderated the listening session with previous submitters and subject matter experts (SMEs) on issues related to population-based TCOC models. She noted that the full biographies and presentations for presenters can be found on the [ASPE PTAC website](#):

SMEs

- Sherry Glied, PhD, Dean, Robert F. Wagner Graduate School of Public Service, New York University
- Karen E. Holt, Vice President, South Region, Collaborative Health Systems
- Valinda Rutledge, MBA, MSN, Chief Corporate Affairs Officer, UpStream
- Christina Severin, MPH, President and CEO, Community Care Cooperative

Previous Submitter

- Jon Broyles, MSc, Chief Executive Officer, Coalition to Transform Advanced Care (C-TAC) (*Advanced Care Model [ACM] Service Delivery and Advanced Alternative Payment Model*)
- Gary Bacher, JD, MPA, Chief of Strategy, Policy and Legal Affairs, Capital Caring Health (*Advanced Care Model [ACM] Service Delivery and Advanced Alternative Payment Model*)
- Torrie Fields, MPH, Chief Executive Officer, Votive Health (*Advanced Care Model [ACM] Service Delivery and Advanced Alternative Payment Model*)

Sherry Glied presented on strategies for reducing cost of care while maintaining or improving health outcomes.

- Dr. Glied explained that the primary methods to reduce cost of care while maintaining or improving health care outcomes include reducing duplicative or unnecessary care; monitoring and connecting people to care to avoid increases in condition severity; and increasing preventive efforts to avoid future care. She explained that these strategies focus on reducing quantity of care. She also stated that reducing or optimizing quantities is also the focus in the context of Medicare and emphasized the importance of differentiating between cost containment strategies that focus on price versus those that focus on quantity.
- Dr. Glied indicated that the movement toward alternative payment mechanisms is based on a perception that the fee-for-service (FFS) payment structure disincentivizes efforts to prevent

unnecessary care or and avoid duplication. However, she noted that there are some advantages associated with FFS, including monitoring performance, maximizing patient choice of their providers, automatically adjusting for risk (i.e., because patients who require more services generate more payments), and leaving providers with very little risk. She also noted that nine peer countries with lower cost and higher quality primarily use FFS to pay outpatient providers, and most essentially use output-based payments to pay their hospitals.

- Dr. Glied then indicated that moving from FFS to the use of capitated, bundled, or flat payment Alternative Payment Models (APMs) or mechanisms generates a new set of problems.
 - APMs have a higher burden of monitoring, and while these payment models are better able to measure value instead of volume, measuring value is nevertheless challenging.
 - APMs require a method for assigning patients to providers, which can create incentives for providers to shift costs. For example, she indicated that during the move to managed behavioral health care, with carve-outs that covered talk therapy but not pharmacotherapy, behavioral health providers shifted patients toward their primary care providers (PCPs); and the use of bundled payment for post-acute care may have resulted in shifting the burden of care to families and informal caregivers.
 - APMs need a way to adjust for risk so that providers do not have incentives to avoid the sickest patients; however, risk adjustment systems can create perverse incentives to over-diagnose conditions and can increase the amount of risk that providers take on when they participate in these models.
 - Voluntary participation in APMs can lead to the development of a multiplicity of models, which can lead to selection problems that result in increased spending because individual organizations can select the model(s) that work the best for them and capture savings that would otherwise accrue to the Medicare program.
 - It is also difficult to accurately assess the performance of many APMs due to selection issues at the patient and program levels.
- Dr. Glied also indicated that it may be easier to generate positive financial results through manipulation of incentives rather doing the more difficult work of improving processes and care delivery.
- Dr. Glied added that while there are a variety of definitions of TCOC, they unit of analysis tends to be broad; and the population is assigned, not discretionary. She gave the example of the Maryland TCOC Model, where TCOC is defined in terms of the entire Medicare program and health care system for residents in the state.
- Dr. Glied also stated that TCOC should ideally account for all aspects of the cost of care, including services covered in Medicare, beneficiary out-of-pocket payments, and informal care.
- Finally, Dr. Glied indicated that that the use of a TCOC measure is a monitoring and management tool that can be used in the context of incentives, not an incentive program itself.

Karen Holt presented on the work of Collaborative Health Systems (CHS) and improving primary care providers' (PCPs') ability to successfully manage patient care.

- Ms. Holt noted that CHS includes 15 programs operating in 22 states, three Independent Physician Associations (IPAs), and the Maryland Care Transformation Organization (CTO) program. She added that CHS supports over 2,000 independent providers and 160,000 Medicare patients.
- Ms. Holt explained that the goal of CHS is to empower providers to run efficiently; preserve their independence; enhance their transition to value-based care; and support clinical

program implementation and administrative and clinical activities. CHS helps providers to incrementally accept more risk by providing tools, technology, hands-on training, and clinical program implementation for providers to support patients when they receive care outside of a practice's physical location.

- Ms. Holt stated that population health management is the management of patients in all care settings. She indicated that care coordination and successful management of patients with chronic conditions require the ability for members of the care team to know where patients are at all care levels, and to have access to actionable data. Within this context, she expressed concerns about issues that PCPs have experienced related to accessing data about their patients who have been admitted based on data from hospitals' admission, discharge and transfer (ADT) feeds. She suggested the potential use of algorithms to reduce provider burden and let all members of the care team know when a patient has been admitted into a facility. She also suggested ensuring that IPAs and Accountable Care Organizations (ACOs) have access to real-time data in the same way that this coordination occurs with health plans.
- Ms. Holt explained that the CHS Core Care Model is designed to support Medicare providers by giving them access to the right information. She highlighted the importance of enhancing ADT data for beneficiaries with multiple chronic conditions who may not have reliable addresses or phone numbers and who may have other data inaccuracies in their personal data that make it difficult to monitor and manage their care.

Vice Chair Hardin invited Committee members to ask Dr. Glied and Ms. Holt questions.

- Bruce Steinwald asked Dr. Glied about the distinction between how providers are paid versus how health plans are paid, and whether there is value in focusing on the latter given the reluctance of providers to shift away from FFS payments. He raised this in light of Dr. Glied's point regarding the use of FFS to pay providers in other countries.
 - Dr. Glied explained that most plans are paid by some form of capitation. She added that countries that have competing health plans also pay based on some form of risk-adjusted capitation. She expressed concern that risk adjustment methods may create perverse incentives for plans.
 - Dr. Glied emphasized the benefits of health plan innovation and allowing plans to make decisions about how to pay providers. For example, stakeholders have learned that micro-payment incentives at the provider level may be too complex and that management in the more conventional sense (such as investing in better data systems or implementing electronic health records [EHRs] to avoid duplication of care) might be more effective. She added that plans also have more leeway to select which providers participate and to observe practice patterns.
- Chair Casale noted that CMMI has focused on how to engage specialists in larger population-based TCOC models. He asked Dr. Glied whether she would suggest having general population-based models where providers and payers decide how to engage specialists or developing more prescriptive models for including specialists in population-based TCOC models.
 - Dr. Glied noted that many specialists' interactions with patients are episodic and time-limited, making it difficult to establish relationships. She also noted that referral patterns between specific PCPs and specific specialists are inconsistent. She suggested

that it is difficult to establish complex payment mechanisms for these specialists that provide episodic and time-limited care, and provider selection into these arrangements may produce unintended effects.

- However, for specialists who have ongoing relationships with patients, Dr. Glied indicated that a single payment covering a scope of service may be appropriate. For example, she explained that for OB-GYNs, there is a clear timeframe and scope of services, and monitoring their work is feasible. She noted that policy makers could think of the OB-GYN specialty on its own with an APM.
- In general, in response to Chair Casale's question, Dr. Glied suggested it is important to consider the extent to which care for patients delivered under a specialist-focused value-based arrangement comes from the broader system versus the specialists themselves, and the specific objectives with respect to coordination and interaction between the specialists and other providers.
- Dr. Glied stated that, for some groups of patients, it may be better to provide prospective payments to PCPs who can work out payment arrangements with specialists. While, for other groups of patients, such as those that receive care on a consistent basis from the same cardiologist, a specific APM focused on specialists may be useful to consider.
- Vice Chair Hardin asked Ms. Holt what best practices she has learned about bridging the relationships between specialists and PCPs.
 - Ms. Holt highlighted CHS's work to successfully manage care and reduce readmissions by using automation and health information technology (HIT) to coordinate appropriate care for patients as they transition in and out of the hospital. She emphasized that CHS can often get patients the right care at home and manage the cost of care by using algorithms to effectively share information necessary to coordinate care.
- Lawrence Kosinski asked Ms. Holt about effective patient engagement strategies.
 - Ms. Holt explained that CHS keeps patients engaged in educational opportunities and disease management focusing on communicating with high-risk patients with chronic conditions. Care coordinator outreach to promote use of patient education is often targeted to those patients with the highest risk of readmissions and the most to gain from self-management.
- Vice Chair Hardin asked Dr. Glied how she thinks about managing carve-outs in value-based care.
 - Dr. Glied explained that carve-outs that cover a specific set of services often create an incentive on the part of the entity managing the carve-out to shift care back into the main contract. She highlighted the importance of monitoring total cost for the full patient population, not just for the carve-out aspect of the contract; otherwise, entities accountable for a broader set of services may find that their costs do not decrease even if there is less money spent on the services covered by the carve-out.

Valinda Rutledge presented on the work of UpStream and barriers to the adoption of TCOC models in primary care practices.

- Ms. Rutledge explained that UpStream is a global value-based risk organization with embedded care coordinator nurses and pharmacists. She noted that they have seen significant improvements in patient outcomes and satisfaction with the model.
- Ms. Rutledge noted that 70 percent of Medicare beneficiaries have at least one chronic disease and account for 95 percent of Medicare spending. She went on to state that, despite the health care industry's emphasis on specialists, primary care is essential for patients with chronic illness. She suggested that the health care industry has not invested sufficient resources into primary care, and practices have been slow to adopt value-based care models.
- Ms. Rutledge categorized barriers to physician adoption of TCOC models into multiple categories:
 - Providers are risk-averse and hesitant to engage in models they view as experimental. This is particularly true given that Medicare patients may represent only 15-20 percent of business for some primary care practices but would represent significant downside financial risk under some circumstances. She also indicated that PCPs are often reluctant to take on financial risk without a clear sense of how to deliver care more effectively and without an understanding or ability to pay for the infrastructure needed to do so.
 - FFS reimbursement is the foundation for clinical encounters but is ill-designed for integrated care team delivery. She noted that the basis for determining the appropriate level for capitated payments often hinges on historical cost of care built from FFS claims.
 - FFS is built on individual clinical encounters for individual providers, which does not recognize the team approach to care. Except for care coordination codes such as Chronic Care Management (CCM) and Transitional Care Management (TCM) codes, remote patient monitoring, and advanced care planning, FFS codes do not support integrated team care. She also noted that many practices do not use these care coordination codes due to the complexity required to bill under those codes and workforce shortages.
 - Many PCPs have difficulty leveraging the benefits of making the best use of technology on their own despite their ability to pivot quickly to virtual care during the initial stages of the pandemic.
- Ms. Rutledge proposed three primary solutions to these barriers: increasing incentives, minimizing risk and overcoming inertia.
 - Options for increasing incentives could include looking at tax or financial provisions to support the creation of more independent primary care groups; engage patients as partners; reduce regulatory requirements; and allocate funds to address social determinants of health (SDOH). With respect to regulatory requirements, Ms. Rutledge noted that waivers available under TCOC models often require burdensome documentation, and that blanket waivers with limited documentation requirements would be beneficial.
 - There are multiple ways to minimize risk to participation in value-based care for independent physicians: 1) avoiding effectively punishing high performers by substantially shifting their benchmarks (such as the approach used in Pathways to Success), 2) providing access to educational and technical assistance programs, and 3) offering financial support for analytic tools.

- Policy makers should focus on overcoming inertia, including making adjustments to the FFS schedule, such as changing split visit codes that reimburse more when care more care is provided by a physician relative to another provider. She also noted the importance of strengthening the Merit-based Incentive Payment System (MIPS) which she suggested has not been effective at shifting providers into value-based care due to limited penalties and other factors.

Christina Severin presented on the Community Care Cooperative and moving from Federally Qualified Health Centers (FQHCs) to value-based care.

- Ms. Severin summarized the background of the Community Care Cooperative, which was formed in 2016 in response to the Massachusetts Medicaid program shifting from a traditional Managed Care Organization (MCO) model to an ACO model. It launched in 2018 with 15 FQHCs and 110,000 members, and currently has 20 FQHCs and approximately 200,000 members in “at risk” contracts. The Community Care Cooperative also uses Epic as their EHR vendor. She noted that its vision is to transform the health of underserved communities by scaling FQHCs advance primary care, improve the financial position of health centers, and advance racial justice at health centers and in society.
- Ms. Severin explained that current research shows health centers can provide better care for patients than other PCPs. She presented data showing that health centers outperform other providers with respect to managing patients with hypertension and diabetes, as well as on patient satisfaction measures such as hours of service and satisfaction with the care experience.
- Ms. Severin went on to highlight an article from the American Journal of Public Health (November 2016) looking at TCOC for a cohort of patients treated in an FQHC relative to patients treated by other PCPs. The study found that the cohort treated in the FQHC was 24 percent less expensive to treat.
- In describing the start-up of the Community Care Cooperative, Ms. Severin emphasized that the non-profit began with limited resources and started out by taking on a Medicaid contract with risk corridors that expanded over time. Currently in the last year of this 5-year contract, the Community Care Cooperative accepts 100 percent two-sided risk.
- Ms. Severin noted that to manage this risk the Community Care Cooperative needed to collect data assets—including clinical data from EHRs, ADT transactions in real-time, paid claims files from all carriers, self-reported data, and SDOH data—into an enterprise data warehouse (EDW). She noted that the EDW is crucial to the operating model, including a rules-based approach to workflow automation, a research database, and a universe for analysis and reporting.
- Ms. Severin also described the financial mechanisms necessary to demonstrate access to resources needed to satisfy regulatory requirements for taking on risk in their state. They did this through a combination of excess loss insurance, risk-sharing with each provider organization, risk-sharing with another service provider, and financial support through their contract with Massachusetts Medicaid.
- Ms. Severin summarized her model of care, including four core components: care management, practice transformation, population health, and other programs. She emphasized the importance of their closed-loop referral for SDOH and practice transformation as the most powerful tools for health care transformation. Ms. Severin noted that the Cooperative’s model is looking to move toward primary care capitation.

Jon Broyles and Gary Bacher presented on the Coalition to Transform Advanced Care (C-TAC) and their experience with community-based organizations to empower patients and families.

- Mr. Broyles explained that C-TAC is an alliance with nearly 200 organizations, including health care systems, state coalitions, and faith leaders, and is focused on transforming patient and family experiences from the point of diagnosis through the end of life. Alliance members include the American Heart Association, the American Hospital Association, and large health systems and health plans. He noted that C-TAC submitted a proposal to PTAC in 2017, and the proposal was recommended to the Secretary for limited-scale testing. Mr. Broyles noted that C-TAC worked with the American Academy of Hospice and Palliative Medicine (AAHPM) to advance key elements of their proposal, and their proposal helped to inform the CMMI Primary Care First Initiative. He emphasized the importance of community partnerships and investments to reach patients outside of the health care system, build trust and provide patient-centered care.
- Mr. Broyles emphasized that there are opportunities for innovation through investing in and building trust with underserved communities.
- Mr. Bacher emphasized the importance of considering different sub-populations being served under any model to ensure that the model's parameters are flexible enough to accommodate those populations. He discussed the tension between a stand-alone model with particular incentives focused on seriously ill populations versus a longitudinal population-based nested model. He noted that a broader population-based model needs to create the right incentives or minimum requirements to be able to offer certain kinds of services (e.g., making sure that the seriously ill patients receive a minimum threshold of care).
- Mr. Bacher suggested that models should avoid disintermediating between TCOC and responsibility for the quality of care for a population. He added that patients who are not aligned to a longitudinal model need a stand-alone opportunity to receive services that are important to their care. Mr. Bacher emphasized the importance of supporting caregivers and others that help patients, creating infrastructure to support community-based organizations, and financing services that would close the gaps in care.

Vice Chair Hardin invited Committee members to ask the presenters questions.

- Mr. Steinwald asked the C-TAC representatives whether they have been able to break down the silos between curative and palliative care, noting that this was an objective included in C-TAC's 2017 proposal to PTAC.
 - Mr. Broyles indicated that their model has made a lot of progress on this front.
 - Mr. Bacher added that there are some CMMI models that directly address this type of concurrent care, including the Global and Professional Direct Contracting (GPDC) Model, which will soon become the ACO Realizing Equity, Access, and Community Health (REACH) model, and the Kidney Care Choices (KCC) Model with a concurrent hospice waiver. He added that the Medicare Care Choices Model (MCCM) was designed to test the effectiveness of providing patients with some degree of conventional care in addition to supportive care for seriously ill patients.
 - Torrie Fields, another member of the C-TAC proposal team, noted that the Blue Cross Blue Shield (BCBS) plans are embedding palliative care services or advanced care planning into their ACO models, requiring the assessment of patients based on need for

services such as palliative care and hospice, and ensuring patients are provided appropriate services. She added that these models are largely a sub-delegated arrangement where the ACO is paying per-member per-month for these services, which are included in TCOC.

- Ms. Fields highlighted a recent paper on a model led by California BCBS, noting that five BCBS health plans that delivered palliative care assistance across the model reduced costs and improved population health outcomes.
- Ms. Fields indicated that Medicaid programs in two states are implementing palliative care benefits. She recommended that Medicaid agencies risk-stratify their populations and examine the seriously ill populations differently to determine the gaps in their care.
- Finally, Ms. Fields explained that some organizations in the private sector are testing value-based insurance designs for hospice.
- Dr. Kosinski asked Ms. Rutledge about the use of CCM and Principal Care Management (PCM) codes when patients may face deductibles and copays.
 - Ms. Rutledge noted that several medical associations have requested that CMS not include copays for care such as annual wellness visits.
 - Ms. Fields noted that for advanced care planning, copays have been a deterrent for patients with serious illness.
- Soujanya Pulluru asked Ms. Severin about her strategy for managing specialists, as well as post-acute spending, and how she includes specialists in TCOC methodology.
 - Ms. Severin noted that this has been a challenge for her organization. She explained that the organization examines the needs of the patient population and spending patterns by major category of service. She emphasized the need for access to behavioral health specialists, noting that health centers have an advantage because many services in the behavioral health continuum of care might reside in an FQHC and part of the primary care team, including ongoing therapy, integrated behavioral health clinicians, and psychiatrists.
 - Ms. Severin added that the Community Care Cooperative is also exploring use of telehealth e-consults as a strategy for connecting patients in a primary care setting with specialty care. Ms. Severin discussed the importance of clinicians developing trusting relationships with preferred specialists within the context of patient referral patterns.
- Walter Lin asked Ms. Rutledge how UpStream has disseminated its central repository of best practices to participating providers.
 - Ms. Rutledge deferred on the question regarding Upstream, but noted that America's Physician Groups (APG) has tried webinars and a website to disseminate information through its repository to its network of independent physicians. However, she suggested that a national database would be optimal.
- Jennifer Wiler asked Ms. Severin about two concerns regarding barriers to participating in TCOC models: 1) infrastructure costs, and 2) concerns about diminishing returns related to performance, while developing and maintaining her program's successes.
 - Regarding infrastructure costs, Ms. Severin noted that the Community Care Cooperative has invested approximately \$5 million in infrastructure. She explained that many safety net organizations lack start-up capital and proposed redistribution of risk-based capital as a potential source of funds. For health plans, state Departments of Insurance will

evaluate the amount of risk a HMO is responsible for. When HMOs contract with providers, they shift some of the risk they are responsible for to the providers. Some of the deferred risk savings, could be seen as potential start-up funding. She explained that a health plan could redistribute such capital to a provider organization as an investment to build infrastructure.

- Regarding diminishing opportunities to reduce costs for providers that are already high performers, Ms. Severin explained that benchmarks for setting performance standards could reflect not only the provider's experience but also the average cost in the market. She noted that the Massachusetts Medicaid program is making progress in this area. In light of her program's success, Ms. Severin suggested that a market-based benchmark would be their preference. She concluded that the proposed strategy would be for higher performers to choose among experience-rated benchmarks, market-rated benchmarks, or a blend.
- Chair Casale asked Ms. Rutledge about best practices for engaging specialists as they move toward larger TCOC models.
 - Ms. Rutledge explained that episodic payment models are best suited for specialists; without them, specialists are less likely to engage in the transition to value-based care. She recommended examining the lessons learned in APG. She noted that APG had many members in California with significant experience taking delegated capitated risk in the Medicare Advantage (MA) population. Based on these members' experiences with different relationships with specialists, Ms. Rutledge recommended that regardless of whether a model is nested or blended, specialists should receive episodic payments to encourage engagement. She emphasized the importance of creating true partnerships with specialists.

Panel Discussion on Definitional Issues Related to Population-Based TCOC Models

Chair Casale moderated the panel discussion of SMEs representing different perspectives on definitional issues related to population-based TCOC models. He introduced each participating panelist, noting that full biographies of each panelist can be found on the [ASPE PTAC website](#).

- Jennifer L. Kowalski, MS, Vice President, Public Policy Institute, Anthem, Inc. (Payer Perspective)
- Emily Maxson, MD, Chief Medical Officer, Aledade, Inc. (Provider Perspective)
- Judith A. Stein, JD, Executive Director/Attorney, Center for Medicare Advocacy (Patient Advocacy Perspective)
- Gail R. Wilensky, PhD, Senior Fellow, Project HOPE (Academic/Policy Research Perspective)

Chair Casale asked the panelists to discuss what types of services are typically included in benchmarks labeled TCOC and what kinds of additional services could be appropriate to include in future population-based TCOC models.

- Gail Wilensky noted that services covered under Medicare Parts A and B include inpatient, outpatient, and physician expenditures, as well as inpatient prescription drugs. She questioned whether the definition of TCOC should be broader to include health care that is not part of traditional Medicare (i.e., Part A and B).
- Jennifer Kowalski noted that the services and components included in TCOC models must differ across payers and across lines of business. She recommended a two-pronged approach for thinking about TCOC:

- What degree of control does the provider have over impacting the services or spending included in the TCOC benchmark?
 - Ms. Kowalski noted that if providers do not have control over the services or spending included in the benchmark, they should not be held accountable. For example, if specialists outside a primary care practice prescribe medication, it is not appropriate to hold the primary care provider accountable. However, Ms. Kowalski suggested that in situations where there is contractual alignment between PCPs and specialists, and both are paid prospectively, it may make sense to hold PCPs accountable for drug spending if they are influencing decisions on how specialists are paid. However, in scenarios where there is a separate carve-out for prescription drugs such as a pharmacy benefit manager (PBM), it does not make sense to use a TCOC definition that includes drug costs to govern payments to the health plan or providers offering only medical benefits.
 - Ms. Kowalski commented that consideration of whether PCPs or health plans should be held accountable for costs related to addressing SDOH or non-medical services (e.g., transportation) should depend on which entity is making decisions about access to these services.
- What level of capabilities and services does the provider have to support the patient population, and how much financial risk can the provider be expected to take on for that set of services?
 - Ms. Kowalski noted that for large commercial insurance populations where individuals get their medical and drug benefits from the same plan, drugs should be included in the TCOC calculation. However, she noted that in self-insured employer arrangements, it is common to have separate entities managing the medical and drug benefits, making it more difficult to include drugs in the TCOC calculation.
- Judith Stein stated that from the beneficiary’s point of view, there is a lack of understanding about the various models that currently exist. She also expressed concern that the continued focus on TCOC has not been shown to increase quality, or to improve beneficiary choice of and access to providers in practice. She stated that the consolidation that has occurred in health care – with hospital organizations acquiring primary care practices, SNFs, nursing homes, and home health agencies – has tended to limit beneficiaries’ access to care. She also noted that the process for beneficiaries to communicate with the entities that are making coverage determinations, such as MA plans or artificial intelligence systems, has become less transparent. Thus, Ms. Stein emphasized the importance of considering the risks and advantages to beneficiaries when discussing TCOC models.
- Emily Maxson emphasized that if Part D prescriptions are excluded from TCOC benchmarks, providers miss the opportunity to improve drug management, and patients miss out on the potential for lower costs; however, she acknowledged it is administratively complex to include Part D prescriptions in TCOC calculations.
- Chair Casale noted that deciding which service elements to include based on whether providers have direct control may increase complexity.
 - Ms. Kowalski agreed and noted that cost is not the only metric in TCOC models; providers can also take on financial risk for quality metrics.
 - Dr. Wilensky stated that excluding costs based on provider control may result in the exclusion of significant costs driving TCOC (e.g., oncology drugs).

- Ms. Stein raised the issue of delivering all services included in TCOC benchmarks to Medicare beneficiaries. For example, she cited a finding from the Center for Medicare Advocacy that beneficiaries are not always receiving services covered under the Patient-Driven Groupings Model (PDGM), which provides prospective payment for 30 days of home health care.
- Chair Casale asked about best practices for informing Medicare beneficiaries about their choices or enrollment in a TCOC model.
 - Ms. Stein expressed her view that standardizing plans is important from the beneficiary perspective. She stated that the average beneficiary has 39 MA plans to choose from; the variation between options makes it almost impossible to properly educate beneficiaries.

Chair Casale asked the panelists whether there should be a single, standardized definition of TCOC in future population-based TCOC models.

- Ms. Kowalski expressed opposition to a single, standardized definition of TCOC in future population-based TCOC models. She noted that there is variation in provider readiness to accept financial risk and differences in benefit structures based on the payer or employer. Ms. Kowalski highlighted the benefits of leaving room for innovation. She recommended grouping providers or lines of business together based on readiness or other commonalities.
 - Chair Casale asked whether Ms. Kowalski felt there could be future standardization of TCOC after a transition period.
 - Ms. Kowalski agreed that a standardized definition could be useful if enough providers are comfortable taking financial risk. She noted that health plans currently take on risk for TCOC because they are paid a capitated amount and can manage spending.
- Dr. Maxson suggested that there should be a single, standardized definition of TCOC in future population-based TCOC models. She noted that using multiple definitions of TCOC may encourage providers to choose between models based on the perceived favorability of the benchmarking methodology. She expressed that a single definition still enables innovation with new payment and service delivery strategies. She also noted that provider engagement and innovation increased once providers embraced TCOC.
- Dr. Wilensky agreed with the concept of developing standardized definitions of the components within TCOC. However, she expressed a concern about the potential impact that excluding significant costs such as oncology drugs from the calculation of a single TCOC metric could have on understanding variations in TCOC and who would be accountable.
- Ms. Stein discussed the need to clearly understand what services are included in TCOC, and suggested that some standardization of the definition would be valuable from a beneficiary-facing point of view in order to improve clarity and facilitate comparison. She also discussed the importance of ensuring that beneficiaries will actually receive the package of services that have been ordered by their doctor as changes are made in the payment system.

Mr. Steinwald asked Dr. Wilensky if large, primary care-oriented models and small, specialty-oriented models can coexist.

- Dr. Wilensky suggested that these models need to coexist. She noted that there is friction regarding how much specialty care should be under the purview of primary care physicians. She suggested that separating these specialties defeats the purpose of TCOC, but there remains a question of attribution of patients to different types of providers that have limited control over or responsibility for some aspects of care. Dr. Wilensky noted the need to try to blend specialty

and primary care services to better understand and identify components that could be monitored by one set of providers over another.

Dr. Kosinski asked the panelists about shifting APM design from a provider-focused approach to a patient-focused approach.

- Dr. Wilensky connected this question to the issue of having agreed-upon definitions of TCOC components but allowing variation in the TCOC depending on the components that are included. She noted that if the components are standardized, it can be easier to clarify for beneficiaries which components are a part of TCOC.
- Ms. Stein raised the issue of MA plans, which are not standardized like Medicare and actively market to beneficiaries. She noted that the consumer may not always understand model design but wants to understand their coverage including health care services and pharmaceuticals.

Dr. Wiler asked the panelists for suggestions to consolidate options in the marketplace to improve patient choice.

- Ms. Stein stated that Medicare is not solely FFS because of the way it pays for and defines some services. She noted difficulty in understanding if services were rendered under capitation due to data limitations. She expressed that all Medicare plans should be standardized and have parity in the amount paid per beneficiary. She stated that standardization and parity would improve consumer understanding and would reassure consumers that they receive the same value regardless of the Medicare model.
- Dr. Wilensky agreed with the standardization of terms but not pay parity. She noted that some models are more efficient than others and should be able to use funds differently as a result.

Dr. Pulluru asked the panelists for suggestions to accomplish CMMI's strategic vision of having all Medicare beneficiaries in advanced payment or value-based payment models by 2030.

- Dr. Wilensky recommended deciding on a limited subset of advanced payment methodologies. Acknowledging that the "best" models are still being tested, Dr. Wilensky expressed hope that by 2030 or earlier there would be an agreement on the best payment models to maintain going forward.
- Dr. Maxson recommended using data to empirically inform a strategy. She noted that some useful data points: how many Medicare beneficiaries receive primary care services; how many Medicare beneficiaries need increased engagement; where Medicare patients receive primary care services; and effective accountable care model designs.

Chair Casale asked the panelists for suggestions to enhance provider readiness for participate in population-based TCOC models and what provider-level barriers limit model participation. He also asked how payments can be structured to encourage provider participation.

- Ms. Kowalski noted four questions that Anthem uses to evaluate provider readiness to participate in value-based care: 1) whether the provider is ready to make the transition in the next 12 to 18 months; 2) if there is a plan for the resources, services, and supports needed during the transition; 3) whether there is an alignment with leadership regarding the transition; and 4) if there is a budget to support the transition.
- Ms. Kowalski noted barriers including lacking EHR infrastructure, that small patient populations often prevent organizations from taking on financial risk, especially independent providers. She also stated that local market dynamics (i.e., monopolistic health care systems not participating

in value-based arrangements) prevent smaller organizations from engaging in such arrangements.

- Ms. Kowalski noted that payments could be structured to transition toward greater risk and greater reward over time as an approach to encourage provider participation. She expressed that there will eventually be a saturation point, or a point of diminishing returns, in terms of provider participation in APMs.
- Dr. Wilensky recommended standardizing Medicare models to reduce the burden on those providing care. She expressed a comfort with standardization of components to allow more variation.
- Dr. Maxson expressed the need for a workflow redesign and more access to claims-based data. She emphasized the difficulty in assigning accountability to specialists in APMs because while specialists can impact TCOC, they are often participating in care but not driving it. She noted that care and attribution should be anchored to primary care practices that can encourage high-value referral and specialist management workflows. Dr. Maxson stated that FFS payments can be productive when they are oriented to the patient's needs, so they should be leveraged.

Chair Casale asked the panelists about the potential equity implications of holding APM entities accountable for TCOC in population-based models (for both historically underserved populations and individuals with chronic conditions).

- Ms. Stein raised the concern that increasing diversity in care delivery and quality definitions within APMs will not best serve vulnerable and underserved patients. She cited research by the Commonwealth Fund and Kaiser Family Foundation that demonstrated that MA did not better serve vulnerable populations. She expressed the need for research into how population-based APMs are developed to determine how they can incorporate the needs of vulnerable patients.
 - Dr. Wilensky noted that minorities and low-income populations disproportionately use MA and indicated that this has been a way to expand benefits offered to those groups.
- Dr. Maxson recommended revising risk adjustment methodologies. She cited research that found that the Medicare Hierarchical Condition Category (HCC) Risk Adjustment Model systematically underestimated the risk of Black patients versus White patients. She noted that delays in diagnosis and health care inaccessibility resulting from structural racism cause Black patients to be sicker than White patients at the same HCC risk level. She felt encouraged by progress on the Area Deprivation Index (ADI) but acknowledged the need for further payment innovation that makes downstream social resources more available. Dr. Maxson suggested considering reimbursement and making social determinants of health screenings mainstream, and then connecting patients to community resources.
- Dr. Wilensky raised the issue of consolidating social service programs sponsored by federal, state, and local governments. She noted that there are overlapping and competing programs that make it difficult to unify services for patients in need. She mentioned the use of MA amongst minorities and lower-income individuals to increase the benefits that were provided.
 - Vice Chair Hardin agreed that consolidation of social services is critical.
 - Dr. Wilensky noted that social service organizations often have invested political constituencies or interest groups. She observed that the political challenges to consolidation are formidable. She mentioned widespread agreement around challenges regarding how health care dollars are spent and how care is provided rather than underspending on healthcare.
- Ms. Kowalski expressed the need for more comprehensive individual-level data to identify inequities. She noted that population-based TCOC models must not penalize or disadvantage

providers who see a greater share of patients who are underserved, have more health-related social needs (HRSNs), or have more chronic conditions. She also noted that models must consider what social services primary care physicians can reasonably provide and that large health systems may have the infrastructure compared to small independent practices.

Public Commenter

Chair Casale opened the floor for public comments. The following individual made comments:

1. Sandy Marks (Senior Assistant Director, Federal Affairs, American Medical Association [AMA])

Committee Discussion

Chair Casale introduced the Committee discussion portion of the public meeting by noting that Committee members would be discussing what they learned from the listening sessions, panelists, public commenter, and background materials provided by the Preliminary Comments Development Team (PCDT). He also indicated that this two-day meeting is part one in the three-meeting series on population-based TCOC models. The Committee's comments and findings from all three meetings will be synthesized in a report to the Secretary submitted after the September public meeting.

- Mr. Steinwald asked the Committee members how a well-designed TCOC model with good data sources and objectives for addressing SDOH would differ from a MA plan designed to focus on TCOC.
 - Terry Mills stated that in the context of seeking to provide all Medicare Part A and B services plus additional benefits, often at no cost to the beneficiary, MA plans have been developing innovative approaches effective approaches for addressing SDOH. However, he expressed agreement with the earlier discussion about the need for increased standardization in order to reduce beneficiary confusion, and discussed the need for identifying a “middle” path between reducing complexity for while still leaving room for innovation.
 - Dr. Pulluru discussed some of the differences between MA and current CMMI models -- noting that MA plans often use narrower provider networks that affect access; MA uses a different approach for patient attribution; and MA plans have the ability to provide supplemental benefits. that facilitate care integration – and suggested that the Committee may want to consider discussing whether some of those components should be available more broadly in Medicare (with regard to population-based TCOC models).
- Dr. Kosinski summarized his key points from the public meeting, including:
 - TCOC can, and probably should be defined.
 - Episode-based models should not be eliminated but a way should be found to nest them inside of larger models.
 - Designing episode-based models around patient needs, rather than around specific types of providers, can help to bridge the gap between primary care and specialty care and clarify responsibility (while also addressing “high beta” services where there is more variability in costs).
- Dr. Pulluru commented that limiting the number of APMs and harmonizing them across the health care system was a common theme in the discussion about transitioning to TCOC.
- Chair Casale mentioned bringing in the beneficiary perspective and educating beneficiaries on model participation.

- Dr. Lin noted that MA plans have the advantage of access to real-time and robust data, (i.e., claims data, ADT data, lab data, etc.) which allows provider to provide timely care and can help new payment models succeed.
- Mr. Steinwald reflected on a point that was made by Michael Chernew during the March 7 listening session about viewing waste as an asset, and the importance of thinking about how to allocate the elimination of the waste (including the potential for nested models and carve-outs to try to take credit for eliminating the waste away from the basic plan). Mr. Steinwald stated that conceptually, he liked the idea of potentially having decisions about whether to have a nested model or some other way of accommodating certain patient subpopulation made within the accountable entity, as opposed to being imposed on the entity.
- Dr. Wiler commented on the idea of the essential versus ideal elements that should be included in future programmatic development or consolidation in the marketplace. Essential elements would include providing participants access to data, making sure that issues related to mandatory vs. voluntary models are addressed, and the need to adjust incentives (specifically benchmark adjustments) to ensure that high performers continue to have reason to participate.
- Dr. Kosinski noted that he appreciated hearing about the idea of “pharmaceutical stewardship” throughout the meeting. He indicated that there may be a way of compensating a provider group for pharmaceutical stewardship. He recalled Dr. Maxson’s point that most specialists are participating in care but not driving it.
- Dr. Kosinski also appreciated Elizabeth Fowler’s comments during the March 7 public meeting about bringing together CMMI, MedPAC, and PTAC to discuss how transformational care can define success.
- Dr. Pulluru asked about the idea of using FFS to build the infrastructure for TCOC. She noted that increasing the use of care coordination codes and decreasing the “one off” FFS codes may help providers and organizations build care teams.
 - Chair Casale agreed with the importance of understanding the strengths of FFS.
 - Mr. Steinwald added that other countries manage overall health care costs better than the U.S. even in the context of FFS. He noted that while providers in other countries that use FFS would prefer Medicare levels of reimbursement, Medicare is seen as a weak payer by U.S. providers.
 - Chair Casale emphasized Dr. Pulluru’s point about strategies within FFS that help build TCOC infrastructure. He recalled Dr. Kosinski’s discussion about the burden to the beneficiary associated with using certain care management fees. He stated that addressing beneficiary and provider burden associated with using care management fees may encourage providers to consider how to better coordinate care and increase their interest in participating in APMs.
 - Mr. Steinwald stated that while there is nothing wrong with paying providers a fee for a service that you want them to provide, it has been difficult to pay less for some lower value services in order to finance paying more for other higher value services under the current system.
- Jay Feldstein emphasized the importance of being cognizant from an outcome perspective about what really works and what represents value when designing payment models within the current context of hyperinflation.
 - Dr. Pulluru noted that the high inflation rates are likely to lead to increased payment for not only providers, but also ancillary medical staff, especially post-COVID-19.

- Dr. Feldstein added that the health care system lost close to 25 percent of the workforce during COVID-19 and suggested that staffing will become even more of a challenge.
- Dr. Pulluru reiterated an interest in including an actuarial perspective during the June public meeting, and Mr. Steinwald requested additional information on the responsibilities of the CMS Office of the Actuary in the context of payment models.
- Joshua Liao emphasized that coordinating and nesting population-based models and episode-based models is likely to involve prescribing some structure that may reduce flexibility. He added that in testing models, it is important to remember that there is not likely to be a one-size-fits-all model because every organization has different patient populations and environments. He also emphasized the importance of ensuring that beneficiaries and individuals are informed of their health plan options.
- Dr. Wiler noted that CMMI's goal of having all Medicare beneficiaries in value-based arrangements does not mention expectations for providers, who are the focus of APMs. She noted that it may not be possible to have both flexibility and 100 percent provider participation.
 - Dr. Liao noted that while 100 percent participation is the goal, mandatory participation creates other issues. He discussed considering the trade-offs involved in determining how much structure to impose on the payment models related to encouraging provider and beneficiary engagement.
- Dr. Pulluru asked if decreased flexibility from nesting payment models due to the attribution methodology. She noted that attribution may need to be revisited because it adds to the difficulty of harmonizing models.
 - Dr. Liao commented on the challenge of attribution, noting that determining who is responsible for care in bundled payments and ACOs will also be a challenge when nesting models. He added that the current flexibility in ACOs and other population-based models allows ACOs, as the accountable entity, to decide on the services, initiatives and care teams. He referenced Ms. Rutledge's idea that the best way to engage specialists is through an episode-based model, which can be debated. Dr. Liao suggested addressing better options through PTAC, if they exist.
- Dr. Pulluru noted that 25 to 30 percent of patients cycle in and out of ACO attribution. Enacting a more structured attribution model could lead to better engagement of specialists in ACO models.
- Dr. Liao stated that he thinks there will be an opportunity during the June and September public meetings to discuss accountability.
 - Dr. Lin referenced Dr. Maxon's and Ms. Rutledge's comments about having PCPs drive patient care, as opposed to specialists. He noted that in some cases referral and usage of specialists is a reflection of the care provided by PCPs.
- Mr. Steinwald asked about how plans navigate situations where patients see specialists, based on their needs, more often than their primary care doctor.
 - Dr. Liao stated that the concept of having beneficiaries or individuals receiving care under some form of accountability is neither at odds with, nor completely consistent with everything in their care being under a single accountable relationship. He indicated that beneficiaries receiving care under multiple providers highlights issues regarding situations where only some of those providers may be in a payment model and assuming accountability.
 - Dr. Lin noted that some ACOs have addressed this problem by establishing a network of specialists to which they can make referrals.

- Chair Casale added that data suggests that roughly 50 percent of a patient’s care is delivered by providers outside their ACO providers.
- Dr. Kosinski commented on the issue that hospital-based ACOs employ a certain set of specialists, but the patient does not always have a choice in a specialist. He added that commercial health plans have identified this as an issue in some of their ACO populations.
- Dr. Mills discussed the challenge of linking specialists in rural areas to value-based models. He commented that it is easier for PCPs to refer to high-quality, low-cost specialists in large urban centers, but more difficult in rural areas.
 - Dr. Kosinski added that this may be an important reason why 50 percent of care is provided outside of an ACO’s network.
 - Dr. Pulluru added that there are many areas of the country where there is not wide uptake of APMs. These areas also face specialty shortages that further complicates model uptake.
 - Dr. Mills mentioned that some models have been successful in more rural areas with limited specialists. He noted that in this situation, a PCP can form strong relationships with specialists because the PCPs provide a significant stream of patients to the specialist.
 - Dr. Pulluru commented about the issue of incentives for engaging specialists in light of the trend that more specialty care is being delivered through telehealth. She indicated that Rubicon has made services for over 250 specialties available virtually. She noted that, currently, reimbursement for telehealth has a mandatory in-person care requirement, so variation in access to in-person services from different specialists by geography is an issue.
- Dr. Liao indicated that some ways for sub-specialty groups to signal a willingness to take accountability and partner in care would include signing up to be part of an ACO, or signing up formally as a participant in a payment model, such as the Bundled Payments for Care Improvement (BPCI) Initiative. He suggested further discussion in upcoming meetings on market share, geography and supply of clinicians, and mandating model participation.
- Dr. Wiler stated that unpredictability increases risk, which is a barrier to participation, so it will be difficult to achieve 100 percent participation without increasing predictability.
- Dr. Lin appreciated the idea of standardizing the definition of TCOC, while also leaving flexibility for each organization to include different components TCOC.

Closing Remarks

Chair Casale thanked the Committee members, presenters, panelists, and the public for their contributions to the meeting. He noted that they explored many facets of population-based TCOC, including defining the relevant concepts and understanding the broad issues. Chair Casale announced that a Request for Input (RFI) on TCOC would be posted on the [ASPE PTAC website](#) and sent to the PTAC listserv. He noted that the June public meeting will focus on the best practices for care delivery, improving quality, and measuring the success of population-based TCOC models.

The public meeting adjourned at 3:46 p.m. EST.

Approved and certified by:

//Lisa Shats//

6/3/2022

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

Date

//Paul Casale//

6/3/2022

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

Date