PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

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PUBLIC MEETING

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Virtual Meeting Via Webex

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THURSDAY, JUNE 10, 2021

PTAC MEMBERS PRESENT

JEFFREY BAILET, MD, Chair
PAUL N. CASALE, MD, MPH, Vice Chair
CARRIE H. COLLA, PhD
JAY S. FELDSTEIN, DO
LAURAN HARDIN, MSN, FAAN
JOSHUA M. LIAO, MD, MSc
TERRY (LEE) MILLS JR., MD, MMM
KAVITA K. PATEL, MD, MSHS
BRUCE STEINWALD, MBA
JENNIFER L. WILER, MD, MBA

PTAC MEMBERS NOT IN ATTENDANCE

ANGELO SINOPOLI, MD

STAFF PRESENT

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

A-G-E-N-D-A

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

10:00 a.m.

* CHAIR BAILET: Good morning and welcome to this meeting of the Physician-Focused Payment Model Technical Advisory Committee, known as PTAC. I'm Jeff Bailet, the Chair of PTAC, and as you may know, PTAC has been looking across its portfolio to explore themes that have spanned several past proposals.

Today we will dive into the topic of care coordination and our next theme-based discussion will examine how efforts to address equity and the social determinants of health can be optimized in the context of Alternative Payment Models and physician-focused payment models.

But first, at this time, we are honored to be joined by a member of leadership at the Centers of Medicare & Medicaid Services. I'm excited to introduce Dr. Liz Fowler, who serves as the CMS Deputy Administrator and the CMS Innovation Center Director.

Before joining CMS earlier this

year, she was the Executive Vice President of Programs at the Commonwealth Fund. She brings with her an extensive health policy experience having also served as Vice President for Global Health Policy at Johnson & Johnson, as well as the Chief Health Counsel to a former Senate Finance Committee chair.

With that, it is my pleasure to welcome Dr. Fowler.

*** Elizabeth Fowler, JD, PhD, Deputy Administrator, Centers for Medicare & Medicaid Services (CMS) and Director, Center for Medicare and Medicaid Innovation Remarks**

DR. FOWLER: Dr. Bailet, thank you so much for that introduction. And thank you to all the members of the Physician-Focused Payment Model Technical Advisory Committee, or PTAC. I really appreciate the invitation.

We might not be meeting in the Great Hall of the Humphrey Building, but I really appreciate that you and your Committee have continued its important work despite COVID and the public health emergency.

I'm delighted to be here, and I'm pleased to have this opportunity to introduce myself. It's been just over three months since I became Director of the CMS Innovation Center, and I'm really fortunate to have this role. I've been learning more about the PTAC from my team and from stakeholders across the board. This is my third time working for CMS, and I have a deep appreciation for the agency, the team, and its powerful mission. I extend that same appreciation for our colleagues at ASPE who coordinate the PTAC.

As many of you know, Administrator Chiquita Brooks-LaSure, our new boss at CMS, also previously served at the Department of Health and Human Services, first as Director of Coverage Policy in the Office of Health Reform, and then as Deputy Center and Policy Director for the Center for Consumer Information and Insurance Oversight, or CCIIO.

Together our experience at HHS[1] and CMS will be beneficial during this critical time for our health care system, and I want to

1 Health and Human Services

explain why. I really believe that we are at a crossroads in value-based care. We have been clearing a path to move this system toward value and away from volume now with 10 years of experience. The path is not necessarily straightforward. We've lost a bit of focus in some respects, and we need to continue taking the steps to move the system toward value-based care.

At this critical juncture, it's a good time to take stock of where we are and where we go next. In the very short time I have with you, I want to touch base on the role that CMS has in setting a direction for value-based care, including how health equity fits in and what part I see specifically for the CMS Innovation Center and how PTAC can contribute to this story.

Over the past few months, CMS, the Innovation Center has undertaken strategic review and refresh based on the 10 years of lessons learned in order to re-establish a shared vision of the health system we're driving toward. What's been most apparent from

all the input we've received, and all the literature and all the recommendations we've reviewed, is that patients should be at the center of that system.

So what does that mean? It means the health system of the future must meet patients where they are delivering care in homes and communities in the least restrictive and most accessible setting possible. Most likely it also means more virtual care, and we've all seen the benefits of telehealth during the public health emergency.

Thank you for PTAC's work in this area. I think it's really been an important contribution. It must deliver high-quality accessible care that focuses on keeping patients healthy; coordinates care seamlessly across settings and providers enabled by data and technology that includes appropriate referrals, management, and payment for specialty care; holistically addresses patients' needs, including behavioral health and social determinants; and achieves equitable outcomes through high-quality person-centered

care for all.

In our mind, it means that every Medicare and Medicaid beneficiary is in a care relationship that includes meaningful accountability for quality and total cost of care, and that quality measures align with goals that matter to patients and align with patients' values, like reducing mortality and improving functional status so that patients can keep up with loved ones.

Achieving this vision is going to require us all to think about bringing high-quality value-based care to every community in America. By advancing a continuum of total cost of care models to engage providers, we need to fix some of the biggest payment issues today so that we're moving forward with value-based care on a stronger foundation.

This includes addressing issues and fee-for-service like prescription drug pricing, as well as targeted initiatives to address populations that are not well served by the current program. Overuse of low-value care, underuse of needed care. And we need to align

across payers and across all stakeholder groups to facilitate patient-centered transformation at the level of both individual providers and regional systems.

Changing Medicare fee-for-service isn't enough. At a minimum, Medicare and Medicaid payment models must be more aligned and focused on improved health and equitable outcomes for patients. This means we have to focus on equity in everything we do. Within the department as we consider policy priorities, proposals, and payment and service delivery models, a very clear signal has been sent that everything we do needs to be viewed through an equity lens.

Achieving our goals and making progress in advancing health equity will take all of us working together. Federal, state, local, tribal organizations, health care providers, plans, individuals, families, policymakers, and other stakeholders.

This brings me to PTAC's value, and specifically the thoughtful way that the Committee rigorously and vigorously reviews the

proposals submitted by individuals and other stakeholders, the recent roundtable discussions on telehealth, and today's topic of care coordination as well. We welcome PTAC's comments and review as we forge our path and continue our journey toward health care transformation and implementing payment and health care delivery models that test and define, first, health equity, payers, providers, purchasers, and other stakeholders in the system may have different responses in addressing health equity, but we should adopt common definitions. The role and importance of data; collecting data, measuring impact, and reporting out what matters a lot. But there's a lack of uniformity in data collection and analytic standards, which adds to the challenges of data-sharing.

Third, the role of payment design. CMMI[2] test payment and service delivery models. Our mission is for America to have the highest-quality and most affordable health care system in the world. We know we're not there yet. So

2 Center for Medicare and Medicaid Innovation

the PTAC process allows for a unique opportunity to identify strategies and solutions to achieve value-based care in the health system. I sincerely hope we can keep these public discussions going as advancing health equity takes off as a national priority, and we continue to develop future payment and service delivery models.

With that, I'll conclude and turn it over to Jeff. Thank you again for your time, and thanks to all members for pulling together this public session and for your dedication to health care transformation.

Thanks a lot, Jeff.

*** Welcome and Care Coordination Session Overview**

CHAIR BAILET: Thank you, Liz, for joining us to provide those remarks. We really look forward to continuing to work with you and your team. Because of the coronavirus pandemic, as you said, we're holding this meeting virtually rather than gathering in the Great Hall of the Humphrey Building. We aim to provide a seamless virtual experience as close

to an in-person PTAC meeting as possible.

That said, we appreciate your understanding in advance if any technical challenges arise such as sound delays or background noise. If you have any technical questions, please email our contractor team at PTACregistration@NORC.org. Again, that's PTACregistration@NORC.org. If you joined us by Webex, you can also message the meeting host with any questions.

Many PTAC stakeholders are directly involved in responding to the pandemic, and we are thankful for your service to our country. We want to thank providers, support staff, caregivers, family members, and others who are supporting patients during the pandemic. We recognize that it's a privilege to have you join us today.

Throughout the Committee’s tenure reviewing the proposals we have received, we have noted common themes that have emerged across multiple proposals from a variety of stakeholders. As part of our last two public meetings, we explored the theme of telehealth

in the context of Alternative Payment Models, resulting in a report to the Secretary on telehealth that we released earlier this week.

Today we will explore a second theme that has spanned several past proposals, the role that care coordination can play in optimizing health care delivery and value-based transformation in the context of Alternative Payment Models and physician-focused payment models.

We have a great lineup planned. First, I would like to provide some updates on the Committee's work since our last public meeting in December. We have worked hard to support stakeholders who may be interested in submitting proposals to PTAC. In April, we released our updated proposal submission instructions. Our main goal with the updates is to make it easier for stakeholders to submit proposals.

We developed a new second track for proposal review to provide additional flexibility for those who have important care delivery, payment, or policy issues to raise

but may have varying degrees of resources available as they develop their proposed models.

Aligned with our interest in providing resources for those who are developing payment models, we also released a reference guide on common APM[3] approaches. That may be particularly useful for those who like to explore some potential payment methodologies that may be appropriate for their care delivery model. You can find that guide on the resource page of the ASPE PTAC website.

As a reminder, PTAC accepts proposals on a rolling basis. The Committee does not have any proposals to review at this time, but know that we remain ready to review proposals as they come in and are eager to engage with stakeholders who want to propose models for our review and comment.

As the new Administration gets underway, we want to encourage the field to develop models and send them to the Committee. This is a great time for new models to come in

3 Alternative Payment Model

from the field for consideration by PTAC, and then for the Committee to share our comments and recommendations with the new Secretary of HHS.

We have a lot prepared for today. First, several Committee members who volunteered to assist in preparing for today's theme-based discussion will provide an overview that will help to provide some context. They have done a lot of prep work for today, including working with staff on an environmental scan that is available on the ASPE PTAC website. Then, our first panel, which is composed of several subject matter experts, will provide a wide range of perspectives on care coordination and Alternative Payment Models.

After a short break, we will have a panel of previous submitters, guests representing organizations that have submitted proposals to PTAC that included care coordination components. This is not a re-deliberation of their proposals but a special opportunity to take a deeper dive into the

topic and learn more from the field about the relationship between care coordination and Alternative Payment Models.

Next, we will have a public comment period to hear additional input and perspectives on care coordination. Comments will be limited to three minutes each to maximize the number of participants. If you have not registered in advance to give an oral public comment, or would like to, please email PTACregistration@NORC.org. Again, that's PTACregistration@NORC.org.

After we hear from public commenters, the Committee will discuss what we have learned, shape our comments for the Secretary of HHS, and share any closing thoughts on the day's events. Finally, at the end of the day, we will announce a Request for Input to hear from others who would like to provide information on care coordination as it relates to APMs.

Taken together, the preparatory work and the online materials, the panel discussions, and the public comments are aimed

at informing PTAC about the most current knowledge from the field about how to optimize care coordination and further the goal of value-based care in the context of Alternative Payment Models.

* **PTAC Member Introductions**

At this time, I would like PTAC members to introduce themselves. Please share your name, your organization and, if you'd like, feel free to share a brief word about any experiences you have with care coordination, today's topic. Because our meeting is virtual, I'll cue each of you starting with myself. I'm Jeff Bailet, the CEO of Altais, a physician enablement organization. I am an ENT[4] surgeon by training.

Paul, you're next as the Vice Chair.

VICE CHAIR CASALE: Thanks, Jeff. Paul Casale. I'm a cardiologist. I lead Population Health at New York-Presbyterian, Weill Cornell and Columbia University. In that role, I lead an MSSP ACO[5], and care coordination fits

4 Ear, nose, and throat
5 Medicare Shared Savings Program Accountable Care Organization

prominently in our work.

CHAIR BAILET: Thank you, Paul.

Carrie.

DR. COLLA: Thanks, Jeff. Carrie Colla. I'm a health economist and a professor at the Dartmouth Institute for Health Policy and Clinical Practice. My interaction with care coordination is largely both quantitative and qualitative research on providers participating in Alternative Payment Models and what they do around care coordination. Thanks.

CHAIR BAILET: Great. Thanks, Carrie.

Jay.

DR. FELDSTEIN: I'm Jay Feldstein, the president and CEO of Philadelphia College of Osteopathic Medicine. In my previous life with a health insurer, I was responsible for care coordination and case management and the Medicaid plan across five states.

CHAIR BAILET: Thank you, Jay.

Lauran.

MS. HARDIN: Good morning. I'm Lauran Hardin. I'm Senior Advisor for the

National Center for Complex Health and Social Needs. I spend the majority of my time with sites, communities, states, and government designing models for complex populations. I've spent the last 20 years leading and designing care coordination for every kind of model ranging from children's hospice, palliative care, every kind of HCO[6], BPCI[7], and now community-based cross-sector collaboratives.

CHAIR BAILET: Thank you, Lauran.

Josh.

DR. LIAO: Good morning, everybody. Josh Liao here, internal medicine physician at the University of Washington in Seattle. I think about care coordination in two roles. The first is through research studying the impact of payment and delivery models. The second is through a role that I have as an enterprise medical director for payment strategy through which I work with our value-based care team and our integrated delivery network to think about care coordination in several programs.

6 Health care organization
7 Bundled Payments for Care Improvement

CHAIR BAILET: Great.

Lee.

DR. MILLS: Good morning. I'm Terry Lee Mills. I'm a family physician, and I'm currently senior vice president and chief medical officer at CommunityCare of Oklahoma, a regional provider-owned health plan. I come from care coordination from both medical group leadership and the health plan side from building care coordination at individual practice levels all the way scaled up to an enterprise level.

CHAIR BAILET: Thanks, Lee.

Kavita.

DR. PATEL: I'm Kavita Patel. I'm an internal medicine physician in D.C., and my role in care coordination, I lead primary care doctors in the DMV[8] area for specifically kind of safety net post-COVID around transitioning to at-home and remote-based care where appropriate. Thank you.

CHAIR BAILET: Thanks, Kavita.

Bruce.

8 DC, Maryland, Virginia

MR. STEINWALD: I'm Bruce Steinwald. I'm a health economist here in Washington, D.C. My experience with care coordination is the lack of coordination with the care that I've received over the past several years.

CHAIR BAILET: Thank you, Bruce.

And Jennifer.

DR. WILER: Hi. I'm Jennifer Wiler, emergency physician by training, professor of medicine, and I'm the Chief Quality Officer for UCHealth in Denver. I'm also a co-founder of our CARE Innovation Center, where we partner with digital health companies to think about how to optimize care delivery, including care coordination and leveraging digital technologies.

My additional experience with care coordination is as a practicing physician in the emergency department. Also for various operational leadership roles, and I was principal investigator on the city-wide grant looking at emergency department high utilizers, where we were able to partner with community organizations and improve health outcomes for

patients.

CHAIR BAILET: Thank you. Thank you all.

At this time let's move to our initial presentation. Three PTAC Committee members have served on the Care Coordination Preliminary Comments Development Team, or PCDT, that have worked closely with staff to prepare for this meeting. I'm thankful for the hard work that they put into organizing today's discussions.

We'll begin with a presentation on some findings from an environmental scan on care coordination and Alternative Payment Models. It is also available on the ASPE PTAC website. PTAC members, you'll have an opportunity to ask the PCDT any follow-up questions afterward.

At this time I'm going to turn it over to the PCDT lead, and that's Lee.

*** Presentation: Care Coordination Components in Proposals Submitted to PTAC and Other Highlights from the Environmental Scan**

DR. MILLS: Thank you, Mr. Chair. I'm happy to present this series of slides, 17 in number, just to set the context of what the Preliminary Comments Development Team and, with staff's invaluable help, has learned about prior PTAC proposals and then the comprehensive environmental surveillance of what really is known versus guessed in the research.

I certainly want to thank and call out the rest of the team: Lauran Hardin and Dr. Angelo Sinopoli, who have invested innumerable hours over the last four months in this work.

Next slide, please. So just as way of introduction, this is to set the context of our conception of care coordination, a topic that I think everybody on the call is familiar with in various ways that holds both incredible promise and importance for individual patients all the way up to the stake of the health care system and ecology in total.

From 2016 to 2020, PTAC received 35 stakeholder-submitted proposed physician-focused payment models, and voted and deliberated on 28 of those to see which of them

really met the Secretary's Criterion 10 -- sorry, the Criteria, which include Criterion 7, which is all about "Integration and Care Coordination."

That's defined as the degree to which the proposal encouraged greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated. We found that one of those 28 met and deserved priority consideration for meeting that criteria. Fifteen met the criteria, 10 did not, and two proposed models, the criteria wasn't applicable.

Next slide. In reviewing these, it becomes evident and is aware that there is a definition problem and that there really is no consensus on the definition of care coordination. Care coordination often has a functional definition that varies from the beholder and the context.

For the work in framing what we know about care coordination, PTAC is using the

working definition from AHRQ[9] as a starting point of conversation, which is that care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.

That means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that the information is used to provide safe, appropriate, and effective care to the patient.

Slide. So another thing that became really evident in working through that is that there are multiple contexts in which care coordination can occur, often operating simultaneously in different proposed models. These contexts are really three or four in number, and one is care coordination for population health, meaning general coordination for all patients regardless of need.

9 Agency for Healthcare Research and Quality

Often that's a whole community, a whole geography, a population health perspective. Then there's care coordination for specific populations typically focusing on individuals with a certain named condition, chronic disease, or a certain vulnerability.

Interacting simultaneously with both of those contexts is care coordination around an acute event, including transitions. This is especially true for interactions between the emergency department and acute care, acute care to post-acute care, et cetera. Then wrapped around all of that, if you will, is the context of health-related social needs and social determinants of health acting simultaneously in all those contexts.

Next slide. At the same time, there's some domains associated with care coordination. It certainly involves a wide range of functions and activities, again not 100 percent concurrent about which are more important, or important, and we would all have a spirited discussion about the pieces of functions and activities that we found most

valuable in our work settings.

There are some functional domains considered key that AHRQ has identified, and these include establishing accountability or negotiate responsibility for coordination; clear communication; facilitate transitions in sites of care; assess patient-centered needs and goals; create a proactive plan of care with patient input, monitor, follow up, and respond to changes in the patient's situation or context for needs; support self-management goals; link to community resources; and then align those resources with patient and population needs.

Next slide. So in all these domains, again, multiple activities of importance, and we could list many more, but PCDT identified these following activities as being particularly important in optimizing patient-centered and focused care coordination in the context of

APMs.

That includes use of care coordinators, named individual people with

responsibility; coordination of treatment and care activities across settings, providers, and sectors; behavioral health management; timely sharing of necessary information across providers of care; documentation of patient needs and preferences, and turning that into essentially a living document that helps guide the whole care team; and then use of shared decision-making, as well as ongoing evidence regarding the effectiveness of interventions and care to create a proactive plan structured to address patient needs.

We acknowledge that strategies could also involve -- there's a tremendous amount of energy spent around structural change such as financial management and planning across operational units. PTAC is particularly focused on the strategies for improving the clinical aspects of care coordination in the context of APMs and value-based transformation.

Next slide. So in thinking through that context, we did want to analyze and look at the proposals that have been submitted and try to pull out themes that rise to the top.

Go ahead. So, first of all, of the proposals that were found to meet Criterion 7 about "Integration and Care Coordination," we did find that in the proposals, the coordination aspects varied by clinical focus, clinical setting of care, and context of the care coordination. Some were focused on specific health conditions or diseases, serious illnesses as a bucket, and other varieties of special conditions.

Some were focused on clinical settings, including primary care, patient home, skilled nursing facilities, transitions of care, and rural providers. Then, lastly, just the overall context of that care coordination whether it was a population-wide management consideration, whether it was specific more focused populations, yet not focused on specific conditions, or whether it was related to acute events. Most of the proposals focused on only one of those, but it's certainly conceptual that a proposal or a successful coordination plan could be focused on multiple of those at the same time.

Next slide. So we also noticed there were some commonalities among the care coordination functions and activities that were included in proposals that were found to meet. Most proposals did, indeed, address at least one care coordination function. That's pretty foundational.

The common functions or activities that were emphasized in models included establishing accountability, or negotiating responsibility; facilitating transitions and coordinate care across settings; communication in streamlining and improving communication and timeliness; and, finally, assessing patients' needs and goals such as documenting needs and use of a patient-centered care plan, et cetera.

Less commonly, some proposals emphasized a care plan itself, aligning resources with patients' and population needs such as the risk stratification process, and supporting self-management goals, including shared decision-making and systematized high-quality education.

Next slide. In summary, looking at

the proposals we received that met Criterion 7, there were some common strengths among those proposals and some common gaps. For those that met, common strengths were that the proposals outlined a clear process for coordination. Outlined explicit data-sharing mechanisms. Had a clear framework for patient engagement. Had defined performance quality metrics around care coordination.

Emphasized payment mechanisms for addressing care delivery objectives and emphasizing care coordination. Had engagement standards for, and among, primary care providers and specialists. Emphasized multidisciplinary teams. Paid close attention to continuity of care and those healing relationships; and then involved in some fashion of bundled episode payment model. Those were the strengths of the proposals found to meet Criterion 7.

There were some common gaps in the proposals found to not meet Criterion 7, which included unclear specifications or requirements. It included a lack of clear

accountability. Included lack of interoperability of the HRs[10] or data-sharing. Included lack of guidance or mechanisms about that data-sharing in accessibility related to proprietary software. Lack of specific quality metrics around care coordination. And concerns about scalability of a proposed models.

Next slide. Finally, with the staff's invaluable work in the comprehensive environmental scan and certain highlights of that, learnings have risen to the top that we wanted to highlight to frame our discussion for today among our expert panels.

Next slide. The first is that there are some key findings on recent initiatives in care coordination related to payment. These findings include that Medicare has introduced, both through G-codes and through CPT[11] processes, some billing codes to reimburse providers for care coordination among fee-for-service beneficiaries. This includes the TCM[12] codes in 2013, and a variety of chronic care

10 Health records
11 Current Procedural Terminology
12 Transitional care management

management codes since 2015.

We had a finding that APMs can reimburse providers for care coordination, and that's commonly done. You see that widely in state Medicaid programs that have transitioned more towards capitated payments with risk-sharing organizations and primary care case management. We also see some states focusing on care coordination and building payment mechanisms in dual-eligible populations.

Additionally, CMMI has designed and launched numerous APMs in Medicare fee-for-service that include mechanisms to support care coordination. There is certainly a variety, and a wide variety, of models to include population-based and performance-based payments, one time or up-front funding, care management fees, capitation, and fee-for-service-based payments around care coordination and quality.

Then, finally, health plans had a wide variety of activity across public and private payers to adopt programs to support

care coordination, including PCMH[13] programs, capitation arrangements, and other value-based models that support coordination.

Next slide. Another finding is that performance metrics are important and have a wide variety of strengths and weaknesses. We found that there's a number of challenges in isolating and measuring the effects of care coordination. That's both a wide variety of metrics that are wholly dependent on the context and situation, as well as for things that may use the same metric, different definitions.

There are certainly reported barriers, including variation in whether and how care coordination is documented, whether it's in claims or EHRs[14], and challenges in measuring care coordination using that electronic data. Often care coordination is as much a qualitative as a quantitative engagement.

Many of the available measures focus

13 Patient-Centered Medical Home
14 Electronic health records

more on outcomes to avoid, such as hospitalizations and re-admissions, rather than the outcomes to be achieved. Some CMMI models measure a caregiver and beneficiary satisfaction or practice-level process measures.

Others of the models proposed to PTAC included direct process measures related to the activity of care coordination, such as number of completed health plans, number of transitions coordinated, et cetera, while other proposed models use measures of cost, utilization, and quality as basically proxies for coordination events that may or may not be directly related, so plenty of metric challenges in defining, measuring, and using metrics.

Next slide. We did find in the environmental scan that there is some relationships between selected assumptions and the available evidence. There are some assumptions that we see in the working models about patients who are likely to benefit from care coordination, then with a positive impact

on cost utilization. That boils down to two populations.

The working assumption is that patients are more amenable to care coordination that will be effective if they have modifiable risk factors, or risk factors in individual patient or team control. And/or if the care coordination activities focus on users of health care services, including those with chronic conditions.

The available evidence regarding the effects of care coordination is quite mixed. Some studies show certain care coordination functions do have positive impact on utilizations, including outcomes, targeting high-risk patients, facilitating care transitions, and primary care population-wide coordination.

There certainly are opportunities to improve care while reducing costs through coordinating care for high-cost patients. There are some promising findings that exist related to reduced spending for post-acute care when those transitions and contexts are better

coordinated. APMs have some promise in improving specific performance metrics when that APM creates an incentive for care coordination folks at that metric. There is evidence in the literature about the positive effects of care coordination, but not any evidence that is dominant or overbearing at this point.

Next slide. The impact of the public health emergency that we've all experienced over the last 15 months has certainly had an impact on care coordination. Care coordination itself when established helped mitigate many of the challenges associated with the public health emergency, enabling providers to proactively reach out to patients and care for the patients that were not coming to the office; removing barriers to access, including transportation; and facilitating communication among providers and patients.

The temporary change in billing requirements under Section 1135 waiver authority was tremendously beneficial and has created a rapid burst of innovation. It's been

fun and exciting to watch. At the same time, the increased reliance on telehealth activity for some providers has posed challenges. This particularly includes small practices or long-term care facilities that may not have the necessary infrastructure to be able to transition to virtual care or care coordination.

Additionally, the public health emergency has brought to light, or surfaced, even more so than previously known, disparities in access to care coordination. It has become harder for some patients to engage in health care due to competing priorities, especially in low income and rural communities and those with social isolation.

Next slide. Care coordination and behavioral health is another important thing that has come out of the literature on environmental surveillance. We certainly are aware, most of us at a very granular level, as well as in the literature, that there's a shortage of behavioral health providers, which poses an ongoing dramatic challenge in

coordinating physical and mental health care.

CMMI models that incorporate behavioral health services exist, including CPC+[15] and Pioneer ACO. The PTAC did receive a proposed model from the AAFP[16] that highly emphasized behavioral health services and integration.

We find that the financial alignment incentive integrates primary care, acute care, behavioral health, and LTSS[17] among dual-eligible enrollees, and Medicaid has other initiatives also focusing or incorporating behavioral health into care coordination, which seems to be a critically important theme for all of us moving forward.

Finally, the American Rescue Plan includes funding for addressing behavioral health needs and encourages grantees to coordinate among local entities and providers.

Next slide. Finally, it's evident to all of us, I know, that there are many areas where additional information and research is

15 Comprehensive Primary Care Plus
16 American Academy of Family Physicians
17 Long-term services and supports

going to be needed. This includes in the PTAC's mind what activities can help optimize care coordination in APMs and PFPMs[18] to improve quality or reduce cost. What types of payment models are likely to incentivize care coordination, including specific functions?

How do care coordination functions, that we've mentioned, vary by context, population, patient characteristic, or geographic region? How has care coordination evolved over the last year due to the public health emergency and with increased attention on the priority of achieving health equity, including addressing social determinants of health?

What are the best ways to measure the quality and effectiveness of care coordination? What is the best time frame for assessing the benefits and the cost of care coordination? Lastly, what types of information or descriptions of care coordination are needed to facilitate the PTAC evaluation of proposals that we receive?

18 Physician-focused payment models

Next slide. I believe that's the end. We have additional details in the appendix, including further detailed analysis of the care coordination components of proposed models that the PTAC has reviewed. An environmental scan of the literature is also available. I did want to thank the other members, Lauran Hardin and Angelo Sinopoli of the PTAC, for their invaluable work over the last several months putting this together.

Mr. Chair, I'll pass it back to you.

CHAIR BAILET: Thank you, Lee, for that comprehensive presentation and summary.

Lauran, before I turn it over to the full PTAC, did you have any comments you'd like to make?

MS. HARDIN: I just wanted to say Lee covered it very well. I think we have a tremendous opportunity to take the lessons we've learned during the pandemic about the vulnerability of our communities, what can happen when we come together across sectors, and also interprofessionally, to really address care delivery from the perspective of what

patients and families need in their homes and in their communities.

It's a tremendous opportunity for the next level of innovation and model development to inform the objectives and priorities of the new Administration as Dr. Fowler laid out.

CHAIR BAILET: Thank you, Lauran. Thank you, Lee. I also want to thank Angelo, who’s unable to join us today, but he was a significant participator in the PCDT. It's been a very helpful background for our discussion today.

I'll turn it over to the Committee members to ask questions of the PCDT at this time, if there are any questions.

DR. FELDSTEIN: Hey, Jeff. It's Jay.

CHAIR BAILET: Yeah. Hey, Jay. Go ahead.

DR. FELDSTEIN: I have a question, Lee. In either your environmental scan or going over the highlights of the previous submitters, did you see anything significant from a technology standpoint because, you know,

historically a lot of care coordination case managements have been labor-intensive? Did you come across anything how either ACOs or individual practices or plans, anything from a technology standpoint that stood out from your perspective?

DR. MILLS: Well, I look forward to Lauran's comments as well, but I think what we've seen in environmental surveillance, as well as just practical experience for most of us, is that technology and communication is either a great enabler or the existential barrier that can't be gotten past.

I would say that using technology to emphasize timely, if not instantaneous communication among members of a care team involved in coordination is a necessary but not wholly sufficient task. It's something that has to be taken care of and dealt with and enabled to even start the process of care coordination that's going to be effective.

MS. HARDIN: I agree with Lee's comments. I think just in addition, there's been a tremendous growth in obviously

telehealth. On the positive side of that, there have been a lot less no-shows for behavioral health and different visits because of the ease of access.

There's been a great growth in resource platforms like Unite Us and NowPow and other technology coming into communities to gather what are the social determinants of health resources in the community-based organizations and how can that be shared across the community to accelerate care coordination.

Then there's been growth in development of platforms for shared plans of care. Some of those things have not landed in the literature yet because they are growing now and the studies haven't been done, but that's what we're seeing on the ground, as well as a lot more AI[19] sort of virtual behavioral health type platforms moving forward.

DR. FELDSTEIN: Thanks.

CHAIR BAILET: Bruce, you had a question?

MR. STEINWALD: Yeah, I do. My

19 Artificial intelligence

mother-in-law lived with us for 18 years before she passed away at age 100, and she had multiple chronic illnesses, and we were determined to keep her here at home. Even though my wife and I have some expertise in the health care field, we were unable to coordinate her care ourselves.

We hired a navigator to help us do that. Actually it turned out to be a good move. She was very capable. My question is have you run into in the environmental scan, or any of your research, did you single out the role of navigators in helping to if not coordinate the care, at least help people figure out how to do it or where to get it?

MS. HARDIN: Do you want me to answer first, Lee?

Again, one of the challenges in this area is how much evidence has actually landed in the literature, so let's talk about practice. I think there's a tremendous need for longitudinal and cross-sector care management, and that's what you're seeing with the navigator.

The person isn't only navigating and helping you with the cardiac disease under an ACO and then it ends when the episode of payment-for-care coordination ends. They are looking holistically at your mother-in-law and your family for what are the needs and what are the cross-sector coordination components that are needed.

On the ground, that's what is moving forward and that's what is working for people. The evidence around that is still emerging, but longitudinal versus episodic care management, I think, is really key in the future, and also the ability to deeply develop a holistic trusting relationship with the entire family to look across systems.

From the patient and family perspective, that's what we all want, is that holistic view and someone who will navigate regardless of payer source, regardless of hospital systems, community-based organization, someone who can see that whole picture. There is a tremendous opportunity for more research and evidence in that area.

MR. STEINWALD: Thank you, Lauran. My impression is that the good navigators are kind of hard to find. It took us awhile. I wondered if that's generally the case.

MS. HARDIN: It really depends on the part of the country when you think about what is the payment source for that, and then there are models of palliative care, and hospice care is probably the closest to that in a professional team that navigates regardless of setting, but not everyone is in the palliative care hospice continuum. Many people with multiple chronic conditions could benefit from that holistic approach that's longitudinal in developing a relationship.

DR. MILLS: I agree with Lauran's comments as well, Bruce, with your family situation. I've experienced it as well. I think part of that speaks to the concept of establishing accountability and negotiating clear responsibility and communication patterns for coordination in a very granular family/patient focused level. To some degree needing a navigator is, I hope and pray --

CHAIR BAILET: We lost you, Terry.

DR. MILLS: I hope and pray that the need of an individual as a navigator to help manage the complexity of communication is a transitional state as we move towards -- as Lauran said, it's more of an ongoing healing continual relationship where the providers and the care team with patients that are focused are continually in communication.

Much like you manage your family relationships with endless texts and instant messaging. It's not the episodic -- place a phone call -- as a single event. That's going to take continued work and continued research to get there.

CHAIR BAILET: Thank you.

Josh, you had a question, comment?

DR. LIAO: I did. Thanks for this, Lauran and Terry and Angelo. I was really struck by kind of how you characterized the different settings, clinical populations, contacts. I know you set up a number of questions about what we'd love in terms of more information.

I'm curious if you combine those. Any sense of the environmental scan about -- you know, we've seen mixed evidence. Where is the evidence, the most positive, and where is it the most -- the least positive when we map it onto the kind of categorization you guys used to form next steps?

DR. MILLS: Great question, Josh. My understanding of the literature, seasoned with personal experience, is that it seems like the best effectiveness -- actually changing quality outcomes and cost seems to be centered on the context of very high-cost disease-based intensive coordination or navigation.

The other end of the spectrum, truly advanced whole population, usually primary care focused, coordination of just whole family and community needs. In a sense it's at two ends of the spectrum, although that may not be the right way to conceive of it. Those are what I've seen both in literature and in playing out in real life.

Lauran.

MS. HARDIN: I would support that. I

would also just add there's a lot of missing evidence about the value proposition or really what do patients and families define as value and how does that translate into evidence around what we should be focused on.

As Dr. Fowler was talking about, functional status, quality of life, trust, safety, being seen and heard. Many of those things we don't put the same financial value on. The evidence is highly focused on cost and utilization, which is good.

We want to reduce cost. But what is the value in that equation of addressing equity, addressing some of the other patient and family value quality issues, and how can we translate that into a new value equation, I think, is what I would say.

DR. LIAO: Thanks.

VICE CHAIR CASALE: And, Jeff, can I just add onto that?

CHAIR BAILET: Please.

VICE CHAIR CASALE: It's sort of a comment and a question. I notice on the key functional domains, the use of care

coordinators was at the top. I think it just emphasizes that coordination sort of doesn't occur necessarily organically. It really does require investment. More to your point, I'm wondering as you looked at the environmental scan, you know, many times we look at the return on investment and that's now we end up looking at ED[20] and hospitalizations because you can assign dollars to that. In fact, what you just described is not only equally but more important.

I think to the points that Lee made in the slides, I don't think we quantify that very well, so when we need to sort of put in a return on investment or what is the financial plan, those kinds of things, how to incorporate that, I think, becomes critical. I think we need to learn more about how to do that.

MS. HARDIN: I completely agree. I just had the privilege of finishing a research project for the Commonwealth interviewing people around the country about how they are making the value case for complex care.

20 Emergency department

What emerged out of that definitely, no matter where you sit in the system, you need to be able to articulate the cost benefit and utilization benefit. Also patients' families find quality measures in addition to evidence-based disease management and quality measures. The patient, provider, partner satisfaction.

Then the impact on equity and how do things that really contribute to equity, like access to care, access to insurance, housing, safety, food security. Then how can you look at that as a combined return on investment equation? Across the board, people leading organizations want to be looking at that fully and really starting to incorporate that. We have a great need for more rigorous measures in this.

CHAIR BAILET: Great. Good discussion. Nice setup for our first panel discussion and then the rest of today as well. We're about seven minutes or so before we start. We're starting at 8:00 Pacific time, 11:00 Eastern time for the panel. We have many of the panelists who have joined us. There are

a few more we are waiting for so we wouldn't want to start before the full panel is convened.

We have really about five minutes. I think what we'll do is we'll just take a brief break. We'll all remain on but just mute ourselves and potentially go off video for a minute but we'll all be back on at 8:00 and start the first panel. Thank you for your patience. We'll be right back.

(Whereupon, the above-entitled matter went off the record at 10:54 a.m. and resumed at 11:01 a.m.)

*** Panel Discussion on Care Coordination with Subject Matter Experts**

CHAIR BAILET: All right. So thank you for your patience. Now very excited to kick off the first panel on care coordination. At this time, I'll ask our panelists to go ahead and turn on their videos.

Lee and the PCDT team helped us level set with definitions and the activities that are included in care coordination, as well

as what we have learned from our environmental scan and from proposals that have been submitted to PTAC. To further inform us about issues related to care coordination, we've invited a variety of esteemed experts from across the country. And they represent several perspectives on care coordination, including providers, researchers, payers, and patient advocates.

You can find their full biographies on the ASPE PTAC website along with other background materials for today's meeting. We have several questions in the queue. We'll work through each one, and I'll vary who's called upon first.

In the interest of time, for some questions, I'll begin by inviting two or three of you on the panel to provide your particular expertise. Then I'll open it up to Committee members to ask any follow-up questions they have for the panelists. I'll also ask that each panelist try their best to keep their responses to a few minutes or so for each topic. I'll ask each panelist to please introduce yourself with

your name and your organization. Because this is virtual, I will prompt each of you alphabetically by last name, starting with Sara Barry.

MS. BARRY: Good morning. Thanks for the opportunity to speak with you all today. My name is Sara Barry. I'm the Chief Operating Officer of OneCare Vermont, which has a statewide accountable peer organization that is all payer in nature and represents about 120 organizations with more than 470 locations in Vermont.

We started two-sided risk programs as an ACO with Medicaid in 2017 and then began a Vermont-specific waiver for a Medicare Alternative Payment Model in 2018. We have about 5,000 physicians and 270,000 beneficiaries in Vermont. And I'm looking forward to speaking with you more about our community care coordination model. Thank you.

CHAIR BAILET: Thank you, Sara. Linda Elam?

DR. ELAM: Good morning, everyone, and again, a pleasure to be with you. I am

currently with Manatt Health where I'm a Managing Director. But recently, I was CEO and Plan President of Amerigroup District of Columbia, which is an MCO[21] serving Medicaid beneficiaries here in Washington, D.C. And previously, I was a Medicaid director for the District and policy director in Medicaid. So as you may imagine, my primary focus is the Medicaid program and what lessons can be brought from that perspective.

CHAIR BAILET: Thank you, Linda. Bill Golden?

DR. GOLDEN: Good morning. Bill Golden. I'm a professor at University of Arkansas for Medical Sciences and Medical Director for Arkansas Medicaid. We've had an active program in Alternative Payment Models, and we had developed one of the first episodes of care for orthopedics.

But in particular, we've had a primary care medical home program which has attracted 1,000 private practice PCPs[22] in over

21 Managed care organization
22 Primary care providers

200 sites. And we've done a tremendous amount of culture changing and transformation of care that enhances the potential for these sites to coordinate care. And I can make some comments later about the creative use of metrics beyond just measurement and how we tie it in different ways to finances.

CHAIR BAILET: Thank you, Bill. Laura Gottlieb?

DR. GOTTLIEB: Good morning. I'm Laura Gottlieb. I'm a professor of family and community medicine at the University of California, San Francisco (UCSF). I'm delighted to be on the panel this morning. I bring a perspective from the Social Interventions Research and Evaluation Network, or SIREN, which is a research acceleration and translation center that I run here at UCSF, really focused on the advancing evidence on the integration of social and medical care, so things like screening for social needs and supporting practitioners to find efficient and effective ways to incorporate social care-related intervention.

CHAIR BAILET: Thank you, Laura. Sachin Jain, please?

DR. JAIN: Good morning, everyone. Sachin Jain, I'm president and CEO of SCAN Group and Health Plan, a managed care entity that serves over 220,000 Medicare Advantage beneficiaries. Before joining SCAN, I was President and CEO of CareMore and Aspire Health, which were the care delivery divisions of Anthem, Inc.

CHAIR BAILET: Thank you, Sachin. Robin Newhouse?

DR. NEWHOUSE: Hi, I'm Robin Newhouse, Distinguished Professor and Dean of Indiana University School of Nursing. So I'm from Indiana University (IU). I also hold an appointment as Deputy Chair of our university clinical affairs and have an appointment with IU Health. That's our largest health system in Indiana.

I bring the perspective first of nursing and second of a scientist that focuses on translation of evidence-based practices and toward improving care and health of people. So

I think it sounds like I have a different perspective and a different area of expertise that others are bringing. So happy to be here.

CHAIR BAILET: Thank you, Robin. Catherine?

MS. OLEXA-MEADORS: Good morning and thank you so much. My name is Catherine Olexa-Meadors. I'm the Vice President for clinical innovation here at Aledade, Inc.

My personal background: I've spent about a decade in the post-acute care and transitional care space on the operation side, both in nursing homes, hospice, home health, and assisted living, and then made the transition to the value-based care landscape when the Bundled Payment for Care Improvement program was launching, and built a company with a great team at Remedy Partners over about four years, launched that program and what ended up being about 600 sites across the country. I'm now with Aledade. I've been here for three years, originally focused on transitional care and now really focused on clinical innovation to include care coordination across our

ecosystem.

Our ecosystem today consists of over 8,000 primary care providers across 32 states, representing over 1.2 million lives under management. And really our core aim was mentioned in the previous hour around making the primary care providers practice truly that center of care for patients and families and enabling them to see both the patients who are coming in today and the patients they need to reach out to. So that is our aim and the providers we support, and I'm really excited to be able to tell you a little bit about what we're doing during the panel today.

CHAIR BAILET: Thank you, Catherine. And last, Sandra Wilkniss, please.

DR. WILKNISS: Good morning. I'm delighted to be here as well, and I'm Sandra Wilkniss. I'm the Director of Complex Care Policy and a Senior Fellow at Families USA, which is a national nonpartisan voice for health care consumers.

I also bring some experience in policy on the state and federal level. Prior to

coming to Families, I worked for six years at the National Governors Association Center for Best Practices on health policy issues, and prior to that, three years on the Hill. And I'm also a clinical psychologist by training, served as a scientist practitioner for about 15 years working with people with serious mental illness. Thank you for the invitation.

CHAIR BAILET: You bet, Sandra. And thank the whole -- all the panelists for participating today. Excited to get into the discussion.

First off, from your own experience, perspectives, and expertise, please tell us what you see as the role and the objectives of care coordination in the context of value-based care. Also, are specific functions or activities of care coordination most important for improving quality and reducing cost in Alternative Payment Models or physician-focused payment models? And lastly, do these functions vary by context or for specific populations? I'll prompt each of you to answer the question starting with Dr. Jain.

DR. JAIN: My personal perspective comes from leading provider groups, as well as leading a managed care organization that serves older adults with complex needs. I think that kind of core need associated with care coordination is connecting dots that are otherwise disconnected for people. We have a highly fragmented health care system, and the role of care coordination has historically been seen as an integrator or bridging function.

I think the most important kind of deficiency in most models of care coordination is a lack of a preexisting relationship with the patient. My personal view is that we introduce strangers to support patients at times where they need strong relationships rather than strangers to support them. And so my approach, both at CareMore, as well as at SCAN, has been in trying to proactively identify patients who may need care coordination in advance of them actually having an acute need, try to build a strong relationship with those patients in anticipation of future needs such that that

relationship capital is available for patients and families at a time when it is going to be valuable for them.

I think in the absence of that, you see care coordination can oftentimes almost appear like an intrusion in the physician-patient relationship as opposed to an important adjunct. And so my personal view is that we need to kind of emphasize the existence of care coordination relationships and anticipation of them being needed as opposed to injecting them at an acute moment in a patient's life.

CHAIR BAILET: Thank you. Robin?

DR. NEWHOUSE: Yeah, the importance of care coordination is to understand the needs and the goals of people, their health goals, their family or the community, and to improve outcomes that are important and they care about in a patient-centered way, better health, lower cost, lower utilization. So care coordination is about optimizing health in ways that people can make positive changes and become resilient, healthier, and live the life and achieve the goals that they intend to achieve. And thereby,

it avoids a misallocation of resources so there's not those failures in some of our processes of care. But the whole point is to improve health and help people live the life that they intend to live.

CHAIR BAILET: Thank you. Linda?

DR. ELAM: Well, I'd like to echo the previous comments. And again, coming from a Medicaid perspective and where we've had a long history of managed care, capitated payments, and value-added benefits and sharing risk as appropriate with providers, it's clear that you have to start with the person and what it is they desire. Different populations, different individuals, different contexts require different approaches. But a whole-person lens is a constant that should be involved.

I'd also add that determining appropriate reimbursements is key. But that payment itself is not enough to drive these important connections. They have to be intentionally developed and maintained.

And, you know (audio interference) is clinical, but a huge part is non-clinical

for the populations that I've worked with. And so connecting people not only to follow-up appointments for making transitions between care but also assuring that they have access to support such as housing, food, and other elements that help them achieve optimal health is really important. I think the last thing I'll say is that IT is another thing that's hugely important but is not sufficient to really drive success. You have to have that personal touch as was discussed earlier.

CHAIR BAILET: Thank you, Linda. Catherine?

MS. OLEXA-MEADORS: Yes, so on this part, I think from my personal experience, it's been interesting to work across different parts of the ecosystem. And I really think it's important to bring out a point here around a very different view of who the care coordinators should be for which patient at any given time. And I think Sachin brings up an amazing point around it has to be a relationship, right?

But what relationships and with whom

and for how long and for which patient is always the question. And the last question which this Committee is considering is, how do you pay for it? How do you get the right money to the right folks at the right time to actually perform these functions? And you may get a slightly skewed view from me as someone who is now really committed to this concept that the primary care practice is that entity and is that unit that needs to behave as the care coordinator and the quarterback for these patients.

And when we think about the for whom, they certainly shouldn't be performing the care navigation functions that were mentioned for everyone. I was using an example yesterday about my recent pregnancy. I had my first child last year, and my insurance plan offered me a care navigator for my pregnancy, which was great.

But I didn't need it. I was someone who could manage all my appointments. I was someone who could really get it, and I knew what my -- I had a great relationship with my

physician. And all of those things were taken care of, and yet I was offered this care navigation service.

So I think it's really important for us to understand who should own this care coordination relationship. Which patients and which times in their lives need help and need support on this and really come at it in a unified way. So it was also mentioned previously that we could have the possibility of getting to maybe what I would think of as an idyllic future state where all of the folks in this ecosystem that we live in are communicating via -- I don't know -- TigerText or something.

And we're all just, like, totally on the same page. And I'm not sure that that is something that's within our reach, certainly not in the current state. And we certainly saw how that wasn't happening through the pandemic, right? And I think everyone is well intentioned. But having an anchor of where we can focus this care coordination work, which is the primary care practice, has to be something

that I think has to underline our common framework around how care coordination should work.

And I think really when you think about that, there's two components, right. What can the primary care practice accomplish on their own, and how do we make sure they're resourced to accomplish that? And what do they need to bring in to bear to support patients, similar to some of the work that Sachin had done in the past related to CareMore or Aspire, the more deep, complex care management that the standard primary care practice isn't positioned to deliver.

So those would be my three points, thinking about the primary care practice as the quarterback and how do we set them up to be successful and not come at the patient from the payer and the hospital and all different types of care coordinators at different points in their life with no quarterback? And then how do we make sure that the primary care practice can pay for that? And how do we make sure that they are able to bring in other services as needed

and as appropriate and frankly from a financial model perspective are incentivized to do so?

CHAIR BAILET: Thank you, Catherine. Bill?

DR. GOLDEN: Yeah, thank you. I'm going to step back to about 50,000 feet and talk about the need to really redefine what health care is all about. Back in 2012, when we launched the first episodes of care for total health, what we began to tell the provider community is that you're not paying for an event, i.e., a surgery. You want to pay for a patient journey.

And by creating the episode of care, that in itself drove care coordination because suddenly the orthopedic surgeon was interested in, what does post-surgery rehab look like? Where does it happen? What is the pre-surgical education of a patient to prepare them for the rehab?

So by switching to the patient journey rather than the surgery as the core function of the payment, people began to rethink what their product was. Likewise,

primary care, they are many times stuck with the visit orientation because of their overhang. And so we told people when we launched the Medical Home program in 2014 that they are not being paid for visits. They're being paid to manage a panel.

And when I chaired the LAN's[23] panel on primary care payment, there was universal agreement that we need to change payments to tell people that they are managing panels and not visits. And when you do that, that begins to change culture and begin getting people to think what do we do, what kind of services do we need to manage a panel? And I can tell you later on, I'll talk about metrics that you need because you first have to identify what's important.

CHAIR BAILET: Thank you, Bill. Sandra?

DR. WILKNISS: Hi, yes. It's always a challenge to bat cleanup here and to say something new and different. But what I would like to underscore that I think has already

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been touched on is really that the purpose of care coordination when done well is to meet the needs of the person as holistically as possible and prioritize that person's goals. And I love the quarterback analogy, and I see the value of those kinds of models.

And what I would add to that is that the person served should be part of the coaching team, right? We're really in a space where we can move to a shared decision-making kind of approach when we think about how to inform not only what services are offered but the care coordination aspects of those. The care coordination approach should be laser-focused on that holistic set of needs for that individual, including his or her own stated goals.

It allows us an opportunity when done well to really centralize care coordination to step back and remind ourselves that the majority of health outcomes are not clinical – clinically based, right? They're determinants of health, and we can get into the details of what those are. And I'm sure we will

later.

But a small sliver of what determines health is in the clinical setting. So stepping back and reminding ourselves of that really can inform a high-quality care coordination approach. And I would say that that means the value proposition in health hinges on doing that successfully across health care, behavioral health, determinants of health settings, including food security, housing. We've talked about this already, environmental factors.

But also things like wealth and social capital are really key determinants of health outcomes for people and should be thought of in the care coordination approach. And I know we'll get into metrics later. Bill just mentioned that.

But I would say that if the goal is improving someone's quality of life, working back from that then determines what the care coordination looks like. And it really makes a strong case to move away from fee-for-service to Alternative Payment Models that allow that

flexibility, allow that type of coordination across different provider types and that communication. And that's what patients want, and that's what providers want to get back to. That's why they got in the business. So those were just some reflections based on what others have said.

CHAIR BAILET: Thank you, Sandra. Laura?

DR. GOTTLIEB: Yes, it's either really hard to bat cleanup or it's a lot easier. I'm not sure. I don't know whether there's better or worse. But I certainly don't think that we need to rehash what the role of care coordination is or why it's important.

What I think I'll do is just layer on the social determinants frame which I think a lot of people have already alluded to. So we did some work with the National Academy of Medicine that I think kind of helps to frame a lot of the interventions that people have pointed to. And I think it offers kind of a useful organizing framework for really categorizing the different types of care

coordination activities that are critical.

So one of those is -- the National Academy referred to as awareness. You just can't coordinate if you don't know what you're coordinating or what the patient's real needs are, and so this need for social risk screening and some consensus around what are we screening for is really critical. And then second, the Committee moved into a whole slew of interventions.

I shouldn't say a slew, four categories of interventions, both very patient directed and clinical care directed and then some very community directed, which others have kind of highlighted that you also need interventions that are changing community level circumstances. But the patient directed ones, it's kind of the capacity of whatever clinical setting, whether it's primary care as Catherine is highlighting or an emergency room setting, to bridge health, medical, and social services has really been lacking.

We lack shared data. We lack shared data governance. We don't have the technology

systems in place. We don't have the ethical guardrails for how we share data, et cetera. There's a lot of work that we need to do that's focused on assistance, on just doing that bridging between medical and social care. And then the third category that I think is really relevant here is that we can use social risk data that we collect to really change the care that we are providing that is really medical care.

It's not just, like, bridging to external services but to improve the care that we are providing, more cost thoughtful or cost conscious prescribing, providing telemedicine services but making sure people have digital or broadband access. Like, there are just so many things that we could be doing more thoughtfully within the medical care wheelhouse. But all of those require workforce and workforce training that is very relationship-centered, technology, cross-sector data sharing and governance, and then I think ethical guardrails that we have yet to develop. I'll leave it at that for now.

CHAIR BAILET: Thank you. Sara?

MS. BARRY: Thank you. That was a perfect segue because the way I think about care coordination is really from a systems perspective as a cross-community organization kind of aggregator as an Accountable Care Organization. So in Vermont, the way that we've really deployed our program is thinking through the lens of population health management.

And more specifically, our complex care coordination program has really come together as an organizing framework for us to reduce fragmentation and to focus on increasing person-centered and team-based care. It's really critical, and I can't believe how often I have to say this. But as an ACO, we don't actually deliver care.

We provide care models. We provide data on analytics. We help reform payment structures to move deeper and deeper into value-based care. And of course, that comes with some tools and resources.

But it's really all about the health care providers in our network who have those established relationships, as previous

panelists have mentioned, and the work that we can do at the systems level to help make the providers' lives easier to help optimize that care process and those outcomes. So in our care coordination program, we've really worked to align expectations across different provider organization types. And that began by just defining what is a common vision for person-centered care.

And that took many, many months longer than one might imagine. And we learned from that, that across health care organizations and across disciplines, people did not use the same vocabulary. So we had to back up and have conversations, what do you mean when you say this or that? And in doing so, we were able to create that foundation, agree on and unify some tools, and ultimately arrive at a singular tool, a shared care plan tool that everyone agreed to use that is very person-centered and really facilitates a dialogue in conversation with an individual about what their goals for their care are.

In that process, learned that

oftentimes as other panelists have mentioned, those goals are more about how I live my life every day than necessarily the clinical care. It's, you know, I want to go to my grandchild's graduation. I want to walk to the end of the driveway to get my mail, whatever those things may be.

I think in recognizing those stories and anecdotes, it allowed our care team that is founded in primary care but more holistic in the sense that it integrates with home health and our mental health care providers, congregate housing, and others to really identify themselves and their own expertise and how they can add value as part of a broader care team. So we really structured our incentive programs in value-based care to ensure that broader community care team has resources and tools available to continue to work on the education and resources to help support and continually learn from that process.

I did just want to reflect briefly on the patient-centered medical home

perspective and say that as things go, we foundationally believe that primary care is the center upon which we create health and wellness, as well as manage populations most effectively. And so we are always trying to balance investments in short-term interventions, things that are condition- or utilization-specific. We're really making sure that we have a portfolio of upstream investments in prevention and wellness.

And that part, that doesn't materialize in dollars saved at the end of the year necessarily. But we really think it's critical to foundationally changing the way health care is delivered. So with that, I will say that the final advantage I see coming from a collaborative ACO model is that we do have the ability to integrate insights from clinical care utilization claims data, social determinants of health data to really get a holistic picture of population health and then to work with our providers to drill that down to an individual's needs and how they can best do that. Thank you.

CHAIR BAILET: Great. Thank you, Sara. So that was our first section. There are a total of four. The next one, as you know, is COVID-19 brought unique challenges in coordinating patients' care, with immediate disruption of regular delivery of services and quick expansion of telehealth.

Can you speak to the evolution of care coordination, especially as it relates to any lessons learned over the last year and a half? And are there any specific lessons connected to equity? And we'll go ahead and start with you, Sara, then we'll go to Laura and then Sachin. Thank you.

MS. BARRY: Thank you. So I'm going to pick up right where I left off. And thinking about OneCare as an ACO and a central convener and organizer and health care providers and working collaboratively with human services, I really think that we have been able to take advantage of health information technology.

An example of that is in April of last year as we all started to have a better understanding of the public health emergency,

we were able to use algorithms that we developed based on a really best practice nationally to identify vulnerable population panels. And by mid-April, we had that out to over 800 care coordinators statewide so that they could reach out.

And we asked first that they conduct care and safety phone calls, just check in so we can see how people are doing with people that we're already engaged with. But we also talked within primary care practices about how managers could do some of that outreach as well. And we learned, I think immediately, three key things.

First, social isolation was way worse than any of us could have guessed. And in a rural state to hear how quickly it ramped up to become a significant problem was somewhat astonishing to us. Second and very practically, pharmacy refills were a challenge. And that was something that people could operationalize around pretty quickly.

And then beyond that, we were really starting to think about how to use the health

services and to have conversations across not only with our public payers but with private payers as well about how we could create flexibility. And then pretty quickly after we got some of the flexibility for audio-only calls and for some of the telehealth, we actually realized as a rural state, we have foundational problems with broadband access, right? We have people that are in communities that currently have no internet access and probably won't for quite a while.

And so in that situation because we have a community care team model, those community teams were still coming together virtually in a format that they already had established. And they were reallocating kind of roles. So if you're going to be on the road, can you check in on this person for me? What can we do to think creatively?

And in our congregate housing sites as an example, they recognized that they could really accelerate the uptake of telehealth by creating -- buying some tablets and creating a lending library for their housed individuals.

And they also realized they needed to provide training and retraining and some support. That turned into a very successful program. We've talked about how to really sustain that in the long term.

(Simultaneous speaking.)

CHAIR BAILET: Thank you.

MS. BARRY: If I could just finish one thought on the provider side that I think will affect many of us for years to come, and that is that beyond the rural nature of our state, we have workforce challenges that are growing exponentially. We have an aging population. We have people that are burned out and really don't have an idea about how to recover from that. And from the ACO's perspective, what we've been trying to do in that space is really try to focus on core satisfaction and where they feel they can connect with individuals and get some of the kind of energy and rejuvenation back, as well as providing skills development training.

So finally, with health equity and disparities, I think I just need to put a plug

in that we need more centralized data. We need to better understand how the data that we have available to us through health information exchange, through claims and clinical information, can really truly be aggregated and used to identify a whole host of vulnerabilities that then we can convene policy makers around. And these will be things like housing, investments in broadband and in transportation, all big issues that would increase the satisfaction of our citizens, as well as our health care providers. Thank you.

CHAIR BAILET: Thank you, Sara. Laura?

DR. GOTTLIEB: Yeah, so the question is about what we saw change in the COVID-19 context that we could apply towards the future, and then what are sort of some big equity considerations, or as I heard the question. And I would take Sara's amazing examples of what they're doing in her region, and I would generalize because this happened in a lot of places.

So we saw anenormous wave of

innovation in response to this crazy tragedy that we are still in the midst of going through where house systems and many social service systems in just this huge cross-sectoral alignment really changed business as usual. They overcame reluctance to do different tasks, to wear different hats, and to work together to get it done. And that's obviously a very positive frame, but I'm going to run with it for the moment. And then we can talk about all the downsides or the negative frame too.

We saw suddenly that health care systems who had been very resistant to screening for housing instability or homelessness suddenly were screening every patient who walked in the door. What? Not only did we see a change in the prevalence of screening, but we also saw a change in what they were screening for. So people started screening as Sara mentioned for social isolation and for digital or broadband access, internet access.

And then we saw changes in using

that same NAM[24] framework, the national framework that I mentioned. So that's kind of the awareness. What were they screening for? We saw changes in what they were willing to assist with.

So we saw health care providers that were expanding home-delivered meals or providing temporary housing and doing remarkable alignment to get that done. And then on the adjustment side, we saw this tectonic shift to telemedicine that was really -- if you think about it as an adjustment, we adjusted care based on the social needs of our population. And of course, those all intersect, right?

So you can't provide telemedicine without also providing more -- maybe bigger loaner programs. So we saw these smartphone loaner programs that Sara was alluding to. We saw other ways where people were paying maybe for six months of broadband access to patients or doing other remote monitoring.

24 National Academy of Medicine

So we saw these huge shifts. And now I think it's incumbent on us to think about, well, are we going to strengthen, sustain, and scale those changes? Is that possible, and how is it possible and for whom?

And that's where I think some of the big equity questions come to play. And I mentioned this in my prior comments that, what are our ethical guardrails around this? How are we sharing data?

Do patients have the ability to consent to sharing -- to whether or not their data is shared? Can they change their data? If we're pulling data from big consumer data warehouses, can they say, no, that's not right? What does it mean if we're asking patients to go -- who are experiencing housing instability to go to housing facilities if it's pulling them away from their families and maybe making them more socially isolated?

I think there's some big questions also about just the availability of these new services or this sort of change in services or strengthening services across the health care

sectors or settings that are, as a Kaiser member, it was awesome when somebody walked me through how to connect to my provider in a virtual visit. But as a safety net provider, San Francisco General Hospital, where we do not have a single person who is going to help my patient to figure out how to use the technology, we haven't done a single video visit.

So that kind of ethical dilemma that we're facing in providing these new or socially informed care models is really a problem. And I don't think that we as a community of health care stakeholders who really want to improve patient care for everybody and address health equity have really adequately grappled with those questions.

CHAIR BAILET: Thank you, Laura. Sachin?

DR. JAIN: Thanks. Yeah, I would say there were two kinds of key areas of focus, one of which was already touched upon, which is loneliness and social isolation. One of the things that we were able to do successfully was

actually leverage a group of our members who we had already kind of had on staff as member advocates to help people navigate their benefits. We were able to leverage them to actually provide outreach to people we believed were at high risk for social isolation and loneliness.

And the kind of impressive kind of benefits we saw from that outreach form the basis for our new Togetherness Program, which is really focused on peer-to-peer outreach, kind of leveraging seniors to actually help seniors. So that's been kind of a key learning coming out of the pandemic. And again, I think having a peer help you navigate the health care system was, I think, in many ways seen as superior because there was a higher degree of empathy expressed by individuals who are experiencing very similar challenges, and I think that was an important learning for us.

I think the second was in advance of the pandemic, we introduced a new benefit called our HEALTHtech benefit which was really, in shorthand, geek squad for individuals who

are using technology to access health care. And that turned out to be a very important benefit for our members as they increasingly leveraged technology to access health care. We saw utilization kind of far exceeding our expectation and really recognized the individual needs that people have to get that added level of support around how they could use technology to access care.

A brief anecdote: we expect that people have all the things in place to do these things. But many of our -- one of our members didn't even know how to set up an email account. And so -- which is oftentimes a precursor to actually using a HEALTHtech benefit -- using a telemedicine benefit. And so we were able to use our HEALTHtech benefit for that member to actually get them the support that they needed to hand-hold them to actually set up the email account.

And so again, I think when we think holistically about care coordination in this new world where telemedicine is going to be increasingly important mode of delivery, we

have to think about putting the supports in place that are going to actually enable people to get the kind of care that we think they can access readily. But in fact, oftentimes, there are unexpected barriers to actually accessing care. So something that we're, I think -- some learnings that we're going to definitely carry forward in the post COVID-19 era.

CHAIR BAILET: Of course I'm on mute. I was saying I'd like to open up this section to the other panelists that may have a point of view on this particular topic. If you want to raise your hand, we'll try and identify you. Looks like Sandra has got her hand up.

DR. WILKNISS: Yeah, great. And I'll be brief. Thank you. I just wanted to add that along with the social isolation which is so devastating, of course, we've also seen a major uptake in anxiety, depression, substance misuse, especially among young people. It's really an opportunity and necessity that we intervene there. And I think as we think about care coordination, that's got to be a major focus.

Telehealth has played a vital role in creating access to that and audio-only opportunities in places with less access to broadband. And it's popped up in really important places. Like, I've learned that crisis response providers have found that telehealth options are really valuable in staying connected with people who need those services. And I think that's a real opportunity across systems to really make some connection there to serve those folks.

Just two other quick points, in terms of workforce and the workforce burnout which is also just devastating, there are workforce extenders, if you will. It's not the best way to say it, but people who provide peer support services, community health workers, caregivers who are really filling those gaps and can be important contributors to really care. And the last thing I'll say about equity is, for us, the testing and vaccine distribution approaches and data around that have really brought into full relief the ongoing disparities, especially around -- in

communities of color.

I mean, it's just a tragedy how different access is in those communities. And it's not just based on hesitancy, which is sometimes in the media. And I think along with data and effectively gathering data by race and ethnicity and disaggregating those, we can't wait. We know roughly where some of these needs are, and I think just need to jump in right now.

CHAIR BAILET: Thank you, Sandra. We have Linda and then Catherine.

DR. ELAM: Thanks. And I just want to underscore that obviously telemedicine has been hugely important during the pandemic. But we've also seen how there are disparities in provider ability to engage in telehealth activities as well. So beyond just what that means for providers in the system, it also has a downstream effect on the populations that they historically serve as well. So I just wanted to make sure that element of the telehealth conversation was lifted up because it does have the potential to further

exacerbate disparities in the system.

CHAIR BAILET: Thank you, Linda. Catherine?

MS. OLEXA-MEADORS: Linda, thank you for saying that because I think it kind of segues nicely into the point that I'd like to underscore, which is that I think even at Aledade as a convener of primary care physicians in MSSP shared savings programs and ACOs across the country, I think we had not fully realized the fragility at times of the financial situation of some of these practices. And when patients stopped walking in the door last March and everyone had to stay home, there were really two major problems. One, there was no money coming in to the practice. And two, they didn't even know who needed help out in the community and which of their patients they needed to reach out to.

And this was an incredible opportunity for us at Aledade because we do serve, as Sara was mentioning, as sort of the infrastructure for them to, in this case, actually get access to a telehealth platform.

We were in a sprint to stand up over 400 clinics in a two-week time box on a telehealth platform that we procured for them because maybe only about one percent of our practices even had access to a telehealth platform prior to that. But we also use the analytics power that we have as the ACO sort of enabler to service the patients that we knew from the literature, that was still emerging at the time, which patients were most at risk frankly for mortality.

And we said we know you're struggling on staffing. You've got people who aren't coming into work. What can people do from home? Well, they can call this list of patients, and we gave them a protocol to help understand.

And to the earlier points that were made around social screening, that's really what it was. Do you have food? Do you understand the risks? Do you understand how to stay home? And we called it the Stay Well at Home initiative.

And so I think that the critical

point for us, and I hope for this group as well as we consider funding for care coordination programs and Alternative Payment Models, is really to say, what have we learned about what's absolutely necessary to do this work in an emergency, because those same things that are necessary in the emergency are necessary every day for these practices. And I think focusing on the ability of primary care to not be dependent on that fee-for-service patient walking in my door today and having a 15-minute encounter is absolutely critical to our success in care coordination and frankly in Alternative Payment Models in general. So it's been hugely eye-opening for us as sort of thinking about shoring up the base of the financial stability of primary care, as well as making sure they have the data and tools they need to do their job.

CHAIR BAILET: Thank you, Catherine. I know Bill has a comment as well.

DR. GOLDEN: Just to follow up on the last comments, Medicaid is not a big payer, if you will, in terms of dollars. But we've had

many practices, pediatrics, and so forth, tell us how important alternative payment PMPMs[25] have been to keep their doors open during COVID because a dependent -- as I said earlier, the overhead overhang can be very, very damaging to these practices. And shift to more up front dollars with less reliance on visit fees and bricks and mortar visits was critical. And we'd like to see more shift of that in the future.

CHAIR BAILET: Thank you. I'd like to just reach out to the PTAC community members if they have any questions for the panelists at this point and before we move into the third or fourth sections. I have one, but I'll look to see if others want to go first. All right. I don't see any hands fluttering.

25 Per member per months

So we've talked about burnout a couple of times so far. The panelists have raised it. And there's a study that shows that pre-COVID, about half of the providers, physicians, and clinicians were either significantly disappointed or burned out. Post-COVID now that number has gone up to about 60, 6-0, percent are either financially, physically, or emotionally depleted.

And one of the things that is driving them under water, if you will, is obviously the burden of practice and the administrative requirements. And care clinician as we've just -- as we're talking about is so vital to driving high-quality outcomes. But on the other hand, you can imagine if it's forced, if you don't have the infrastructure, if you don't have the template and how to do it, it can be seen as yet another burden.

And so what I would ask, I know Catherine with Aledade, you're sort of at the elbow with the practices helping enable them with care coordination and what they need to focus on in the moment. But I really would like

to open it up to you, Catherine, and others to talk about what have you seen as best practices that really make care coordination part of the fabric of care delivery and without it becoming overly burdensome to the provider community? Thank you.

MS. OLEXA-MEADORS: I'm so glad we're going to talk about this because it's certainly on the forefront of our practices' minds. And some of that has resulted from just the busyness and the emergency response mode that folks have been in for 15 months, as well as the financial burdens that have been on folks and wondering if they're going to be able to pay their staff, et cetera. In terms of implementation of care coordination activities, I couldn't agree more, that it can feel onerous and cumbersome and how do we get there. What's the road map?

And the first question is always, who's going to pay for my staff -- hiring staff, right, because I think -- and we work with practices across the spectrum, all the way from the small solo practitioner in Arkansas to

the large multisite community health center in New York City. And I think the answer on implementation and making care coordination the grease on the wheels instead of the friction, kind of to your point, Jeff, is we have to, A, have the resources in place, which means there has to be funding for those resources. But I think it's also important to remember that if we put a lot of requirements and enablement, what we think of as enablement criteria around the payment model, it does become onerous.

So the way we have seen it work and if you read Brad Smith's recent review of the CMMI program over the last decade, he talked about Comprehensive Primary Care Plus. And unfortunately, that program which paid for care coordinators in primary care space effectively upfront money and had sort of these enablement requirements that you have to check these boxes to get your check, that alone did not work.

It ended up costing the system more than it saved. And the one bright spot there was that the practices who were participating in CPC+ and MSSP, so really more of the

financial alignment model versus the enablement model, they actually did succeed at a much higher level. So allowing the practice to participate in a model that financially aligns them to the goal, the outcome and not only on the process we think is so key because when you look at this spectrum of practices, reducing burnout is going to look different in each segment.

And ensuring that they have the right tools and staff and process is going to look different. So really thinking through that, how do we make care coordination the thing that takes something off a physician's plate, a provider's plate, how do we make it hum in terms of the support system and the support structure for the physician I think is really a key to success in reducing burnout.

CHAIR BAILET: Thank you, Catherine. Laura and then Bill had a comment to my question.

DR. GOTTLIEB: Yeah, Catherine highlighted some of the points I wanted to make. So I'll do a slightly different tack

which is just to really underscore how important the social determinants component to this is. So we did a study across I think 500 different health care providers in the San Francisco Bay area.

We saw this tremendous correlation between the capacity of the organization to identify and address social adversity and provider burnout. And then the American Academy of Family Physicians replicated that survey in a recertification process that they had and found the exact same thing. So the ability of the process to identify and intervene on social adversity is highly correlated with provider burnout. I just -- I can't emphasize that enough because we think about all the other dimensions of burnout, the EHR and the payment problems and the keeping your staff and retaining your staff.

And there's so many pieces that we have to add to that mix of capacity to really provide whole person care which providers recognize is really critical. Clinicians recognize it's so critical to effective high-

quality care. And then the second piece that I think is really important here is the workforce point that Catherine made. And I'll just briefly say that I think while we recognize that the social adversity-related intervention are really important at the organizational level, it can't fall to the advanced practice clinicians to do that work.

And again and again, we see people who are more satisfied with their social care programs who have community health workers, other patient navigators, or the availability of staff who really are able to develop relationships, know the community resources better. And it's not so much the technology that makes the big difference there. It's the staff and staff training that really makes a big difference.

CHAIR BAILET: Thank you, Laura. Bill?

DR. GOLDEN: Yeah, Arkansas Medicaid is not managed care. But we have invested a lot of money in providing data feeds to our practices to help them understand what they're

managing, as well as working with our health information exchange and also provider networks, phone calls so people can model with each other. Catherine mentioned the CMMI article that was here about the costs.

And I think there's a flaw in that article and that thinking because fundamentally as we get into medical homes and the investments, it's a different product. You're paying for -- you're not paying for visits anymore. You're paying for a panel management which is a different cultural product. It's going to cost more. And when you say you're paying more for that product, it's really a product that's more consistent with the new National Academy of Sciences report of what primary care could and should be and how you pay for it.

CHAIR BAILET: Thank you, Bill. We've got 30 minutes left. We're going to move into the next section which is really getting around getting your thoughts on opportunities, best practices, and facilitators that you see for implementing and evaluating -- evaluating

care coordination activities broadly, including any specific delivery models, payment mechanisms, and performance measures that have proven to be most effective. I'll go ahead and ask Bill to start, then we'll hear from Robin and then Catherine. Thank you.

DR. GOLDEN: Thank you. So we have been on this journey for a while. And we have used metrics different ways. One is, what is the structural aspects of the practice environment? A second one are quality metrics that we use as a toll booth you have to pass in order to qualify for bonuses and then bonus money.

So you can use metrics in different ways. And when we started with PMPMs to rural primary care practices, we said, first of all, no more answering machines at night. We have to have 24/7 live voice access. If you can't reach your doctor, you can't coordinate care.

And within a year, we got rid of answering machines in the state of Arkansas, which may not sound like a big deal, but that's a pretty big deal. We also began to demand that

their notes look a certain way and that they identify high-priority beneficiaries. Do they have a problem list? Did they address the problem list?

The quality of the patient care notes was frankly awful. And I suggest you can go out to a lot of primary care practices in the country, it'll be similar. One of the biggest failures that these notes had, it was no statement about when the patient had to come back. Well, how do you manage diabetes, how do you manage asthma if there are no return visits set up? You can't do it.

So we began to change the expectations, and that was a long journey. It took three years to get people to realize that their fundamental notes that they had to do and the metrics put in place were critical in order to coordinate care because you can't coordinate care that you don't know needs coordinating. Or you don't -- when you see the notes, what's the patient's expectations and needs?

So those are the kinds of things we've been doing. And frankly, that when we

start putting those expectations in the structural aspects of what we've built, it starts changing how people get assigned duties in the office. It starts to empower the nurses differently from the physicians.

And we had a practice in South Arkansas, in El Dorado, Arkansas, that become the poster child for CMS about what can happen in rural sites because they redesigned their practice with color-coded care teams, with nurse practitioners and physicians and care coordinators, team together in different colored scrubs. It totally transformed the product they delivered in there. And it also resulted in them being able to recruit people to work in their practice as opposed to desperately trying to find people to come to their town. So I'll stop.

CHAIR BAILET: Thanks, Bill.

DR. NEWHOUSE: And I'll talk more about the implementation part of this question. And I think this is just such an important area because we have many models that we know work that are efficient and effective. The American

Academy of Nursing, for example, has close to 20 care coordination models that already demonstrate both cost effectiveness and efficacy for implementation. Now we're talking about this as if care coordination was one thing or one intervention, and I'll come back to that before I finish.

But how do we get these models into practice would be what I'd like to address. And I think the first step is, number one, making sure we think about this in terms of a diffusion of innovation. So there are lots of models that help health systems implement evidence-based practices and just like care coordination, where we start with the antecedents.

We get the organization ready. We work on implementation strategies, et cetera. And we have both clinical, administrative patient outcomes that are associated.

Certainly, there are interactions with broader kinds of things like the resources, available change agency, et cetera. But also there's something about the active

strategies that we use for implementation. So I think thinking systematically about how to get these and spread in your practice would be fantastic.

You probably are familiar with Mary Naylor's transitional care model, and there are many more like that, that could be spread very easily. We in Indiana, we had a very innovative position. Krista Brucker, who started a project point when patients came to the emergency room that encountered an -- that had an overdose from narcotics or opioids where they're paired with a peer recovery coach to transition them into the community.

That was incredibly effective with getting people into treatment. So I just -- I could go on and on about the number of models that we could spread. But the implementation strategies are sort of one of these things that are in a black box for clinicians, that we have to make it easier for them to use and not more difficult for them to use.

So creating a structured approach is important, as well as providing tool kits. So

those that are developing these interventions have to help clinicians know, how can I use them and what are the essential parts of this intervention and what are the points that I can adapt or change, because contextually, I have some difference in my practice setting. So creating tool kits would be, I think, another strategy.

In addition to introducing the implementation strategies, for example, the expert recommendations for implementing change, AHRQ strategies. So when we do a study with health systems, we provide this tool kit with these strategies and help people understand how to use or tailor the way we implement to their own practice and their own context which, by the way, context does affect our effectiveness of care coordination. So I think certainly in describing what the components of the care coordination are, are another very important part of this because as a complex intervention, there are many moving parts.

And sometimes these parts are independent and sometimes they're

interdependent. So understanding what parts of this care coordination are important are something that we need to do as investigations that would develop these care coordination models. But it has to be clear what that causal link is from that function to the outcome.

So we have to spend some time thinking about that. And when we implement the care coordination models, there should be an evaluation plan that corresponds as well to describe this process evaluation so that we can learn from each other. And oh, by the way, the outcomes that we select should also be included.

The other thing about implementation, I think the functions of care coordination that we talk about of the model, the AHRQ model, these are things that we do as clinicians. And this whole issue around the methods of patient engagement and how we engage people in setting their personal goals and the family is incredibly important. There's the work that PCORI did, the Patient-Centered Outcomes Research Institute did early about

what is patient engagement and how do we engage patients.

And that's in terms of comparative effectiveness research, not implementing into practice. But I say this because there's a way one engages, and there are many, many different strategies. We learn to -- we have to learn to engage well, understand those personal preferences, values, beliefs, and goals, because they are central to our ability to achieve the goals that people want to achieve.

And then their goals are usually tied to our goals. We might talk about them in a different way. But I think that's absolutely foundational to the ability for us to translate these models.

CHAIR BAILET: Thank you, Robin. Catherine, please?

MS. OLEXA-MEADORS: Thank you. I really appreciated Robin's comments on implementation. And I think the comments I'd like to make are really going to be focused on, how have we organized primary care practices holistically to achieve success in the shared

savings programs that they are a part of?

And when I think about care coordination, I think one of the challenges we have with the payment model for folks who are not in shared savings programs is that it really does silo the care coordination or the care management activities. And we have maybe -- - maybe an overly casual phrase that I'll share with you all here. You don't want a care manager in a corner working alone, calling patients for 20 minutes a month, trying to bill CCM[26] codes or RPM[27] codes or whatever he or she thinks are the right interventions to perform for the patients.

And you don't want Provider A saying, I'm going to send you over to Sandra's desk and she's going to really work with you here, without having some of those really actually integrated approaches for the care team. And so when I think about how we incentivize our practices, and I would never come to this panel and tell you, we figured out

26 Chronic care management
27 Remote patient monitoring

the recipe card for care coordination, because we are just frankly after seven years, I would call us sort of at the beginning of our journey on this. And last year was an incredible eye opening thing around care coordination with telehealth appointments and doing many of the things others talked about there.

But really if you can align the physician around the outcome metric that you're trying to achieve, right? So there's the idea of implementation of required elements like Bill was talking about. There's the implementation of a specific care coordination model that Robin was talking about.

But I think the truth is if we peel back the layers and we really think about the people in these practices across this country, they are tired. They are overwhelmed. They are booked from morning to night. They've tried 10 different things. They've tried 10 different technologies, and they just can't see their way through it.

And so putting a whole bunch of new requirements on them or quality measures on

them is not going to get us what we're hoping for here. And so if we can start to align around as we are currently doing in our ACO programs, like, how do we have the funds flow to the practice based on the outcomes that they're able to achieve? And then they're going to be looking for the recipe card.

So instead of saying, here's the recipe card, implement this, we're saying, here's the outcome that has the dollars attached to it, whether it's a percent of transitional care management visits and 30-day episodes that have been initiated and completed for patients who've come out of a hospital. Or if it's the number of formerly severe hypertensive patients who are now controlled, right, because they've had their appropriate follow-up protocols. The practices then come to us and say, well, tell us how to get there.

Give us the ADT[28] data that we need to know when patients are coming out of the hospital. Give us the protocol so that we can implement it across our care team to make sure

28 Admission, discharge, transfer

that those patients who have that 160 over 100 blood pressure actually do come back in the next two weeks and we don't just say we have a protocol, right? We're actually working together because we're all aligned.

So I think really focusing folks on the one thing that is existential, which is their finances, their funding for the community health centers, it's a slightly different perspective than the private practice. But they still are relying on their grant money, their funding. And then saying, how do we work backwards from that to actually implement programs that work across the care team and not have the care manager in the corner making 20-minute-a-month phone calls?

We're not going to make progress until we can get there. So I'll report back. But that is the journey we are currently on.

CHAIR BAILET: Thank you, Catherine. And I want to open it up to other panelists. And I know Sachin has a comment he would like to make.

DR. JAIN: I want to just plus one

in bold and underlined, Catherine's sentiment around kind of having sometimes the wrong people reaching out to patients. One of my observations with this work is we oftentimes have kind of the least experienced people in the health care system kind of levered to actually work with the most complex and difficult to manage patients. And we have this workforce problem where I think we're constantly trying to lower costs by lowering the skills level of the individual performing tasks.

And in fact, the population that needs care coordination actually requires a combination of medical, social, psychological kind of management oftentimes which is outside of the scope of the people who are actually performing the front line work. And so you do have oftentimes largely unsupervised, kind of lower level health care workforce interacting with kind of some of the most complicated and complex patients who are oftentimes looking for answers that the person on the other end of the phone or the other end of the interaction are

unable to deliver. And so this question around who is the right kind of care coordination workforce is really important.

I know Catherine's perspective is that it needs to be kind of driven out of the primary care physician. I couldn't agree more. At the same time, I think if there's a notion around supervision models for people who are doing this work because in practice, they are largely unsupervised, doing the very best they can as opposed to operating within a framework that produces robust outcomes.

And so that's why I think the data on care coordination has always been as mixed as it has been. I don't think we've actually -- I don't think it's a bad concept. But I think ultimately the workforce that we put in place to do it is often underpowered to do the work that we actually ask them to do, and I think it creates more cycles, not less.

CHAIR BAILET: Thank you, Sachin. Laura?

DR. GOTTLIEB: Sorry. It was a little hard to get off mute there. Just I

wanted -- all of these points I feel like are so critical. I want to lift up also Robin's -- one of Robin's first points.

So she talked about -- I would categorize them as effectiveness research and implementation research. And I think we -- she pointed out that we do have a fair amount of effectiveness research. I think -- and that we really need to push on the implementation research lever.

I think we need to push on both, and I'll explain why. I think, Robin, this is not to disagree with you. I think you were saying both, but you only talked about implementation research.

But I think what we've seen in the care coordination literature is the kitchen sink. So the kitchen sink works. And I don't know that the kitchen sink is feasible for the health care system to sustain and apply universally. And I think we've heard that in other people's comments.

And so we think that social, medical, and behavioral interventions are all

really important. But we need to know which are the interventions that are most effective for which populations and then how do you put effective interventions into practice. And then I just want to thread the needle there to build comments about measure development.

We have now had a chance to talk with I think almost 15 state Medicaid agencies. And I know NORC[29] has done some great work with state Medicaid agencies, trying to understand how they are approaching measure development around care coordination. And for our work specifically, it's been around measures related to social determinants.

And I just want to underscore that what we're hearing from state Medicaid agencies is this very phased approach around -- I'm going to put it in terms of the Donabedian model which I know not everybody thinks it's perfect. But that we need measures that are going to walk people through how to do this. And that means structural measures, just like, do you have the capacity to do this?

29 NORC at the University of Chicago

Do you have workforce -- a workforce that can do -- provide social care? Do you have a technology system that can connect medical and social care providers and have closed-loop referrals? And then there are the process measures.

Then we're going to hold people accountable for how much do they use those systems. How many patients or which patients? I may need to figure out which is the right target population, and then we move on to the impact and outcomes. And so I just -- I think that that just is an important layer when we start to talk about quality measures in the ACO.

CHAIR BAILET: Thanks, Laura. Robin, you had a final comment on this section?

DR. NEWHOUSE: I did, thank you. And I would never say we don't need more comparative effectiveness, if I understand Laura. Oh, no. I wasn't talking about implementation instead of, absolutely.

And that's exactly why the standards for comparative effectiveness of these complex

interventions were developed because people have so much trouble writing proposals, for example, and including the aspects of this complex intervention and care coordination is one of them. So we need much more. Boy, we are not done with developing models.

And just saying that we do have somewhere effectiveness and efficiency are established and should be spread. And we don't tend to think about the implementation, so thank you for that. Also want to make the case about the supervision.

So there are four million -- over four million nurses. And in the academic setting for the undergraduate nurse, care coordination is something they leave our school with. So it's something that nurses can assess people, particularly with these complex diseases that can actually make an assessment and make a good judgment about how to connect them back to their care team, their physician, et cetera.

So the advanced practice nurses have been able to provide care. They're qualified

clinicians. But the baccalaureate nurses are not. So I just would say that the baccalaureate nurse is a, I think, jewel for care coordination activities. They are ready. They know their communities, and they can work very autonomously, I think, and would even say in some circles could have their own care coordination model.

So I would say think broadly as we all do, but the more complex patient I would say needs someone like a nurse that can do an assessment, look at them, look at their functional status, look at where they're living, the social -- all the things we talked about. But I just want to mention that when we talk about supervision.

DR. GOLDEN: I was going to add a brief comment that when we talk about metrics, the CAHPS[30] survey is now about 30 years old. And it's probably outlived its time. But we used to get 30, 35 percent response rate. We're now in the 20s.

It's becoming a ritual more than a

30 Consumer Assessment of Healthcare Providers and Systems

valuable survey tool. And frankly, it probably doesn't bring up issues of care coordination, social determinants of care. So for those of you out there, maybe Robin, your group, it's time for a new CAHPS survey because frankly it's probably a little out of date and needs some refreshing.

CHAIR BAILET: So the sand is running out of the hourglass here. And I said this to the panelists earlier when we first met before today's session that despite our best efforts, it's still very challenging to get through all of the questions. So I apologize if there are thoughts and comments that folks want to make that we're not going to get to.

But I think it's important as we sort of wrap up the session, I'd like to give a -- if there's any sort of barriers or things that we should focus on in our comments and our discussion around enablement of care coordination. We talked about payment. We talked about access to resources, technology, particularly even as basic as internet access.

But if there's just maybe -- I've

got Bill, Sandra, and Laura have sort of been teed up, and Sachin, for this. But I don't think we're going to have time to get through all of that, but -- everyone. But if there's something very specific that we haven't talked about already as it relates to barriers or things that could really enhance the ability to coordinate care, it'd be great if we could go there. And I think Sandra has raised her hand. Maybe I'll call on your first, Sandra, and then others.

DR. WILKNISS: Thanks, Jeff. And I'll be very brief. I just wanted to recognize that as we get into this discussion about complexity, the locus of care coordination may shift depending upon a life span where someone is in the life span of where they touch the system but also levels of acuity.

And just to remind us that there are others that are doing care coordination as well as you get into more complex spaces like people who are in a Housing First model. There are care coordinators all over the place. So as we think practically about the implementation

science and models, recognizing that there are multiple care coordinators for people is really important and will also help us figure out how they integrate better with the systems if we understand where that's happening.

CHAIR BAILET: Thank you. And I'm going to take a little bit of our break time. So we're going to go a little longer than the bottom of the hour. So we have a little bit more time. So any other panelists want to talk about their perspectives on challenges and things we should focus on through enabled care coordination at this point?

DR. GOLDEN: The whole interoperability conundrum is a big issue. SMART FHIR[31] may be the answer. But if we can get extraction from electronic medical records into useful data flows, that'll be a major revolutionary step forward. It's a barrier, and it's been a barrier for several years. Maybe we're getting closer, but I'd put that at the top of the list.

31 Substitutable Medical Applications, Reusable Technologies Fast Healthcare Interoperability Resources

CHAIR BAILET: All right. Anyone else? Any Committee members that have questions for the panel? We have a little bit of time left. Again, I have one, but I'd like to hear from my Committee members first.

VICE CHAIR CASALE: Jeff, this is Paul. I just had a question about payment mechanisms which some have alluded to. And Catherine, you particularly are alluding to use of TCM and CCM and things. I think we are -- in reality, we are in a fee-for-service world currently as we're moving towards other models. But just comments on how the current payment fee schedule can be used effectively as you're implementing these care coordination models.

DR. GOLDEN: I am deeply concerned about CMS' overreliance on risk for primary care, particularly Primary Care First. Again, I think the biggest issue is transformation of care and patient focus. And frankly, putting small practices at financial risk when they can't control biologic variations of small populations is a mistake and potentially counterproductive.

The goal should be better health care delivery. And you may not get there by putting people at financial risk. You'll reward better activities, better approaches to how you deliver care. But that may not necessarily mean you have to put them at financial risk.

CHAIR BAILET: Thanks, Bill. Catherine, you had a comment?

MS. OLEXA-MEADORS: Maybe just a slight counterpoint there, Bill, to your comments because I think what we've seen is that when the practices are able to take on financial risk in a partnership where they don't have the potential to totally lose their shirt, right? They have a partner that can help them get through that scary part of taking risk. We actually do see that we could get them to a point where they're able to implement and focus on the outcomes, right?

So for me, I think that this one is critical for us to consider in terms of not just asking folks to implement a specific program. And where we need to go is help them understand for whom and for how long. And I

would underscore your comments about access to admission, discharge, and transfer data as a key to unlock one of those doors because unless they know who is out there that needs support, that is urgent, they're going to sort of pour a broad intervention as thinly as they can across their population to drive up that particular fee-for-service element.

So when I think about CCM and RPM, I'm thinking, wow, the reimbursement is so low per event that the incentive is to do it for as many patients as possible, whereas what we should be aiming toward is a higher reimbursement structure that gets you to addressing the most critical patients who need that with the right level of licensure, right? Not a medical assistant but with an RN that can actually help them. So that would be my point of thinking about the fee-for-service element as adding on but within the risk-based pool.

CHAIR BAILET: So we're going to lose several panelists at the bottom of the hour. So I think I'd like to thank each of you for taking your time to share your expertise

and experience with us today. I'd like to -- again, if we were in the Great Hall, we would ask the audience to join us in giving you guys a round of applause.

But just on behalf of the Committee and the audience, I can't thank you guys enough for all of your help and participation. This has been really, really a great discussion. And again, I wish we had more time, but we sort of don't.

So again, thank you all. We're going to take a short break, and we're going to reconvene in about a half hour at 10:00 a.m. Pacific Time, 1:00 p.m. Eastern Time for a second panel. If you're joining on Webex, you can stay.

But know we're going to a practice mode. So don't worry. We'll be back in time for the next panel and guests whose organizations made proposals to PTAC in the prior years. They'll be on, and we hope to see you all then. So we're going to take a quick break. Thank you, guys.

(Whereupon, the above-entitled

matter went off the record at 12:29 p.m. and resumed at 1:01 p.m.)

*** Panel Discussion on Care Coordination and Physician-Focused Payment Models (PFPMs) with Several Previous PTAC Proposal Submitters**

VICE CHAIR CASALE: So I want to welcome everyone back to the PTAC public meeting. I'm Paul Casale. I'm Vice Chair of PTAC. So we will now continue our discussion on care coordination in the context of APMs and physician-focused payment models.

Over the years as PTAC reviewed proposed models the stakeholders have sent in, we noticed that care coordination emerged as a theme, in part, because "Integration and Care Coordination" is one of the Secretary's 10 regulatory Criteria for reviewing physician-focused payment models. In fact, most proposals submitted to PTAC included at least one care coordination function as Lee and the PCDT pointed out in their presentation earlier today. We've invited several previous submitters of these proposals to join us today

for a second panel discussion.

As Jeff said this morning, this is not a re-deliberation of their proposals but a chance to learn even more from the field about the role of care coordination and Alternative Payment Models. Our panelists' full biographies, as well as their organizations' proposals and the documents related to PTAC's review of those proposals, they all can be found on the ASPE PTAC website. So I'm going to briefly introduce our guests and their current organizations.

First we have Shari Erickson from the American College of Physicians and Christina Borden from The National Committee for Quality Assurance. ACP and NCQA partnered together to submit a proposal last year. Next we have Kate Freeman representing the American Academy of Family Physicians.

Dr. Narayana Murali from Marshfield Clinic Health System, and Kendall Hagood from Contessa Health, they're representing the proposal from personalized recovery care. Dr. Susan Nedza from Health Policy Insights is

representing the American College of Emergency Physicians. And finally, Dr. Joe Rotella joins us from the American Academy of Hospice and Palliative Care.

So you can see we have a great panel and some different care settings and proposals represented. We have several questions for our panel. And so in the interest of time, for some of the questions, I'll begin by inviting two or three of the panelists to respond, then I'll open it up to Committee members to ask any follow-up questions that they may have.

So I ask each of our panelists to try to keep their responses to a few minutes and look forward to a robust conversation. So first, would each of you please provide a brief description of how care coordination was incorporated into your proposed physician-focused model? And I'll cue each of you for this one. So we're going to start with Joe.

DR. ROTELLA: Okay. Thank you. AAHPM's model, which we call Patient and Caregiver Support for Serious Illness, addresses the gaps in Medicare coverage for

community-based palliative care for patients with serious illness. That is, patients with potentially life limiting medical conditions associated with decreased function who are at increased risk for potentially preventable ED or hospital visits, particularly those who are not thought to be in the last six months of life and therefore not eligible for hospice care or who don't choose hospice.

Under our model, community-based interdisciplinary teams would be paid to furnish high-quality palliative care, starting with a comprehensive assessment of the patient's needs, goals, and preferences and development of an individualized care plan centered on what matters most to the patient. Interdisciplinary palliative care teams have special expertise in discussing goals of care, relieving pain and symptoms, and providing emotional and spiritual support to improve the quality of life for people with serious illness. Disciplines represented on the palliative care team may include physicians, nurses, social workers, spiritual care

providers, nurse practitioners, physician assistants, pharmacists, counselors, and more.

Care coordination is a foundational element of palliative care, integrating not only the patient's concerns and the assessments and interventions of palliative care team members but also input from all of the patient’s other physicians and health care teams to create an integrated and individualized care plan that's updated whenever there's a significant change in the patient's circumstances. This includes arranging for services from other professionals and teams and communicating with them on an ongoing basis to ensure that all aspects of the patient's care are aligned and consistent with the care plan.

Our paradigm of care coordination goes well beyond the traditional focus on a patient's medical needs and engagement with other physicians. We take a holistic, comprehensive, person-centered approach and also address a patient's psychological, social, spiritual, cultural, financial, and practical

needs and concerns. In addition, we engage a broader circle of partners in their care, including caregivers, family members, and community supports.

The palliative care team practices active care coordination to prevent disruptions in care and maintain the wellbeing of their seriously ill patients that requires that they be accessible on a 24/7 basis. And you know that crisis call they get at midnight may be triggered just as easily by an overwhelmed and exhausted caregiver as by a new medical complication. And that's why the interdisciplinary holistic approach of palliative care addressing not just medical but also social and other determinants of health is so essential for getting the best outcomes and delivering value for this population. Thank you.

VICE CHAIR CASALE: Thanks, Joe. I'm going to turn to Shari.

MS. ERICKSON: Hi, yes. Thank you. Do you hear an echo from me, or is that --

VICE CHAIR CASALE: No, I think --

MS. ERICKSON: Okay, good.

VICE CHAIR CASALE: -- you sound fine.

MS. ERICKSON: I heard one for a moment. Thank you. And I want to thank you for inviting both ACP as well as NCQA to share our views on the importance of care coordination and Alternative Payment Models and how our Medical Neighborhood Model would be able to demonstrate mechanisms for ensuring effective and efficient care coordination, particularly between primary care and specialty practices.

This is critically important given that the visits to specialty care clinicians account for more than half of outpatient visits in the U.S. And referral rates are increasing over time. Mutually respectful inter-clinician relationships are required for effective collaboration, and this is something that we have built directly into our model.

Participating specialty practices must meet consensus-based standards to improve care coordination and advanced care delivery and incorporate a pre-screening process for all

visits to ensure that patient visits are maximized. From the patient's perspective, they work with their primary care practice first to agree that a specialty referral is appropriate. The primary care practice then refers the patient to a participating specialty practice.

The specialty practice will pre-screen the referral request and accompanying documentation to ensure it has all information it needs and scheduling a specialty visit is the most appropriate next step for the patient. Then during the patient's visits, a specialty practice would establish a care plan with the patient and referring primary care practice and enter into a care coordination agreement that would be between the primary care practice and that specialty practice. And that agreement will be -- and the care plan would be based on the needs of the patient and in consultation with that referring clinician.

The specialist may be actively involved in the care and then would be designated as either the patient's principal co-manager along with the referring primary

care practice or as the primary manager of the patient's care for the referred condition. The designation along with the completed office visit would trigger an active phase of attribution under the model, which would commence model payments to that specialty practice. Automated triggers would be in place based on visit frequency to determine if the specialty practice is taking on a less active role over time which would then unattribute the patient to that practice and cease the model payment.

However, reattribution could occur at any time based on the patient need. I believe that this approach layers in the patient needs, as well as the expertise of that specialty practice and that of the primary care practice to ensure the most effective and efficient care coordination for that patient across the continuum of their care. Thank you.

VICE CHAIR CASALE: That's great. Thanks, Shari. Kate?

MS. FREEMAN: Hi, and thank you all so much for inviting us to be here and talk

about our Advanced Primary Care Alternative Payment Model or as we like to call it, the APC-APM, because we need more acronyms in health care. So we submitted -- the AAFP submitted this proposal to the PTAC back in 2018. And it was really an envisionment of moving further away from fee-for-service and CPC and CPC+, the models being tested by CMMI.

We really viewed those models at the -- the evolution of this model as allowing practices to deliver care in a more innovative way with less restrictions, reducing administrative burden, and really focusing on delivering the right care to the right patient at the right time. The other piece of this model, we really wanted to focus on increasing the investment in primary care and focusing on the long-term ROI[32] that these types of models and care coordination can really show, which is something that the recent National Academies of Science report really focused on as well. So I think in terms of care coordination in comparison to CPC+, we really focused on not

32 Return on investment

requiring a reporting burden, which a lot of the CMMI models do for care delivery, and really focusing on attestation, understanding that care delivery in all of these practices really looks very different but allowing those practices to really have the flexibility to meet the needs of their patient population.

The other thing we really thought was important, especially as we're making models that are available to a variety of practice sizes and segments of employed versus solo independent, those types of things, is that there's really a need for technical assistance for those practices to make the transition to understand how this different type of payment can help them deliver care in a way that's more effective for their patient population. So I think highlighting the decrease in burden, providing technical assistance, increasing that investment to primary care really provides a foundation to move practices away from fee-for-service and really deliver the type of care delivery that's beneficial for health outcomes, improving costs

-- improving quality and reducing costs.

VICE CHAIR CASALE: Great. Thanks, Kate. Narayana?

DR. MURALI: So our model was really focused on providing hospital care at home. And our care coordination fees, as well as all the elements related to that, were significantly strengthened by the input of the PTAC Committee when we had brought this as our initial proposal.

It's a multidisciplinary team. It includes not just the primary care physician or the hospitalists but also the specialists, the mid-level practitioners, the pharmacists, the nurses, the social workers, the physical and occupational therapists, as well as home health resources. Central to the whole dimension is the presence of a care coordinator. The care coordinator assumes two roles, one as a physical care coordinator who's involved and engaging with the patient when the patient comes into the emergency room, identifying the eligibility criteria, assuring that that patient can be screened and managed very well,

meeting the necessary criteria and then will enter acute phase as well as the 30-day period, a combination of the physical plus a virtual care coordinator who manages the entire episode of care over a 30-day period.

The model is designed around risk payment and is very effective. Now when the patient comes into the ER[33], after the screening criteria is met, basically confirming that the patient is not in a critical separation that they request ICU[34] care or ventilation or does not need be in a SNF[35] criteria which is very important from the standpoint of whether we should be providing that care at home. And finally, whether they have adequate home support from the members of the family or other determining criteria.

Once that is done, there's coordination from the standpoint of all of the durable medical equipment, the home care elements, the telehealth elements where you basically have a kit in a box, infusion, all of

33 Emergency room
34 Intensive care unit
35 Skilled nursing facility

the treatment elements that are covered by the (audio interference)[36]. And then there's logistics related to the same piece. It is all managed.

We have continuous feedback back to the primary provider through the televideo and the telemetry technology. And that acute care period spreads over a duration of between three and seven days. Once the patient is discharged from the acute care, we continue to manage the entire episode of care for 30 days, coordinate that in terms of scheduling most visits with the primary care physician, their own primary care physicians, providing them a discharge summary, giving them all the necessary information at the conclusion of the episode.

36 Dr. Murali provided a written statement to clarify his statements where there was audio interference. He inserted the following text: ''related needs such as oxygen and nebulizers etc.''

So the telehealth technology empowers it and is necessary from that standpoint. From a social work standpoint, because the nurse is actually visiting their home and providing the care at home, you're very close to all the elements that are required from the standpoint of the social determinants of health, (audio interference)[37] that are required from the standpoint of care coordination. In fact, the entire model of Hospital at Home is centered around care coordination.

VICE CHAIR CASALE: That's great. Thank you. And then turning to Susan?

DR. NEDZA: Let me begin by saying thank you for the invitation and also thank you to the current and former PTAC staff who did an amazing job of helping us through the process and helping us to understand based on their knowledge and also the knowledge of some of the models we're hearing about today, how we could improve the model that we were proposing. It is

37 Dr. Murali provided a written statement to clarify his statements where there was audio interference. He inserted the following text: ''connecting with MSW's for appropriate community based resources''

called the Acute Unscheduled Care Model. For those that like acronyms, it's AUCM, and that was probably the biggest contribution I made to the project. Just kidding.

I had the opportunity to serve as the principal investigator for the data that was used upon which we deliberated and was joined by a number of other experts from emergency medicine, mainly who were involved not only in health policy but also were in practice. So I would like to describe the model by using a scenario if I may. And that was the scenario of an 84-year-old female, comes in at 2:00 in the morning on a Friday night after experiencing some abdominal pain. There's a workup completed.

During that care process, staff asked, is it safe for you to go home? Is there anybody home? Do you live alone? Do you have stairs to negotiate? Do you have a ride to the doctor's appointment the next day?

The physician becomes made aware of those particular items of interest. Physician also discusses with the patient and with the

patient's family the opportunity to go home as opposed to being admitted. It's important to know there really are no financial benefits for emergency physicians to discharge patients at this point.

It's also in the hospital's financial interest to admit patients. So in order to ensure that we have the ability to provide a safe discharge for patients, that requires care coordination. So I pointed out the care coordination during the episode of care.

But the second point of care coordination is at the point of discharge disposition. This is the most expensive decision we made as emergency physicians, admit, transfer, observe, or discharge. And it is also the point where we're most likely to have an interaction with family and undertake shared decision-making.

In the past, what would've happened, at least in my practice, is I would've called the primary care physician, spoke about whether or not they could reexamine the patient the

next day, or potentially they wanted to refer them to a surgeon for an exam, or if they wanted to come back the next day for an exam. That would've been decided between the clinicians who are involved in the patient's care. And then adequate arrangements would've been made by our discharge nurses. This is for care coordinators.

We know how to coordinate care in the emergency department. We know what we need to do during episodes. The model was built based on the current practice and processes. So we weren't disrupting or creating anything new.

We were just including incentives and measures such as including shared decision-making, a safe discharge assessment, a conversation with the follow-up primary care provider or their other person that might be covering for them. And then finally, to ensure that the discharging physician who's now accountable for that decision makes the best possible decision with the patient, with their family, and with whoever is going to follow up with them. The model is then designed to

reimburse emergency physicians for those activities, for care coordination, for taking part in shared decision-making, and for reviewing safe discharge and participating in safe discharge assessments.

None of these were developed de novo. They came from other models that CMMI has instituted and that are if you consider good practice -- best practice for discharging patients from the hospital in general. So we really felt that this model was where we wanted to focus. And as we go through some of the other questions I hope I'll receive, I'll provide more details. But that's the core of the model. Thanks.

VICE CHAIR CASALE: Thank you. That's great, Susan. So I appreciate the overview from all the panelists. Very helpful. I think next we're going to dig a little deeper.

So what specific functions or activities related to care coordination are the most important for improving quality and reducing costs in APMs and physician-focused

payment models? And how might these functions vary by context or setting or for different patient populations? So for this, we're going to start with Shari.

MS. ERICKSON: Great, thank you. There's a lot I could say about this question. I'm going to keep it as brief as I can and then also ask Christina to supplement what I say about this.

So our Medical Neighborhood Model is not limited to any one clinical condition. So it can be effectively implemented for multiple patient populations. It's designed to provide effective and efficient care coordination for all patients that have a need to have their care shared by a primary care practice with a specialty practice, whether that be for the short term or over a longer term basis.

I think as the COVID-19 pandemic has demonstrated, pure fee-for-service model leaves a significant financial problem for many practices and serves to exacerbate the already challenging health disparities and access issues that many in our populations face. So an

APM such as the Medical Neighborhood Model offers the opportunity for practices to be supported in providing coordinated care to all of their patients who need specialty services, whether that's in person or quite frankly via telehealth which has become -- which has grown so much over the past year. While the model is perhaps most applicable to patients who require management of their chronic conditions, the standards the specialty practices will be required to meet will also facilitate improved access and care for patients with acute care issues.

And additionally, a critical component of our Medical Neighborhood Model is the use of the care coordination agreements that are put in place between the primary care and the specialty care practices. I mentioned that earlier. These lay the groundwork for how patient care will be shared between these practices and can be updated over time based on the needs of the patients that are shared between that practice. So I'm going to turn it over to Christina so that she could touch on

some of the relevant standards that these practices need to meet in order to be effective specialty care practices that share the care with the primary care practice.

MS. BORDEN: Thanks, Shari. And so as Shari mentioned, really the standards that we've developed, both primary care and specialty care work hand in hand and so that neither one feels like a lone iceberg in the ocean floating away. And so the standards that provide the support for the care coordination functions, in addition to the care coordination agreements, other things like improving clinical access and expanding access to timely care, including providing same-day appointments based off of urgency, electronic access to the patient's information -- and we've definitely seen the importance of this as we've integrated telehealth more and more -- having a standardized process for closing the referral loop so that once an important referral goes out that we know that that has been taken care of and that referral loop has been closed. Tracking and coordinating care across all

settings, providing culturally and linguistically appropriate services, really focusing on a team-based approach so that all know what kind of care needs to be given and that it's coordinated to the highest level, identifying and coordinating patient populations using electronic systems to monitor clinical data and implementing evidence-based reminders and decision supports, and planning and managing care that includes medication management support for patients, self-care, and electronic prescribing.

I also just wanted to note that not just large integrated systems have demonstrated effectively executing these care coordinated practices and standards. In the Medical Neighborhood Model but also many small practices and a variety of specialties have achieved PCSP[38] recognition demonstrating the applicability and success across the different sizes and types of practices. Thank you.

VICE CHAIR CASALE: Great. Thanks, Christina. We're going to turn to Susan.

38 Patient-Centered Specialty Practice

DR. NEDZA: Thanks, Paul. I think the most important focus for care coordination in the model that we've developed is that discharge disposition period of time. And it's the problem that's been identified from the first report, to err is human, through quality chasm.

There is a chasm between emergency department discharge and the next person seeing the patient. That was discussed in this morning's panel. And I think a number of people spoke very eloquently to the issue of the lack of information and often unfortunate consequences with ED dispositions.

It's designed to make that handoff and to coordinate that handoff in such a way that the emergency department becomes an integrated part of the care delivery system, as well as provide services that make us part of the solution and not the problem. Many of the models look at avoiding ED care as part of their goal. And that's appropriate for a certain population.

But acute unscheduled care,

especially in the Medicare and Medicaid populations, will continue to occur. And this care coordination recognizes the fact that that will continue to occur and also allows flexibility to put in place care coordination models dependent on the context of the facility. What's pretty unique is the fact that we are very much dependent and our decisions are dependent on and always have been dependent on social determinants of health.

Do people live alone? Do they have a ride? Do they have family? What are the potential patient safety hazards in their home? That's been part of our practice for years in deciding whether or not to discharge patients.

This care coordination model is designed to help fill those gaps in some of the areas that we heard from Shari, as well as to ensure that there is information transfer between the emergency department and the follow-up primary care providers or specialists while we wait for interoperability to occur. As I demonstrated or spoke of earlier, we used to do this by telephone. We can still do it by

telephone.

It would be better if we had in the medical records that translated. And one of the things that we discovered when we built the model is that five percent of ED visits happen out of state. Medicare recipients do not stay home. They travel. They go to Florida for half of the year. So the idea of being able to provide some type of connected service to a provider in that community was also included in the model.

VICE CHAIR CASALE: Great. Thanks, Susan. Narayana?

DR. MURALI: Yes, Paul. Would you mind repeating your question because I think you've hit two specific elements, and I just want to touch on them.

VICE CHAIR CASALE: Absolutely. So the first part is, what specific functions or activities related to care coordination are the most important for improving quality and reducing costs in APMs and physician-focused payment models? And the second part is, how might these functions vary by context or

setting or for different patient populations?

DR. MURALI: All right. So I will take the second question first. In the situation of Hospital at Home, we pretty much take care of any patient who meets the criteria of being admitted into the hospital except if they need to be intubated, they're hypoxic or have hypertension and the physician does not think it is safe to move that patient outside ICU care.

So I think from the standpoint of the DRGs[39], we have over 150 DRGs in which we provide care. So it provides the complete breadth and depth of care. So build that in a story, I will tell the story of a 93-year-old gentleman who was admitted to the Hospital at Home with severe heart failure, as well as severe chronic obstructive pulmonary disease, who we admitted at the home hospital in addition to getting the rehabilitation, both physical and occupational elements to provide his care.

So there was a cardiologist involved

39 Diagnosis-related groups

in his care, diuretics that were given by IV, oxygen that was arranged for his COPD, in addition to his nebulizers and all the necessary physical therapy to get this gentleman functional. Approximately a week or so into his care, his health deteriorated and he made a decision that he would prefer to go down a palliative (audio interference)[40] arrangements and we ran into a snafu. He was too sick to go into a home hospice program. He was too sick to be provided care for in a nursing home program.

So we elected to use all of our support networks from the care coordination to basically provide him coverage for that duration of time till he passed away much to the liking of his family. I think the proof of the pudding lies in really tasting. And I think that is demonstrative in the studies that we have done.

40 Dr. Murali provided a written statement to clarify his statements where there was audio interference. He inserted the following text ''care route and needed higher level of care than what could be provided in a nursing home or home hospice program. Our multidisciplinary team worked tirelessly in getting hospital level care for this patient at home. Patient died peacefully at home with his family per his last wishes. Our care team stood firmly with the family and helped them through the difficult time and''

Comparing patients who are hospitalized to patients who are hospitalized at home, the patient satisfaction subsequent to the care coordination after a 30-day episode was 90-plus percent. Our safety outcomes were phenomenal. We had scores of 100 percent in terms of functional status assessment, as well as zero percent in terms of fall, 100 percent in terms of medication reconciliation, and a 44 percent reduction in re-admissions to the hospital.

It just tells you (audio interference)[41] can be critical from that standpoint. So then what are the elements that are really relevant to make this better in terms of quality and value? I think there are three challenges.

The number one challenge is really the interoperability of electronic health records in the resident health systems. Presently in the nation, there are over 350 hospitals that do Hospital at Home. We were

41 Dr. Murali provided a written statement to clarify his statements where there was audio interference. He inserted the following text: ''interoperability and workflows''

among the first nine that instituted this during the COVID pandemic.

And in the interoperability, we have bypassed that by using a care document that is available in a PDF format and each resident health institution so that can be easily identified and available. We have provided access for the care coordinator to read the EHR and all the orders so that they can read them and verbally communicate and make sure that the entire episode of 30 days that is taken care of. So that's one critical element.

Interoperability is important, not absolutely necessary because there are ways you can do it. But having an EHR that is interoperable and has these documents nicely curated is very, very important. Number two is the planning and logistics that are required for these care coordinators.

This is an RN who is not just focusing on providing care at the clinical level but also has to be smart enough to understand the logistics and be trained to manage those logistics. Imagine the difficulty

of taking oxygen to somebody's home in the middle of winter when you have close to two foot of snow on the ground to make sure that that care is not impacted. All the necessary safety pieces that need to be put in place to make sure that your caregiver, the nurse, is safe and so is the patient safe at that home.

So there are huge elements from the social work standpoint, as well as the necessary background checks and the work that needs to be done from an assessment. That is very, very critical. So that's the second piece.

The third piece that I think is equally important is the way we go about payment and payment models for this. Our opinion is that these have to be risk-based models. Basically, there has to be a model that covers your hospitalization cost. And that cost could be covered in comparison to the standard historical cost of an institution or the region or the nation.

And you tie in an incentive from the standpoint of meeting quality metrics, safety

metrics, and outcomes within that building. Now the payment mechanisms could be done with approximately two-thirds of the cost on the front end and a third of the cost or a percentage of the cost applied to quality and outcomes as a reconciliation subsequently. So those are the three things that I believe are the biggest challenges in terms of integrating care coordination and getting the appropriate improvement, (audio interference)[42] standpoint of hospitalization at home, across the nation. Kendall --

VICE CHAIR CASALE: Great.

DR. MURALI: -- would you like to add anything to these points that I might have missed?

VICE CHAIR CASALE: You're on mute, Kendall.

MS. HAGOOD: How about now?

VICE CHAIR CASALE: Now it's great, we can hear you.

MS. HAGOOD: So, I think the one key

42 Dr. Murali provided a written statement to clarify his statements where there was audio interference. He inserted the following text: ''value and outcomes from the''

important thing is this multidisciplinary chain that Dr. Murali talks about is integrated and empowered through that telehealth kit.

So, because we are managing that patient through the 30 days, not only are we screening for eligibility, managing all of those social determinants in the patient's home and making sure that they're getting all of the acute care that they need, but then when that patient is now ready to be put back into their post-acute care (audio interference)[43].

VICE CHAIR CASALE: Have we lost her or is it just me? We lost her.

DR. MURALI: I think we lost her.

VICE CHAIR CASALE: Sorry, Kendall, if you could try again.

(Simultaneous speaking.)

MS. HAGOOD: Any better?

VICE CHAIR CASALE: We can hear you again. Sorry, we missed your last point.

MS. HAGOOD: I just wanted to address that we're engaging that PCP with those

43 Dr. Murali provided a written statement to clarify his statements where there was audio interference. He inserted the following text: ''space, that is also well-addressed''

vitals, the trending vitals, of that telehealth kit that empowers the multidisciplinary team to manage that patient for that risk episode.

VICE CHAIR CASALE: That's great. Thank you. Before I turn it over to the PTAC members for any follow-up questions, I do want to just check in with Kate. I don't know if you have any particular thoughts around this question, around specific activities that you think are critical to improving quality and reducing costs around care coordination.

MS. FREEMAN: Thank you for asking. I think there have been a lot of really good points. I think what's really critical, from our perspective, is that there is coordination between specialists and primary care. And that the responsibility for that, especially in these models where primary care is taking on the risk of the patient, is that there's the ability for primary care to actually manage those patients also.

So I think one of the biggest things that we see that is a barrier to care coordination, effective care coordination,

especially in risk-based models, is that there's not widely available cost and quality data for specialists available for primary care physicians to use.

And I know that's not quite exactly the answer to the question, but I do think that's a really critical piece that we are continuing to think about in terms of how do we help primary care physicians really make the best decisions on where to send their patients so that they can effectively manage the care for their patients in those risk-based models.

VICE CHAIR CASALE: That's great. Thanks. And, Joe, I wanted to give you an opportunity, if you had some thoughts as you think about the palliative care model.

DR. ROTELLA: Okay. Thank you. I'm not going to presume to talk for all the various populations, but when it comes to the serious illness population, one thing that's very clear is that the patient and family have to be partners in the plan of care that then drives the care you're coordinating. It isn't enough to just be sure all the doctors are

talking to each other or we have an updated medication list.

For this seriously ill population, they often are receiving medications or treatments or interventions that are actually counterproductive to their goals or don't meet their preferences and values.

So it's not enough to do a medication reconciliation. You actually have to look at those meds and say, do we have polypharmacy here? Are we using meds that are actually doing more harm than good?

And that's where you see us, in the palliative care world, saying nothing's more important than anchoring this to that comprehensive assessment, that plan of care that actually is individualized and focuses on what matters most for that patient.

I think that's more than just what we would call care coordination, for the purposes of this discussion, and that's the reason that we think we need that additional palliative care boost for this population. Thanks.

VICE CHAIR CASALE: Thanks. That's a very important point. So, I'll open it now up to PTAC members. Any follow-up questions? Please raise your hand.

Okay, I'm not seeing any, so let's move on, then. So, next, I wanted to explore COVID-19 with its immediate disruption on in-person care delivery and rapid expansion of telehealth.

So, how has the pandemic affected the evolution of care coordination, especially over the last 15 months? And have you had any recent experiences, related to the pandemic or otherwise, that have informed or extended your thinking on care coordination and how it relates to APMs? And, finally, have there been specific lessons related to equity?

So, I'm going to start with Susan.

DR. NEDZA: Thank you. I think everyone would agree that the emergency departments were at the epicenter of much of what happened during the pandemic. This included care for the patients who actually were symptomatic with the disease, those who

thought they had the disease, those that needed testing, as well as the patients who could no longer access primary care for any number of reasons.

Many of us who are involved in the building and the testing of this model, the AUCM model, were struck by how the things that we put forth in the AUCM model would have been, and could have been, critical in changing outcomes for patients.

We routinely saw patients who would have normally been admitted to the hospital but who we no longer had capacity for, who we were then discharging with a pulse oximeter, without a pulse oximeter, to families who didn't understand what to do, who couldn't access 911, and telling them to go home and isolate when they lived in a multifamily dwelling.

This was especially true for many of the essential workers who continued to go to work. You know, we have to go to work; what do we do?

So there were many, many ways that people were working to try to educate the

population, but, in fact, we were left with very few ways and very few places where we could transfer patients to. This include long-term care. So I would have really appreciated the chance to have connections to folks in Hospital at Home, which would have been great, the FQHCs[44].

From a humanitarian perspective, it was probably the most difficult practice that our members and our doctors have had. How that speaks to this particular care coordination, I think I've pointed out couple of those points, but I would like to leave my comments with the idea that we would like to be able to fill the gap. Again, we're going back to that quality chasm. There were patients that could have been admitted, should have been admitted, that weren't.

We also learned a lot about who we could treat at home now and not admit. So there are going to be major changes in our current practice that will carry through, and the ability to take what we've learned in COVID-19

44 Federally Qualified Health Centers

about the patients that were transferred home and did well would be, I think, a very valuable lesson and a way to study the impact of the care coordination. I know emergency departments did a lot of care coordinating. It was unreimbursed. There were some efforts at telehealth in some places, and that was looked, again, as a stopgap until primary care could have resumed care of the patient.

So, telehealth, this ability to care coordinate, it all came together for us in the urgent need to really focus on the types of things that we included in the AUCM model, of getting patients bridging the gap to the other parts of the system where they can be provided care. Thank you.

VICE CHAIR CASALE: Thanks, Susan. And I can certainly relate to that experience. I was in New York City back last March. It really was the emergency room that was the epicenter, and we stood up, just as you did, a lot of the care coordination. A lot of the primary care offices were starting to close. Getting patients connected was really a

struggle. And so it really was the ED that became the epicenter for doing a lot of this care coordination very quickly.

That's great. Thanks, Susan. We're going to turn to Kate.

MS. FREEMAN: Thanks. I think Susan and Paul both made really good points that I would like to echo, that primary care did really suffer at the beginning of the pandemic.

And we believe that if our model, the APC-APM, had been widespread at the time of the pandemic, with the prospective payments, primary care would have been a lot better off. Because we've seen that the practices that received prospective payments and had that type of payment model really fared better than their counterparts that were strictly fee-for-service. They were able to adapt quicker to telehealth.

And I think COVID-19 also exacerbated disparities for patients. So I think we're really at a juncture where there's a real opportunity to design payment models in a way that optimizes care coordination in an

equitable way for patients, wherever they are.

And when we think about that, you know, we obviously want telehealth to be equitably available. We've talked about the broadband issues in rural areas where folks don't have access. And so thinking about prospective payment models that allow for flexible care delivery where they may be able to use audio-only to connect with those patients that might benefit from virtual visits and those types of things is really a way for innovative models to move forward and move away from fee-for-service.

The other point that I'd like to make is that access to these models is also an equity issue. So, a lot of these models are tested regionally, and have been tested in the same region for a long time. The APC-APM, our goal was for that to be a national model. Obviously, that's not how CMMI tests things, and we understand that tests are limited in scope and scale for evaluation reasons. But when you think about moving away and being more equitable, testing things in the same region

over and over again doesn't really allow for innovation to foster in new places.

And the other thing I wanted to say, just in terms of risk adjustment, because we haven't really talked about that a lot, but we did propose a risk adjustment based on social needs in our model to CMMI. And I think that has become a new and emerging thing with this new Administration. They're very interested in equity.

And so I think Andrew Bazemore and Bob Phillips had a Health Affairs article, blog post, last week about just exactly what we proposed to CMMI in terms of using social deprivation indices to risk adjust prospective payments to provide resources to practices that are serving at-risk populations that they can then use to provide holistic patient care.

So, I'll stop there.

VICE CHAIR CASALE: Thanks. All great points. I appreciate it. I'm going to turn to Joe.

DR. ROTELLA: Thank you. The COVID-19 pandemic certainly underscored the

importance of palliative care. And it was not just to support the patients with serious illness and their families, but also the other health care professionals and teams involved in their management.

For patients and families, the pandemic has added another layer of stress, more uncertainty, limitations on family visitation. So, not just telehealth; we're doing televisitation. And disruptions in care.

And, on top of that, we've seen other health care professionals are turning to palliative care teams for support as they've had to grapple with uncomfortable new roles, maybe have goals of care and difficult conversations that they are not accustomed to having, or dealing with high mortality in their patient population.

And we've really seen unprecedented levels of grief, moral distress, exhaustion, and burnout in general in our clinician workforce. And it's sometimes the palliative care team that's providing that support to the other carers.

I would also echo Kate and other people's remarks about the importance of telehealth. There had been some experiments in telehealth and palliative care, but those were certainly more radically accelerated when the pandemic hit. And those new telehealth flexibilities have made a difference and provided new tools to manage a patient's care.

That's been especially important for the serious illness population, who routinely have experienced difficulty accessing their care, even outside of a pandemic. Now, with telehealth, we've been able to provide regular active engagement with patients throughout the public health emergency, a broader level of care coordination than we could have done before.

And, again, we can address not just their medical plan but their psychosocial and spiritual needs, and engage with family members, caregivers, and coordinate with other members of the health care team.

So telehealth has allowed care teams to undertake these care management and care

coordination efforts more efficiently, particularly in rural areas.

We often have to make home visits to check in on patients and assess ongoing needs. With telehealth, time and resources can be saved, and we can sometimes care for more patients in a more timely way because we're eliminating the travel burden.

And telehealth can be critical to addressing urgent issues as it allows for a rapid and timely response, especially for patients who may be isolated in rural areas.

It's incredibly valuable to be able to conduct initial patient assessments in the home, and so there will always be a need for in-person visits. But we've really found telehealth has made such a difference in being able to meet people's needs when they can't leave their home, or are even afraid to have clinicians visit their home because of the pandemic and risk of infection. So the paradigm of comprehensive assessment -- I guess I'll sound like a broken record, sorry about that. Palliative care is deep, but the concepts are

kind of simple. The paradigm of comprehensive assessment also supports equitable care.

And I share that concern that as we see new tools like telehealth, we want to be sure that telehealth access is also equitable, so we do have to address issues around broadband internet, around the digital divide.

But when it comes, then, to that personalized care, we find that how can you expect to have health care equity if you didn't base your care on a deep understanding of each individual patient's preferences, needs, wishes, their psychosocial history, their spiritual and cultural needs, the social determinants and other determinants of health? If you don't start there, how could you ever hope to provide equitable care? So I would say, again, these things are all converging. Being flexible to meet needs during a pandemic, supporting equitable access to care, it all boils down again to finding all the ways we can to keep that patient front-and-center and build their care around what really matters to them. Thanks.

VICE CHAIR CASALE: Thanks, Joe. Before turning to the Committee members, I just want to check in with Narayana and Kendall, if you had any thoughts particularly around this question. Certainly with COVID-19 and the Hospital at Home, I think we all would have liked to have Hospital at Home.

DR. MURALI: Yes, I am more than happy to share a couple things. I actually echo the sentiments that Kate and Joe shared, and I'll complement them, but I think the pandemic enforced the value of care coordination, as well as the hospital.

So, it allowed us to very rapidly deploy the ability to provide support at home, have them isolate patients, and then you scale it up from the outcomes so that as vital signs started to -- if they needed adequate hospitalization with ICU-level care, we could do that. So that is something that is phenomenal as a consequence of models that were put in place that help us. So, I do agree that is extremely important.

On the other hand, I think it is

also important for me to touch on the compelling arguments that Kate and Joe are making related to the digital divide.

So, if I think about that system and the service area where we provide care, we provide care in the most rural parts of Wisconsin, roughly about 45,000 square miles, there are more cows than there are people.

And you would not be able to access care without quick broadband. I have situations where, at least in the month of April, 12,000 of our primary-care-side appointments were all done by telephone audio. There's some situations I have patients actually use school parking lots to be able to do their televideo visits because of the expectations that were set up.

And that was the case that I shared with the finance company on the importance of focusing on the digital divide and investing in that, because it's extremely important.

So I feel the need to actually consider that for risk adjustment, because if you don't do that then you are really not

creating models that will augment the ability.

And equity is not just in terms of race. So, for the poor, sicker, older patients who basically do not have the younger folks available to provide care for them.

So, all of those elements are extremely important. The Hospital at Home actually allowed us to leverage it and do it quickly.

VICE CHAIR CASALE: That's great. Kendall, any additional comments on that?

MS. HAGOOD: No, I just echo what Dr. Murali said. And we were actually able to really help facilitate the health systems in this time of burden. So, for patients that definitely had to be in the hospital, they were able to get a room and have that ability, where patients that could go home could have that hospital-level care in the home and safely still receive care rather than holding off on care. And then being managed appropriately by that care coordination and those telehealth kits.

VICE CHAIR CASALE: I'm sorry, go

ahead.

DR. MURALI: Sorry, Paul, I just want to add one more point. When remdesivir came in place, we were able to actually help make the hospital stays at home so we were able to open up things much faster to accommodate the rate of patients that were coming into the ER. That was another functional element that this pandemic exposed about the weakness of our health care systems.

VICE CHAIR CASALE: Great, thank you. Shari and Christina, any comments on this question?

MS. ERICKSON: I can keep it brief, but, yes, just to add a couple of -- I want to agree with pretty much what everyone else said about the telehealth aspect of it. I think that was critical.

And Kate also mentioned audio-only as a component really to help address some of the issues that particularly the Medicare population faced with having access to appropriate technology to be able to do full telehealth visits. I think that was critically

important.

And in relation to care coordination and our model more specifically, one of the aspects we have there into it is this pre-consultation between the primary care practice and that specialty practice. And that can be any consultation.

And in fact, one of the case studies we talk about in our paper is a 2001 study of an e-consultation intervention at a rheumatology practice. And it found that at least four of 10 patients didn't actually require a full rheumatology consultation in order to provide those patients with appropriate care. Some of those issues were rapidly resolved without having to have a visit with that specialist.

In other cases, especially consultation, it was made more efficient and effective because they had the information they needed and they knew what was happening when that patient came in the door.

And I think that gets at the equity issue as well in addressing disparities, and

this type of an approach allows for ensuring that those visits are appropriate when they happen. And that also opens up the schedule a little bit more for the specialty practice, as well as, quite frankly, for the primary care practice if they're sure that they know what's happening with their patients with the specialty care practices. So it really does allow that access, whether it is via telehealth or an in-person visit or simply an e-consultation that they look to address the issue.

One other thing that I'll mention that I don't think I heard so far, and that is the importance of all-payer in this type of thing. And the reason why I bring that up in this context is Medicaid.

I think we need to have more models that work across both Medicare and Medicaid to really get at addressing the needs of a broader population of individuals that really need services for both primary care as well as specialty care.

And one other little piece I'll

mention too is, Kate, I think it was you who mentioned the risk adjustment. I think that's really important, and I think we're talking about measures maybe next a little bit, but I think we all recognize our limitations within HCC[45] coding within the scores for the measures themselves.

And we really do need to evolve, and I'm going off of our model just a little bit, but we really do need to evolve to a place where we have better options, whether that's built into HCC or whether that's layered with it to assessing the risk of patient populations and really taking into account the social drivers they are facing.

So, Christina, if you wanted to add anything to that?

MS. BORDEN: Yes, I'll just add briefly, I think COVID-19 brought many things to light, especially the changing of everybody's social situations, whether folks lost jobs or had to leave their dwellings.

And so I think care coordination can

45 Hierarchal condition category

really address social risks by utilizing some of the same mechanisms when it comes to care coordination with community-based organizations to be making those connections.

And so I think there's really an importance that the model that we have addresses, that is capturing those social needs and utilizing that information, really knowing their patient populations and being able to connect to those community resources.

And that was before COVID-19 but highlighted because of COVID-19, it will be afterwards, but I just wanted to say that capturing and analyzing that information about the patients to directly connect to the community is very important.

VICE CHAIR CASALE: Thanks, Christina. I appreciate that that is very important. So, I just wanted to open it up to PTAC Committee members for any follow-up questions. You can raise your hand if you have any.

So, if not, we're going to turn to the next question. So, tell us where you see

opportunities and facilitators for implementing and evaluating care coordination activities broadly. So, what are some of the best practices, whether they relate to care delivery, payment mechanisms, measuring effectiveness, or addressing health equity challenges, and why?

So, Shari, I know you started speak to this a little bit but we're going to start with you.

MS. ERICKSON: Thank you. And I want to reiterate what Christina talked about a little bit earlier when she discussed what's incorporated in the standards that we're asking the specialty practices to meet. I think that's a critical component here when we start to think about what are those practices. I think those really lay them out quite well for the specialty practices in particular.

With regard to broader, how do we assess and what are the best measures, in addition to those standards, we call for really using a robust set of quality utilization measures, and I think that's critical for

models. I won't go into all the specifics of the measures that we talk about, but I think we could all recognize that those that do exist are limited for a variety of different reasons.

I mentioned the risk scoring component of it. I think there's variable validity data across different measures. I think that some of them are more applicable obviously to certain patient populations than others.

And so the approach we took was really looking at -- our ACP Performance Measurement Committee undergoes or takes on a very rigorous statistical and clinical validity review of measures, particularly focused on those used in internal medicine in both primary care as well as specialty care. And so we really focused on those for the purposes of this model and particularly for testing it.

And the other thing I would say about this is I think we would need to try to provide more on-ramps for practices to move

from MIPS[46] into Alternative Payment Models like this.

So, what we tried to do, too, is to think through how a structure of a model could be more aligned with what CMS is trying to do with the MVPs[47], the value pathways within the MIPS program, really trying to think through how could models provide that on-ramp to really help them get to a place where they could more realistically take on the risk that's required to be an Alternative Payment Model.

We think that this combination of best practices with these standards, along with ensuring that the measures are as robust and applicable and useable, useful as they can possibly be for the practices, is a way of better assessing how care coordination can be conducted. Initially you mentioned health care experience and we talked about this a moment ago so I don't know that I have much to add to what I said before. But I guess, just to reiterate, when a practice is able to ensure

46 Merit-based Incentive Payment System
47 MIPS Value Pathways

more appropriate timely access to the right patients, and maybe some through an e-consultation or through seeing other data upfront, are able to determine they don't need that visit or maybe they need something different, maybe they need to go to a different specialist.

That really does open up the opportunity for other individuals to have access to that practice and receive the care they need. And I think this is also particularly important relative to the recent pandemic in that I think we have heard, I don't know if there's a lot of data out there yet, that patients did delay care during this time.

And so there's really an importance for ensuring this type of care coordination in the short term as fast as we can make this happen, because we need to have that care available to them and have it be accessible.

Christina, I think you wanted to add on a few things, too, as well?

MS. BORDEN: Thanks. It was brought up before, but the access to data is so

important, and having data liquidity and data-sharing to facilitate the effective coordination of care across all settings and also be able to give access to patients, families, and caregivers.

And then Shari mentioned about measures, we think a lot about measures and we really feel, especially as part of the model, that there needs to be alignment of measures across different levels of accountability.

But the data sources are different for clinical data, for the clinician level, and then claims data for the plans. But, like Shari mentioned, the model focuses really on looking at measures around utilization and wanting to make sure that outcomes are the main focus.

And then just lastly on disparities, the model emphasizes the importance of collecting and really knowing the patients that are coming to the office and what their needs are around cultural language and diversity needs, and making sure that the patient's care is adapted to that. So, both in primary care and specialty care, it's important to keep that

in mind, and making it equitable to all, so that's it.

VICE CHAIR CASALE: Thanks, Christina. Narayana, I'm going to turn to you next.

DR. MURALI: So, Paul, I think from the standpoint of what is required, I think there are two critical elements.

One is the aspect of training to care coordinators both with respect to the clinical and social assessments of the patients, as well as bringing the family into the assessments. In addition (audio interference)[48] the logistical pieces that are very, very critical in this space. They need access to the EMR[49], get to know what the others are, make sure that coordination is very well taken care of.

The second piece is obviously in terms of risk-based global payments because that will allow us to actually invest and

48 Dr. Murali provided a written statement to clarify his statements where there was audio interference. He inserted the following text: ''multidisciplinary teams, scheduling and logistics of post acute care, ongoing monitoring, patient education and transitional care and''

49 Electronic medical record

achieve the result of the outcomes and low cost. So, those are two key criteria.

In terms of the metrics, we use specific metrics that we track. I am not one to say that these are the only metrics we should use, but I think these are the metrics that I think have significant value.

One is the care coordinator communication (audio interference)[50] make sure the care plan is created and completed, and we track the number of (audio interference)[51] before the end of that first episode and then before the end of the 30-day episode. Both are equally important. And third is to focus on tracking related to transition of those plans for the health care managers so that each episode where the patient is on the health plan managers have also taken into account.

We focus on gaps in care, so the first rate of episodes of gaps in care are checked. We close any outstanding item before

50 Dr. Murali provided a written statement to clarify his statements where there was audio interference. He inserted the following text: ''access to Medical Social workers, risk stratification tools, and to''
51 Dr. Murali provided a written statement to clarify his statements where there was audio interference. He inserted the following text: ''quality, operational and outcome metrics''

that 30-day period is complete, and we shoot for greater than 90 percent and apply it to 100 percent at this point in time.

Another very important element is the PCP follow-up. We make sure that the appointments are not only just reviewed but also attended within that seven-day period post-acute episode and the follow-up appointments are all previously scheduled and accounted for.

You heard from Kendall how we share all of the vitals, as well as the tracking metrics, so the primary care physician knows precisely what happened during the hospital stay.

And then we track the acceptance rate because some of the acceptance rate is dependent on what the social determinants are and also the exploration index that Kate was alluding to earlier.

Finally, completion of the advanced care plans, so when you have an older population bigger than 65, you want to ensure that the care plan as well as the decision to

make it are clearly documented.

And documentation is available to everyone for follow-up and is easily locatable by the primary care physician. And then you make sure the patient's missions are managed.

All of those elements are critical and these tie in (audio interference)[52]. So, those are the metrics I would probably use but I want to say this is (audio interference)[53] care coordinator and she's probably going to be far more eloquent than I am. So, I'll shut up at this point.

VICE CHAIR CASALE: That's great, you are fading in and out a little bit, we don't want to miss any of your nuggets of knowledge. So, just to let you know, we caught most of it but --

DR. MURALI: Sorry.

VICE CHAIR CASALE: No, that's okay, sometimes the blurred background takes extra

52 Dr. Murali provided a written statement to clarify his statements where there was audio interference. He inserted the following text: ''seamlessly

53 Dr. Murali provided a written statement to clarify his statements where there was audio interference. He inserted the following text: ''closer to the recovery''

bandwidth.

DR. MURALI: My bad.

VICE CHAIR CASALE: That's okay. Kendall, anything you want to add to that?

MS. HAGOOD: No, I think where Dr. Murali was going and what people might have missed a little bit is all those metrics that we hold all those care coordinators to.

So, those key components that we make sure that we train the care coordinators upfront, as Dr. Murali mentioned. But then we hold them accountable from the perspective, so making sure that they do those care plans, those advanced care planning, list the patient, they are communicating based off of those vital signs with those patients throughout that.

They are setting up that PCP appointment within seven days. All of those are key areas that we find, that way you can have a successful 30-day episode and reduce those readmissions, just as we've discussed before.

Without that, there's no way to really measure and track the effectiveness of the care coordination.

VICE CHAIR CASALE: Thank you. Joe, I'm going to turn to you?

DR. ROTELLA: I have just a couple of remarks about quality measurement incentives and payment to support care coordination.

What you'd like to do, of course, is identify some associated quality outcomes that you would expect with good care coordination, and then incorporate them into a reasonable quality accountability structure.

But that's actually been a little bit hard to do because there are substantial gaps in the current universe of quality measures that really matter for people with serious illness. In fact, most of the currently existing measures that are NQF[54]-endorsed and have been used for a while are process measures. And often, they're capturing the process of comprehensive assessment.

The problem with process measures is they can lend to a check box approach, done, not done, you don't know if it was done well. And that also can lead to them becoming topped

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out and a hard way to tell good performers from poor performers.

So, what we hope is we could move from process measures to something more like outcomes, patient experience of care, or utilization-related measures that get at the important things. We appreciate that actually, the Academy has been into a cooperative agreement with CMS to use some MACRA[55] funds to develop a couple more measures that we hope will move us forward.

These are patient-reported experience measures around being heard and understood or getting the help wanted with pain. We hope that will move us forward and we see now, new measures coming down that are surveys again of the patient experience.

What we've had before is that after someone dies in hospice, their caregiver is asked a few weeks later to report on their experience of care.

But we haven't had surveys that get at the experience of care that a person with a

55 Medicare Access and CHIP Reauthorization Act

serious illness is having themselves while they're still with us.

So, we see those coming, we see things like days of homecoming, but I would say if we were just to look at concepts, the key concepts for the seriously ill we think are the experience of care, the key outcome might be potentially preventable hospitalizations and more days at home.

And another very important one is the timely and appropriate use of hospice care because the purpose of APMs was not to in any way interfere with or undermine a really good comprehensive benefit we have for people who are eligible, hospice care for people in the last six months of life.

And so we want to see appropriate utilization, not super short stays, and not people missing out on hospice because they're doing something else that's not been proven yet. One remark about payment is to recognize that care coordination and the deployment of palliative care teams might take an upfront investment from many practices that

would participate.

And so a payment structure that does provide adequate upfront payment is really important if we're going to give this a good task. We can't make it just about some shared savings that you get years later after you've finally had a final accountability.

And so I think we need adequate payment upfront. Usually that's something like a per-patient-per-month kind of structure that really will support the palliative care team, the interdisciplinary team being available 24/7 to provide that comprehensive assessment and the care that flows from it. Thanks.

VICE CHAIR CASALE: Thanks. I'm going to move to the next question, which is what are the major challenges or unanswered questions that you believe need to be addressed before the health care system can better incorporate and optimize care coordination in APMs and PFPMs? So, Kate, I'm going to start with you.

MS. FREEMAN: Great. Thanks, Paul. I think, first, it's worth making the point that,

obviously, all of the care coordination that happens and all of these types of varying settings is good, high-risk patients, high-cost patients, patients with advanced specific diseases.

But without the basis of primary-care-centered population-focused care coordination, I think it will fail to see improved outcomes, reduce cost, all of the things that we really want.

So, I think when we're thinking about making our health care system and care coordination really foundational in primary care, Shari made a really good point about having an on-ramp and a continuum of care or of models available that really address and meet the level of risk that a practice is able to take on.

So, not overly burdening small practices with risk that is not a good business decision for them, and making sure that practices are able to deliver care and pay their staff, and improve quality and outcomes and not have to worry that they might have

money clawed back from them that is going to cause problems down the road.

Another point I'd like to raise is around stability of models and off-ramp from models. I think we've seen with CPC+ ending and Primary Care First being the next option, there are some challenges with designing models in boxes that don't talk to each other.

Because they're creating these financial cliffs that are really going to impact a practice's ability to deliver the care coordination that they've created this infrastructure to do.

So, I think that when we're thinking about long-term model development, we really need to think about both the beginning and the end of a test and what that looks like.

And then the last piece I think I'll really touch on is especially for CMMI models, when we're talking about evaluation of those models, it's really challenging to understand the true outcome of a model because of all the model overlaps.

So, I think that when we're thinking

about do we want more practices to move to value-based payment, we want to move away from this fee-for-service system that doesn't serve patients or physicians or the health care system as a whole.

The ability to effectively evaluate those models or to decide what deserves expansion or how those are tested is really something that we've been mulling over a lot.

So, I think that's a big challenge and if we don't address the challenge and the ability to expand these models nationwide, we're not creating an equitable system overall.

VICE CHAIR CASALE: Thank you, Kate. Susan?

DR. NEDZA: So, even while we've been on the call today, patients have been accessing emergency care.

Sometimes they call their primary care providers or are sent there for consultation, for access to tests, potential treatments, and in some cases it's just technology, a CT or an MRI that might not be available.

Or they've had traumatic issues, they've fallen, they've had syncope, chest pain, abdominal pain, you can go through the list of undifferentiated symptoms that we provided a unique set of skills and services to the patients we treat.

And our most difficult problem has been recognized as part of the solution, I'll be very honest. Most of the measures today are how do you avoid emergency care?

I for one have a $500 copay myself for going to the emergency department as someone who could serve insurance on the exchange.

There are many, many things that are in place to keep patients out but not much on the back end after we've seen the patients. It's a nine-to-one savings if we choose to discharge a patient safely to a home environment or to one of the systems we heard about today, and to get in touch with people.

I think Bill talked about it earlier this morning. Primary care practices got rid of their answering machines and had people answer

the phone. Or timely access for us to access the kind of services our patients need after.

So, one of our challenges and probably one of the largest challenges has been being recognized as part of the solution. And I think the PTAC was pretty verbal in suggesting that was a good idea last year or two years ago when we went through the process.

And I think the second is understanding that what we're asking for is not in the payment model in general. It's just extending current payment models to be used in the emergency department.

So, care coordination fees, allowing us to use telehealth which we have been using successfully during the COVID-19 pandemic, giving us the opportunity to see a patient again, not by an emergency physician.

If there's no one else available, it's Friday night and it's Sunday afternoon, to be able to re-examine a patient with abdominal pain rather than admitting them to the hospital.

And all of those things that can not

only generate cost savings but don't take a major investment on behalf of payers or practices. More or less, it's the will, the political will and the policy will to integrate the kind of care we provide into the system.

From my perspective, for patient safety reasons because we're very, very worried about our patients and the chasm between post-discharge emergency care and return to other parts of the health care system, but also for patient safety and just for the health care system in general.

So, again, thank you for asking the question, and I hope my responses were helpful.

VICE CHAIR CASALE: Very helpful, thanks Susan. Joe?

DR. ROTELLA: I guess I'm going to just lean in to an elephant in the room for a second that we experienced from palliative care, and that is all of this APM activity is being done with a mandate that it will be cost-neutral or hopefully save the system money.

But if you look at palliative care under traditional fee-for-service

reimbursement, it is not adequately paid for.

There are members of the interdisciplinary team providing vital valuable services who can't bill the physician fee schedule, the social workers, the spiritual care provider for example.

And so we don't have the access we should have to palliative care in traditional payment structures because there hasn't been adequate reimbursement.

So, if you do an APM and you say let's see if an APM around community-based palliative care can deliver better outcomes for less money, you're comparing it to a traditional fee-for-service system that actually is limited because it hasn't paid for it.

And it sets a bar that's very hard to hit in terms of both showing value and achieving cost neutrality or cost savings.

So, I know that's outside the bounds of what we can do today, but if I could pick one thing that would make a difference, it would be if you improve the care of patients,

then let's test it, let's not test it only if we can artificially try to show some sort of a cost saving when we're not capturing all the costs first of all.

I guess I'll just make that my soapbox for today, and I appreciate the opportunity to say it. Thank you.

VICE CHAIR CASALE: Thanks, Joe, I appreciate it.

So, we have about eight minutes left and before we wrap up our discussion with this panel. I'm going to ask one last question. And the question is are there any additional critical insights you would like to share about care coordination, APMs, and physician-focused payment models?

The relationship between them and potential for optimizing outcomes for patients and transforming value-based care. Before we get started, Jeff, can we go over a few minutes if the panel is available? Or should we end at 2:30 p.m.?

CHAIR BAILET: If the panel is available I would say yes, go ahead.

VICE CHAIR CASALE: Great, thumbs-up, that would be great, we'd really like to hear from everyone. So, I'm going to start with Shari?

MS. ERICKSON: I again just want to say how much we appreciate the opportunity to share with all of you and with whoever out there is listening to our views on how we can better incorporate care coordination into Alternative Payment Models.

So, one of the things I reflected on when I was thinking about this is I looked at what you all have in there as your definition of care coordination.

And I think it's important to note there are a couple aspects of it, you talked about deliberately organizing patient care activities, including the consideration of patient needs and preferences and timely communication.

And I think this idea of deliberately organizing patient care activities and then figuring out how to lower that into a payment model is what's really important.

And I know we and it sounds like others have incorporated in theirs as well, incorporating the patients' needs and preferences up front in shared decision-making and before the referral is made.

And then actually throughout the time the care coordination is happening, and I think deliberately incorporating those into whatever the attribution process is for this model is really important to get at true care coordination. And I wanted to emphasize that, and I think the other thing is there are a lot of practices that are really trying to do their best and do this for their patient population.

And I think this is getting at what was mentioned earlier -- there's not enough upfront investment for them to be able to do that.

And so we need to find means such as the ideas that are being presented here to support that type of an effort so the practices can invest and build their own internal infrastructures. And I believe this can be done

in all different size practices to be able to provide that type of care.

And just reflecting back as well on the pandemic that we went through and how many practices really suffered great financial and mental strains without having any APM opportunities in their region.

Particularly those who are fully on fee-for-service, it just re-emphasized all of the challenges that practices are facing out there trying to stay above water within a fee-for-service system.

And just for a moment to also note coming back to the challenges component, I think we do need more opportunities for these practices and we need to figure out how, and I think what Joe was mentioning, we invest in those opportunities and we certainly, obviously, want to get to a place where there are savings or there's at least cost neutrality.

But that's not an easy thing to get at when you're trying to invest in care coordination, it's not going to happen

immediately, it really is down the road. And we need to think creatively about that and innovatively about that.

And I feel like the PTAC has really looked very closely at a lot of these models, and I'm hopeful that this conversation is helpful as well. And so we can figure out how to get these off the ground.

As Kate mentioned earlier, we need to provide off-ramps and stability for those that have been in models, which has been more available to primary care practices rather than those outside of primary care.

And we certainly are supportive of more for primary care as well but there's just a limited amount available.

And the other aspect I'll mention about it is I think we also need to think about how these models, and we talked about this earlier, can better be enabled to reduce health inequities, again, something else that came up throughout the pandemic.

And if there are ways that we can invest in these APMs and the performance

measures they're using so that they can try and assess other risk factors like housing and transportation, et cetera, that really affect a patient's ability to adhere to the care plans that are being worked through with them and with their primary care physician and with their specialty practice. Trying to take that into account when it's being built out but there are challenges that arise along the way.

So, I just want to close by saying thank you for having us on here, and I appreciate that opportunity to share, and I'm happy to answer any additional questions that the Committee may have.

VICE CHAIR CASALE: Thanks, Shari. I'm going to turn to Kate.

MS. FREEMAN: And so I'd like to echo something that Joe said and something that Shari said. I think the first is we believe that fee-for-service has chronically undervalued primary care. So I think we would wholeheartedly agree with Joe's assessment that models that are built on fee-for-service, which is the majority of APMs available to primary

care today, we're competing against a benchmark that's already too low in terms of cost savings.

So, I think that is something that we are very cognizant of, and I think there's a lot of work to be done to really recognizing the true value of primary care and to develop models that pay for primary care at the level of care delivery that it's delivering.

And the other point I think I'd like to make is that payment reform really needs to precede care delivery reform.

And so I think the idea that there are these on-ramps and that there is a continuum and a transition and that this allows practices to move towards payment that better reflects the types of care they'd like to deliver to their patient population that really meets the patient's populations needs is really necessary in payment reform in terms of providing these upfront investments in primary care are really critically necessary if we are going to see the types of outcomes we really expect from these types of models.

So, I think I'll end with that, and I want to echo Shari's sentiments that I really appreciate the invite to sit on this panel and answer questions as they arise.

VICE CHAIR CASALE: Thanks, Kate. Narayana?

DR. MURALI: Paul, I want to start off by thanking the PTAC because our journey of the Hospital at Home began with the PTAC and has come full circle after the pandemic program and particularly CMMI and CMS have gone on to create acute care without walls program during the pandemic.

The pandemic itself has clarified that there is no place like home for recovery from the standpoint of hospital care.

So, that is very clear, if CMS could extend this program beyond the pandemic, that would be the number one piece to keep in mind.

Number two, when CMS does that, there is also pressure on other health plans that have not adopted these plans. We can lower cost and improve value and actually improve patient experience, that is probably very, very

important for the rest of the pandemic. (Audio interference.)[56]

CHAIR BAILET: Dr. Murali, we're having a hard time hearing you.

DR. MURALI: Let me do one thing.

CHAIR BAILET: Maybe, Paul, while he's re-upping, why don't you go to your next panelist and then come back to Dr. Murali?

VICE CHAIR CASALE: Sure, Susan?

DR. NEDZA: I'd like to echo and further reflect back on those last comments because the journey with the PTAC process really has generated a great deal of knowledge and innovation in our own specialty.

Quality and cost were siloed prior to the development of the PTAC model. They were in different committees, they didn't really meet, they were thought of differently, reimbursement was one thing and quality was another and quality measures were another.

56 Dr. Murali provided a written statement to clarify his statements where there was audio interference. He inserted the following text: ''In our work we know that this lowers the cost by 10-15 percent. That by no means is chump change when we think of dollars spent in acute care.''

And this brought us all together, and in developing and looking at the data about what happened after patients left the emergency department, we learned a great deal about variations in practice.

Post-discharge, what happens to patients? We generally don't know when we send someone home what happens, so we learned a lot more, including the fact that sometimes 20 percent of Medicare patients with acute conditions like chest pain never see anyone within 30 days.

And these are fee-for-service Medicare patients, these are not the uninsured. We were looking specifically at Medicare data so we found gaps there.

This informed our COVID-19 care because we had been talking about all of these ways that we can improve care coordination. It certainly is feeding into our development of an MVP as a bridge for those of our members that are in MIPs and that are trying to get to that APM model.

And so our MVP proposal that has

gone to CMS really does focus on these undifferentiated conditions, and that would have never happened without the data that we put together during the PTAC process.

And we certainly learned a lot more about inequities. We've always known they were there, but we started to look at the variation at both regional facilities, the idea that the social determinant of health has such a profound impact on our practice of sending patients home.

It was something that we knew but weren't able to quantify. So, all of those have been benefits, and I really encourage those that are think of submitting or even those of us who have already submitted to consider perhaps thinking about how you might do it with some of the information you've garnered today.

And I'll close by saying I still think the biggest challenge is that until CMS integrates some of the things we learned and some of the items that are included in our Alternative Payment Model proposal that has gone to CMMI, it's going to be very difficult

for us to impact any of those other things I mentioned.

This has been a driver for us, and in order for us to be able to do that, there needs to be a payment reform, and it always starts with CMS and then the private payers follow.

We have been in conversations with private payers including Medicare Advantage plans for over two years, and they are all waiting to see what happens at CMS at their leave, and we're more than willing to also work with anybody here on the call or others in the audience who would be interested in how you can drive cost savings in your models through coordinating post-discharge ED care with us, so thank you.

VICE CHAIR CASALE: Great, thanks Susan. And Joe, you may get the last word.

DR. ROTELLA: First, I absolutely want to thank PTAC first for hearing our proposal a few years ago and even recommending it. For all that we've learned from going through that process and for opening a door for

our ongoing engagement with CMMI on a number of different models has been a great process. And thanks for inviting us back for this really great discussion.

I would say that based on this idea that traditional fee-for-service really doesn't have a mechanism to support community-based palliative care, and yet that has been shown to provide great benefits to people with serious illness who are a population that have high risk and high needs and often receive low-value care.

Given that, we really need to see a demo of community-based palliative care, and we're happy to see that palliative care is included now in some other models such as the Medicare Advantage VBID bid model that's being tested.

And we had hope that we would see the serious illness population model tested within Primary Care First, but as I'm sure you all know, that's on an indefinite hold right now.

And I would say when push comes to

shove, we probably ought to be testing two or three different models of palliative care simultaneously.

It's clearly part of the value solution and we can't wait because the traditional fee-for-service world is not supporting it for our patients.

But thanks so much for having us back, this was a fantastic experience, we appreciate it.

VICE CHAIR CASALE: Thanks, Joe, appreciate it. And I know we went over it a little bit, I appreciate the panels staying on. I'll just ask the PTAC members if they have any questions that they want to ask before we close this session.

Not seeing any, on behalf of the Committee and our audience, I would like to thank each of our panelists for their really tremendous insights today.

We're absolutely grateful that you've been so generous with your time and sharing your expertise. So, Jeff, are we going to take a short break?

CHAIR BAILET: Yes, I think we should take a 10-minute break. Why don't we get back at 2:45 p.m.? We'll try that.

VICE CHAIR CASALE: So we will take a short break and reconvene at 2:45 p.m. Please come back. PTAC will be taking public comments and then discussing all of what we've heard today to prepare for a report to the Secretary on care coordination and then releasing an RFI[57] to get even more public input on today's topic.

So, thank you, everyone.

(Whereupon, the above-entitled matter went off the record at 2:38 p.m. and resumed at 2:45 p.m.)

CHAIR BAILET: Welcome back to our PTAC meeting. Thank you all for joining us.

*** Public Comment Period**

This is the period of our meeting where we invite public commentary. We do not have anyone identified that is actually signed up and on the line. But before we move on, I want to just check one more time with the host to make sure that there isn't someone from the public who

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would like to make a comment. I'm checking.

All right. So, there aren't any public commenters, which is fine, which allows us now to move into the Committee discussion, incorporating thoughts from today's session, the environmental scan the PCDT team shared with us earlier.

*** Committee Discussion**

We're going to start again, just like the Committee has done before in telehealth, we're going to take all this information in, our comments from today, at the end of the day now or at the end of the session, create a report to the Secretary on our point of view on optimizing value-based care related to care coordination for Alternative Payment Models and physician-focused payment models.

So, there's been, and will be, a lot of information to sift through. So I'm going to ask the team to share the framework -- if you could put the framework up, that would be helpful -- that we will use to structure our conversation.

We want to make sure that the staff who are following along have the opportunity to hear the Committee's point of view and the individual perspectives to make sure that they can incorporate our comments into the ultimate draft Secretary letter that we can react to.

So, there are a couple of things. I think we'll just walk through the list, and I would open it up for Committee members to respond. And, again, if you don't respond here but have a point of view after the meeting, we'll clearly work to incorporate your thinking before we finalize the report.

So, promising approaches for optimizing the use of care coordination in value-based care to improve quality and reduce costs. This is, you know, clearly the thrust of what we were trying to effectuate today. I have some thoughts, but it would be nice to hear from the Committee on what were some of the key components you heard, functions, activities that we should incorporate in the letter.

You see the other sub-bullet here, which is the extent to which promising

approaches are likely to vary based on context, specialty, et cetera. Why don't we start with that first section and open it to the Committee if there are any additional comments people want to make?

All right. I know --

(Simultaneous speaking.)

VICE CHAIR CASALE: Sorry. I was trying to raise my hand. That wasn't working very well.

(Laughter.)

CHAIR BAILET: I know. It's okay, Paul. Technology, you know, hey. But go ahead.

VICE CHAIR CASALE: Well, you know, in terms of the -- one of the things I heard, I think both with the subject matter expert panel that came through and as well with the prior submitters, you know, is around the function of the care coordinator.

And, you know, there's a lot of discussion around, you know, who is the -- descriptions of what the care coordinator -- who that should be. I did hear quite a bit around the benefit of that coordinator having

some relationship with the patient or have some familiarity with the patient being particularly helpful.

But even in some of the other comments that were made by some of the past submitters, including Susan from ED model around, you know, the critical importance of that role in care coordination.

CHAIR BAILET: Thanks, Paul. Any other comments? Bruce?

DR. COLLA: Bruce, you're on mute, I think.

MR. STEINWALD: Every now and then somebody will make a remark that kind of sticks in your head. I think it was Dr. Jain who said we entrust a function that's most in need by patients with complex illnesses to strangers. Paul was just alluding to this. And that's the way he said it. That's why it stuck in my head. Then he went on to say, I believe, that very often the people who have that trust are not only strangers, but they're often not very well-trained and often lowly compensated.

And the last panel, they talked

about the training, but they didn't address the role of having a personal relationship with the patient. And I guess I wondered if that's -- unless you interpret what they said about primary care having a key function in care coordination, the presumption being the primary care doctor would have a relationship with the patient.

So I was just trying to put all those things together and wondered if there's a point there to be made that we might want to put into our report, or at least test with some other people, including Committee members.

MS. HARDIN: I would like to follow on from what Bruce said. So, working directly in this space in so many different directions, that trusting relationship is so key. And I'm very sad I lost signal because I wanted to ask the panel about what they've learned about different disciplines or roles and how they intersect.

So, the emergence of community health workers, the emergence of people with lived experience, especially in the behavioral

health and substance use disorder space, is being really key with being able to build trust and understanding. And also related to equity, people from the culture being the translator and navigator for the culture I think is a really important emerging theme.

I loved also what Sachin said about the longitudinal nature of that trust. So I heard another theme about the disruption from episodic sort of helicoptering in of care management and then it leaving again in that if we want to see long-term change, that longitudinal relationship and that trust is really key. And I see that in practice on the ground, and I think that's an area that is really promising for this research.

DR. FELDSTEIN: You know, to just add on to Lauran and Bruce, when you look at it in terms of, you know, who is the best person to be the care coordinator, and the challenge in today's world is it's so complex because so many of the patients have such complex needs.

Is it best delivered from the primary care office? Is it best delivered from

the health plan? Is it best delivered from the ACO? You know, is it best delivered from a specialist who is delivering the majority of the care at the time?

You know, it's almost -- in the old days, you've seen one health plan, you've seen one health plan. Well now, if you've seen one, you know, care coordinator, you've seen one. And obviously it almost screams that the level training definitely needs to be escalated.

And the flip side is, you know, how do we compensate for that, which I think came through loud and clear. Now how do you provide the resources so we get the right person providing the right care coordination in the right setting?

DR. WILER: Jay, I want to echo your comments. I think what struck me is we talk often about care models and then how the payment model may incent that care model.

What we heard a lot today is exactly what you described in that there are areas of excellence of multiple care models that exist. And yet we still don't, it sounds like, you

know, know what although we described a number of best practices.

But it's in its infancy, although we've been at this now for decades or more, to sort of create a payment model that incents an undifferentiated care model. This is where it feels like we're in the middle of this conundrum.

DR. MILLS: Yeah. I appreciate and agree with all those comments, especially Lauran's and Bruce's. I was struck by something else Sachin said, which was that for surgeons or procedurally focused care that they were successfully able to change the conversation from managing the procedure to managing the patient journey, including pre- and post-care.

And for primary care, they're paid to manage a panel, not paid to manage a visit. And that's a really fundamental concept which it links to the domains and the functions that we've decided are more important than the medical care.

You know, optimizing the care for the encounter that only develops, only drives

10 percent of cost is kind of foolhardy. It's linking the journey to the wider context, the patient's community and social determinant needs that’s going to really change the outcome in care continuum.

So that just strikes me that all the effort around building care coordination on a fee-for-service menu with codes keeps it focused on the visit, on the encounter, on a reductionistic, I do a bunch of stuff and get to submit a bill. And we really have to move this conversation to value-based care and change that paradigm or we probably won't be able to move past the innovators into scalability.

CHAIR BAILET: Going back to Jay's comment, you know, Jay really highlighted a really significant challenge, which is there are so many different places that care coordinators could reside and where does it make the most sense?

And it's clearly not going to be one size fits all. If you think about the social determinants, a lot of the insights that need

to be delivered to the patients come from the community.

So you can argue effective care coordinators are really the ones that are embedded in the community and know some of the assets firsthand and how to access them.

I think there needs to be a way to tether care coordinator community to the care team. And it doesn't mean they have to be employed by the care team, but they need to be connected to the care team. And it should be fluid based on the patient needs.

Within one practice, you can imagine some care coordinators may emanate from the community, some might emanate from the plan. And we can't let the level of complexity avoid us moving forward with the value of care coordination because I will say firsthand when you see it and it exists, the impact is tremendous on driving outcomes.

The other comment I will make is that we talk about payment, but I think payment and sustainability are, well, I should say durability, are two important points. You can't

say I'm going to pay for your care coordinator for the next 24 months and then it's a black box.

Practices are not going to devote the resources to building these programs if they think it's going to be the flavor of the day and then funding is going to be pulled.

And again, I'm not being critical of past practices, but this is a problem that people need to solve. And if, in fact, we're going to go down the road of care coordination and really getting deep in supporting it full and wholeheartedly, we have to be committed to the journey, which means some of the things we'll get and have happen won't be correct and we'll have to pivot. But that should be -- you know, that should not be a reason for us to abandon it. And I would say it's sustainability, which is absolutely critical if we're going to go ahead and start paying for these services long-term.

MS. HARDIN: I also think there are some key practices. I didn't want to interrupt

our SME[58] panel and didn't get to call those out. But actually hearing them speak I realized over the last 20 years, I've actually worked with several of them in what they were developing.

So I thought it might be helpful to call out some of those core component practices I've seen them do that they referred to that I think start to solve for some of the challenges we're bringing up.

So in Vermont, I worked with the state of Vermont when they were doing their SIM[59] model and designing what they were going to do across the state. And they adopted some of the practices from the complex care model I developed in Trinity, which included a principle of the intervention was to identify the cost continuum team regardless of setting. So that included identifying not only primary care, specialty care, payer care management but also the faith community and the trusted neighborhood relationship. So that's a

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principle.

And then they hold a shared case conference of all of those people to develop an integrated story of the patient and a shared plan of care.

And they identify who has the strongest trust relationship to carry the main contact with the patient, and they actually built into their ACO payment for development of that shared plan of care.

In CareMore's model, they do something similar with how they have an interdisciplinary shared team that develops that shared plan of care. And then they follow the patient longitudinally. So they have a clinic, but they also round in the hospital if their patient is there or they go to the home so it's longitudinally and cross-continuum.

And then with Catherine from Remedy would be BPCI. The other component was they have a structure to create a community of practice amongst the care coordinators so that best practices can be shared and accelerated and translated into pathways for

standardization and quality improvement around how complexity is misled.

DR. LIAO: Just to add to some of these comments, I think I agree with a lot of them. And what I'm kind of turning over in my head is this idea -- I love this idea of moving from kind of a smaller unit of a case to a journey of a patient to a panel to a journey.

I'm trying to square that with comments that I've heard today from Committee members and SMEs about kind of like how close any team member is to, like, the locus of control over that, right?

So the letters BPCI have been mentioned a few times. Whatever we think about that, it very targets the energy, right, between the hospital and the post-acute setting. And that is pretty hard for a primary care doctor, who we may or may not know, you know, based on the data feeds that patient's admitted and may not know what the plans are, to reach in, kind of distally from where they are to address that point.

And so I just think about as we

expand to that journey though, we do need nodes along the way, right, and some insight about who is as close as possible and appropriate to kind of intervene in a way that achieves quality in crossing.

I think we heard a lot of perspectives on it. It's an open question in my mind, and I think worth consideration going forward.

CHAIR BAILET: Bruce? Do you have your hand up?

MR. STEINWALD: Not on purpose.

CHAIR BAILET: Okay. Very good.

DR. MILLS: Josh made a really interesting point that got some neurons firing for me. And you could see the beginning development essentially of a standard model of interconnected care coordination models.

There's one from acute to post-acute. Then you manage the interface before it goes to population primary care-based care coordination and in selected patients that wind up with a disease or high risk condition interface and you manage the interface and the

handoff between the disease-focused care management, care coordination panel.

Suddenly, you start to get, you know, two or three, three or four defined models with defined interfaces that can be managed and handed off. Suddenly, you can wrap care coordination kind of systematically around most patients that need it with the appropriate model and inputs at the time they need that.

CHAIR BAILET: Thanks, Lee. Amy, maybe you can drop the slide. I think all of the Committee members printed out these bullet points in advance. That way we can see each other and it's a little easier. Can we -- any other comments before we move to some of the challenges?

And again, we sort of touched on some of them already, but just to make sure we cover the waterfront. There are four challenges, five challenges here listed.

The first one is related to the beneficiary and the caregiver needs. I would say, you know, it's interesting, we all talk about how much money is spent by CMS and CMMI

for providing care.

I think the unsung hero here is the dollars that get poured out from families when they can least afford it when providing care and care coordination. That is not very well known. It's not very well quantified, but it is material and it's only going up. It's only going up.

So, I think that a huge challenge is to really understand the economic consequences and how difficult it is to navigate the care coordination, meaning to get to the place like you said, Bruce, earlier with your family member, to get to the point where you're actually connected to a care coordinator. You almost need a navigator just for that.

So, I'll stop there and turn it over to other folks on the Committee for their input.

DR. WILER: I have two more points to raise and one, Josh, your comments made me want to speak to this and we heard this from our panelists around data and data governance, and who in that care journey has access to

information and data.

What's the level of validity of that data, privacy issues, and that really we've talked about this before in other settings, including our telehealth conversation, but that keeps coming up as a real challenge in order for us to not only communicate with patients, but in order to really understand their story without having that verbal interaction, but being able to use it, you know, digitally or in written form.

That's one comment and then my other comment is around, you know, this has really gotten me thinking about, you know, we're thinking about payment models to incent all of the unit who might ultimately impact or help manufacture a good outcome related to health care, but what we didn't actually surface much today were what are the incentives for patients that were successful in these programs to participate?

You know, there's not just financial incentives, right. There's obviously other incentives that exist for engagement, but it

did get me thinking about, you know, might there be a model, even if for financial incentives, much like we saw, you know, in the -- which sparked national conversation around, you know, payments related to COVID.

I know those weren't specifically for health care needs and were more for economic, the economic crisis, but it feels like that's something that we haven't focused on that could be an opportunity.

CHAIR BAILET: And Lauran, you had your hand up?

MS. HARDIN: So, just to follow on what you said Jeff, I think it's really important to highlight the cost to families and caregivers.

So, when you look at models like BPCI and many others, there's an incentive to reduce the costs of post-acute care, and that cost then gets translated to the family of the patient.

So, we heard a lot of themes about the importance of patient and family-defined value, so paying attention to the costs, the

access, and then on the other side of the equation, we didn't talk a lot about care coordination with behavioral health and substance use disorder.

And in that space, it's often a place where the family is not integrated in care coordination, partially because of policy and regulation, and also perceptions about HIPAA[60].

So, there's an opportunity to enhance that family unit, but really pay attention broadly to the cost to that unit and what support is needed just as data.

CHAIR BAILET: Thank you, Lauran. Maybe I'll just read the rest of the challenges because we are touching on them as we move along, but there are the health system challenges.

There are challenges that are related to the providers, including incorporating community health workers. We've talked a little bit about that, infrastructure challenges. Jen was talking about data, and I

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think that that is a --

You know, that is just, you know, like in all of the care delivery components, that's a huge issue, and interoperability or lack thereof has been a longstanding challenge, and health equity challenges, which we heard about a little bit today. I know Kavita has her hand up.

DR. PATEL: Hi, guys. Thanks, Jeff. Lauran, just when you talked about behavioral health, it just kind of also reminded me.

It feels like, and I think those of you who do this kind of in the ED or in primary care can commiserate, even if we were given, like even if HIPAA, even if all of these policy and regulatory barriers were relaxed, the combination of not having an adequate workforce, which has been touched on, but then also just it's very hard to kind of get through --

It's very hard to coordinate behavioral health care due to the very, I don't want to say unique nature of behavioral health because that makes it sound like it's separate,

but it is separate, and there's just a very -- I hate to say it.

Most of what I need is done with a psychologist, not a psychiatrist, and so there's a very different approach to kind of therapy and their notes and how they understand kind of the medical condition.

And so, Jeff, it was reminding me like, you know, when you're in at-risk, probably what you led back in the day, like if you're an at-risk multispecialty group provider, you're motivated to like figure out how to get people to work together, talk to each other.

And so, yes, the payment helps and the policies need to change, but there's something about like both the workforce and then just the -- and PTAC can't fix the woes of medical education and, you know, the problems with that.

But it does seem like as we do these APMs, like these leaders that come to us and these submitters when you were talking about Hospital at Home, and when Liz referred to kind

of, you know, thinking about something that's, you know, where everybody has to do it, so to speak.

You aren't going to get there if we can't really kind of fundamentally augment like the bread and butter APMs with some way to give people almost like a toolbox, kind of like ACOs, of like and "here is how you do it for dummies."

And again, that's not PTAC's job, but it's an interesting thought that like these submitters or people who are advanced in their thinking, they've got that toolkit.

You know, they can't submit it in their 20 pages, but they've got that toolkit. Can that become like a place and a place to build off of?

But I can't underscore behavioral health enough, and I'll tell you that even when we all try and do things and work together, I feel like we're speaking different languages and it results in, you know, I can't even read their notes because they're so long, and I don't have time, and you know, I need the punch

line.

And so you really have to have a relationship with somebody and that takes a different culture and mindset. Anyway, just, Lauran, you just really kind of brought it home for me.

CHAIR BAILET: Thanks Kavita, and it almost -- you know, I mean, just for the kind of folks that really need care coordination, the folks with multiple disease states, and complicated disease histories, and lots of comorbidities, they're the ones that really need that behavioral health support and their family need that connection.

You know, Kavita, you were -- many sophisticated practices embed behavioral health to some degree in the primary care practice and that has shown to be hugely successful. I have not seen a lot of catastrophes when that's done, and actually it's just the opposite.

It's very impactful and very effective, but again, it's not -- there's, you know, limited supply and limited infrastructure to make that happen, but I'd like to --

I think it's important to key off of the fact that if there's a playbook where, you know, people can learn how to do it -- you know, how do you do it if you're not in a multispecialty group practice that's owned by an integrated delivery system?

How do you do it if you're a one in two, you know, individual primary care practice? What about the specialists who often get burdened with these behavioral health challenges and really have no ability without completely blowing up their practice to get the patients connected to behavioral health?

I mean, it's very arduous and we need to simplify it. So there's one, the need and recognition that behavioral health is a critical component that really will impact care coordination.

When you think about all of the specialties where care coordination needs to be embedded, behavioral health probably is at the top of the list.

And then if you think about that, then what are the multiple permutations on how

to deliver behavioral health services to the community of practitioners and patients in a rural setting, in an urban setting, and get that out there so we don't have to have multiple chemistry experiments like you were saying, Kavita.

DR. LIAO: At the risk of oversimplifying it, I like that idea of a playbook, and I wonder if the way that I'm hearing in some ways, Jeff, from what you're sharing is there's multiple versions of it. There's multiple playbooks.

I think if you have an integrated system that has multigroup practice that has a large enough footprint that spans the gamut where you can actually zoom into what Lee was describing, kind of primary to hospital, hospital to post-acute and back, I think that looks a certain way.

Many of the comments I've heard today feel like aspiration actually, you could get there. I think it's much less interdependent than on the other side where you have one, two, three, five primary care doctors

who need those data feeds, who need infrastructure, or the subspecialists that have analogous issues.

Without really an infrastructure, I think it bears being overcome on that side. I think it's hard to take those really important values that might work in that more integrated setting and say we can use it here too or we can begin to get there.

I think it's very unlikely, so I'm just trying to braid together some of what I'm hearing, and maybe there's a distinction there about what the near-term targets can be, and within that, what PFPMs can reasonably do.

CHAIR BAILET: Well, I agree with you, Josh, but I would challenge the folks who are listening in. We've got over 170 people from around the country listening to our discussion today.

I know, I know that there are communities that have solved this problem across the entire clinical spectrum, from integrated delivery systems to very small practices as you just described, and we need to

make sure that their voices are heard and that we get, we collectively --

I mean the people, not just the PTAC, but the people who are trying to establish and create these models and then pay for them, that CMS and CMMI hear from that stakeholder community and understand how they did it and then incorporate those elements into a model and into a playbook.

I think we talked about stakeholder technical assistance, and I know that that's not something that the PTAC is set up to do, but we certainly can raise that issue and encourage CMS and CMMI to pursue it, so thanks for that point, Josh.

DR. WILER: I'm going to make an adjacent point, but one that I still think would help ultimately the stakeholder community and the idea of a toolkit.

And Lauran, you discussed this earlier, and that's that we wait for randomized controlled trials to be published in the peer review literature to justify big moves because, right, this is high stakes.

You know, we're looking at large populations of patients, you know, big dollars potentially, and so there's often a reluctance to make decisions without that really hard evidence.

That said, I think, Jeff, to your point, there is excellence out there across the country that we may hear about in various pockets, but it's not escalated and made transparent or celebrated in spaces that are outside of traditional research.

So, I think really there's an opportunity to partner these care model clinical operators where excellence is happening with our health services researchers, our implementation scientists, and really link them together, because there are excellent outcomes that are out there that have not been described, and I think that's really where there's a gap.

MS. HARDIN: I just want to follow on what Jen said. I completely agree, and when you think about it from an equity perspective or social determinants of health, they spend a

lot of time in the most extreme spaces. They're also often the most under-resourced from a financial perspective.

So, it can be very difficult, but it also can be a land of tremendous creativity and creative solutions, and I think there's a great opportunity there to highlight some of the lessons from working with outliers that can really translate to a broader systems change.

There isn't competition for that market often, and so the people working in that space are often collaborating in new and different ways, and in working individually with care coordination for patients, simultaneously working on what are the system changes that need to be followed, whether it's build the ecosystem and services or process improvements between systems so that we stop creating more complexity and more people in this bucket.

And those lessons, I think, are very valuable to translate in the care coordination space because they start to not only improve outcomes for the patient and family, but

actually change the root cause in the system, but a lot of them are not in the literature because of the lack of research support.

VICE CHAIR CASALE: And just to add on again to those comments, and I think to Jen's point and it was brought up by the PCDT, you know, if you look at care management, I mean, it's been hard to prove in terms of sort of cost effective and cost point.

I mean, and as several of the SMEs talked about, you know, and they brought up how, you know, the idea of just looking at ED and hospitalization as the outcome is really limiting.

And so to the points being made that there are many creative -- just to emphasize, there are a lot of creative models and to rely on sort of either a randomized trial or sort of this pre/post kind of analysis with all sort of -- it may not be the answer as opposed to sort of the real world experience of what's working.

DR. LIAO: This kind of reminds me of an analysis I did a number of years ago actually about the BPCI program where, you

know, because of the DRG payment, most of the attention looks at what happens after the hospital, where they go, how much care they use.

And we were able to look at data in the hospital and see are the hospitals reducing costs, you know, and what are they doing to quality, and that gave just a total different lens to the data.

This is a very specific example, I think, but it speaks to the broader point that without that, it's going to be hard because our eyes will be drawn to where you can count the dollars or count the quality and not see other places, and I think that's to our detriment.

So, I think, you know, Jen's comments and others about kind of bringing attention to it and kind of finding ways for researchers and people who study data to work with communities of excellence, I think is really critical.

CHAIR BAILET: I wanted to talk about shared decision-making. It was brought up by Sandra in the SME panel and Robin also

talked about engagement, the patient engagement.

And my feeling about shared decision-making, it's easy if you say it fast, but it's very complicated, but when it's done and it's done well, it's incredibly impactful.

There's been lots of studies that have showed of all of the things that have been the cost curve. Shared decision-making is the number one or one of the sort of primary ones that actually bends the cost curve.

When patients have the information they need, not only does their mental health improve, but so does their clinical status, believe it or not. Even when they looked at patients with end-stage cancers, shared decision-making actually improved the overall health status of those patients.

And if you think about if you're a patient and you want to get the information -- we talked about the care coordination. Those are lots of different points if you think about points of providing potential insights that help the patient navigate their care.

And so there's -- the care coordinator has a lot to do with that, but it's also the clinical community that has to weigh in, the care team if you will. It has to weigh in and make sure that the patient is informed.

In my experience, not everybody is good at care coordination. Not everybody is good at having those shared decision-making conversations with patients. It's not like a gene for shared decision-making. It has to be a learned skill.

And if you look across at folks who have led large practices or had exposures to lots of different clinicians in their day, some you'll find that are really, really good at having those very critical, crucial conversations with patients to help them and their families make the right care decisions, which sometimes, we talked a little bit about it, is not some aggressive procedure, but actually going down more of a palliative care road that is more appropriate, and certainly I think from a mental and clinical outcome standpoint is probably more cost-effective.

The dollars will follow. My belief is you can't set it up for dollars. You have to set it up for what's doing the right thing and then I think the dollars will follow.

So, I just, I wanted to make sure that we did not lose sight of shared decision-making because it's critically important.

DR. LIAO: Just a quick comment on that. I'd say that you're right. It's easy when you say it fast, and even faster when you say SDM[61] and just acronymize it.

But I do think one of the key things behind that, for me at least, is that, to your point, I think, Jeff, is that behind that decision, it's agnostic to the dollars. It's saying let's do the right thing. Let's have that conversation. If it leads to this care, or that care, or neither, that's good.

So, I think as I step back and see kind of the communities that have come to discuss care coordination and the comments we've heard from SMEs today about we mean different things, right, it's not a semantic

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exercise.

I think it is because some people come in the back of their mind, it is a dollars thing, so behind the decision, they were trying to, you know, solve that issue.

Other people are thinking from a how do I get evidence-based guideline concordant care, which oftentimes, especially with an equity lens, may mean more care, right?

And if we adopt a view that says let's do the right thing for people and their caregivers, what direction to go, I think it's yet a different, and healthy, but a different view, and so I do think some coming to the middle on that issue is helpful. It plays out in definitions, but probably other areas too.

CHAIR BAILET: Thank you, Josh. Any other comments? I don't want to -- we've got a few more minutes.

I think one of the other comments I wanted to make was about disruption. You know, I find myself, if I don't purposefully monitor my thinking, I go down the traditional health system, health care, hospital, clinic, that

kind of care delivery.

But I'm here to tell you, you just have to open up the journal, any journal, any day of the week, and you'll see all of these new companies that are coming out into the marketplace that are causing and creating a significant amount of disruption and changing the paradigms on how patients and how family members get access to care.

And a lot of it is good. Most of it is good. And certainly the health care system, I think, needs this injection of disruption to get us to move forward, but I do think we need to also understand that there are going to be patients of these disruptive companies as they enter the primary care space, Medicare Advantage, all of the venture capital dollars that are going into it, and there is a boatload.

We need to understand, try and look over the next mountain and see what the ramifications are for all of this consolidation and all of these new, young, energetic companies that are introducing the marketplace

and disrupting the delivery system.

And again, it's a little off point for care coordination, but a lot of what makes these companies successful is their ability to get in there and connect directly with a patient and their family and coordinate their care in some way, albeit primary care or otherwise.

And so I just think it's something that we should just call out and make sure that CMS and CMMI have the bandwidth and the attention to pay attention to these new companies and their approaches to the marketplace because I don't think they're going away, and they're going to become more pervasive, not less, and we need to make sure that the payment models and the clinical models support them.

DR. FELDSTEIN: So, Jeff, you must have been reading my mind because this week you had Medical One acquiring Iora Health, which in the Medicare Advantage space, just basically builds their model around care coordination.

And there's a lot more publicly

traded companies that are growing and growing, and their primary focus for obvious reasons are commercial products, but we do need to understand what their, you know, downstream effect will be on the Medicare space and Medicaid.

And, you know, it may behoove us at some point in time to do a miniature version of what we did today with a select group of those companies so that we can get a better feel and understanding of how they're looking at the future of care coordination because quite a few of them are care coordination companies.

CHAIR BAILET: You're right, Jay, and look, I'm in complete alignment, which is why I brought it up, and you can see. You don't have to think too deeply.

You can see positive benefits. That's an oxymoron, but you can see benefits, but you can also see downstream ramifications that might be harmful.

You know, cherry-picking isn't the right word, but if certain care mixes gets shifted into certain models and hospital

systems are left holding and caring for a disproportionate number of more challenging patients where the economics are not as favorable, you can imagine there's a lot of downstream consequences, and that's why I think we need to get ahead of it --

DR. FELDSTEIN: We do.

CHAIR BAILET: -- now, so we can be thoughtful and not have to get behind the curve. I think that's your point, Jay.

DR. FELDSTEIN: Right.

CHAIR BAILET: -- if we can, you know, bring these people in and start developing a dialogue.

DR. FELDSTEIN: Because it cuts to the equity issue, you know, it really does.

CHAIR BAILET: Yeah, absolutely, and very deeply. It cuts very deeply. Lauran, you were going to say something?

MS. HARDIN: I was just going to follow on to what you said. So, I think there's a couple of disruptive but valuable ideas that are coming forward from a lot of those companies, and one is that screening and

addressing social determinants of health isn't an optional activity.

It should be required just like a medical head-to-toe comprehensive assessment. It is part of holistic assessment and care of a person, so that as a principle is key.

And then the other principle I'm seeing many of them operate on is high utilization, whether it's the emergency room or in-patient, is a metric that indicates systems failure.

There isn't a reason someone should access the emergency room 100 times in a year. There is no clinical reason for that. There is no clinical reason for utilization beyond a certain threshold, but we don't hold accountability for that in the system now.

And taking that in deeply, the people who are doing that are starting to change how they approach what they're delivering, and it makes it less vulnerable to disruption from (audio interference) sort of approach and cherry-picking certain parts of the population.

CHAIR BAILET: I think just for the purposes of our colleagues who are listening in and trying to track our comments, if you would indulge me, I'll just read through the rest of the framework to make sure that there might be other comments people are thinking about that might not have been raised yet, and this is around the role of APMs and physician-focused payment models.

The two bullets under that are how can APMs and PFPMs help to incentivize the optimal use of care coordination? Clearly, some of our model submitters who talked today, they believe and have embedded those concepts into their models.

I'll just read through the questions and then we can open it up. What types of payment models are likely to incentivize care coordination, including specific care coordination functions?

That's under the role of APMs and PFPMs. Any comments from the team that haven't already been made that people want to make in that section before we move on?

VICE CHAIR CASALE: Yeah, I would just say what was said earlier, that really focusing from the encounter to the journey is going to then incentivize the importance of care coordination in whatever model.

CHAIR BAILET: Yeah, Lauran, are you still on? We might have lost Lauran.

DR. MILLS: I was just going to add I agree with Paul, but it's almost maybe it's too simplistic, and I have a simple brain, but essentially there shouldn't be an APM that doesn't include care coordination in the domains that are important in that venue. I mean, it's table stakes.

CHAIR BAILET: Well, certainly, Lee, the Secretary thought so. That's why it was one of the criteria, right?

DR. MILLS: Yeah, right.

(Simultaneous speaking.)

CHAIR BAILET: And we're all in on that, for sure.

DR. MILLS: You bet.

MS. HARDIN: I think I'm back, Jeff. I think what was really interesting this

morning and also I heard it as a theme from our presenters is the concept of can we really create integrated care coordination across payers, so payer agnostic, that it's a principle of what we deliver from the health care system. I think that's where there's real promise for significant change.

CHAIR BAILET: Well, it's good that you mention that, Lauran, because we had a conversation with Liz Fowler in the morning prior to the public session, and one of the things that we talked about was a multi-payer strategy given the challenges that CMS and CMMI have as it relates to model development, and commercial payers are often better positioned to test in smaller communities given CMS and CMMI's reach.

And I think that there -- you brought it up and I'll just say it here for the purposes of our report, I do think a multi-payer strategy in coordination with the commercial payers is going to be critically important because they offer optionality that is challenging CMS and CMMI.

When you talk about the timeline of model development, it's very long, and there's reasons for it and I'm not being critical, but it takes a long time to get a model from concept to deployment. You know, 18 months to 24 months has historically been the case.

Now, I know they're working to speed that up, but nonetheless, that is a challenge, and I think the commercial payers can add a lot of value here, and they have a lot of insights, and they already are working in this space, but it would be great if more of that energy could be coordinated.

MS. HARDIN: Agreed.

VICE CHAIR CASALE: And I just wanted to add on I was just thinking about what Lee said about table stakes, which I think is right, and I think that's --

You know, as we've reviewed so many of these models, you know, we felt that, you know, a certain number of the models really, whether they commented on care coordination, they really didn't sort of do a deep dive and really give us enough to believe that there

was, you know, that it would really be well coordinated, others were better.

But even in the ones that sort of met, you know, looking at the PCDT and some of the information that was in there, you know, it seemed that the majority were focused on specific populations, and I think we tend to do that.

We tend to, you know, think around whether it's a clinical condition or, you know, a specific piece of the journey I'll go back to, and really going from that sort of whether it's a clinical condition or a clinical type of population to that broader, I think it continues to be extremely challenging.

I think we've learned a lot today to help flesh that out further, but there's still a lot of challenges around that.

DR. LIAO: And I just had one comment within that which is kind of going back to that piece of the journey, if we can think of care phases not as an exact proxy for, but kind of steps in that journey.

When I think about the models that

have existed, again, there are some that are focused on hospital to post-acute, some that are focused on primary care exclusively, and some that are thinking about populations and types of providers, so to speak.

You know, one of the -- I'd actually be really curious what other people think, but when I look at the landscape, what I don't see as much about is that node, if I take the analogy of hospital to post-acute, that node between primary to other specialty care and that referral process out and back in, right, which is one I think we would all agree has some opportunities for greater equity, or quality, or maybe utilization changes.

And so I just want to kind of say that as one specific area within the context of covering the journey. That seems to be an area we have fewer pieces of evidence.

VICE CHAIR CASALE: Yeah, I agree.

CHAIR BAILET: Let me -- I just have a few more, five more bullets that I want to make sure at least we raise them.

We talked about measurements,

certainly in both the subject matter expert and the proposed submitter panels today, but what are the best ways to measure the quality and effectiveness of care coordination?

And I think that maybe we could spend a minute on that. If people have thoughts about that, I think it would be important to get them on record.

VICE CHAIR CASALE: Well, I really like the idea of the patient or the family, you know, weighing in on if they feel their care is being coordinated. You know, as I said, I know I keep bringing up the ROI is often focused on the ED and the hospitalization.

I mean, that just falls way short of what, you know, what I think we really want to look at, and somehow that patient -- I mean, some patient-reported outcome that really speaks to that, I think, would be really helpful.

DR. COLLA: Especially in light of like so many of the studies that focused on costs and the fact that, you know, there are cost savings being able to point to better

measures of patient satisfaction, or I can think of things like the collaborative measure which is asked of the patient or the family. It could be really great also in improving its value.

CHAIR BAILET: Thanks, Carrie. I liked what Lee said this morning about outcomes to avoid versus outcomes to achieve.

That stuck with me, and I think I wholeheartedly am on board with that principle, that we need to move away from the avoidance and move towards the achieving outcomes. Bruce, you had a comment?

MR. STEINWALD: Yeah, I was going to follow up on what Paul said, I guess. You know, I go back to my family situation that I reported on earlier. We hired a navigator. A navigator is not a care coordinator.

In fact, I think it was Lauran that said navigators are transitional, but the navigator did the needs assessment and got the resources in place for us to look after my mother-in-law, and in 18 years, she had one

brief hospital admission for a TIA[62].

I'm totally convinced that if we were left to our own devices, we would have spent thousands of Medicare dollars on her going from -- she had multiple chronic conditions.

She might have had surgery that we decided not to go on, and so many of the stories that you hear about people like her being passed from specialist to specialist, incurring a lot of expenses and not necessarily much quality of life.

The problem is measuring those benefits is really difficult. You know, maybe if we were in a thousand person clinical trial with, you know, some people getting traditional care and some people getting coordinated care, you could find the metrics.

But I guess my point is to make sure that our base is broad enough that when we start to talk about what families can do for aging relatives or others with chronic conditions, there is a lot that we could do and

62 Transient ischemic attack

did, but the problem is, of course, you don't -
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We can't measure how many hospitalizations we avoided or how many trips to the emergency room we avoided. I'm convinced that we avoided a lot, but I just don't know quite how to measure it.

CHAIR BAILET: Thanks, Bruce. Other comments on measurement before we move to the next question?

MS. HARDIN: I was just going to add that emerging interest in including measures of equity.

So, in addition to just aggregating the data and outcomes by race, ethnicity, and other factors, looking at impact on equitable issues like housing, food security, some of the social determinants on access to care is just emerging as an area of real interest and continuing to round out the return on investment value case.

DR. WILER: A comment I would make is what one of our SMEs highlighted, and it appears in this space, and I think in as much -

- said this. You know, it's beyond those traditional outcome measures that you all have noted.

It's going to be about process measures and sub-process measures, and again, back to the data and how easy is it to access, but it may be not proof that you made a phone call, which is the example one of our SMEs gave, that just because you made a lot of phone calls doesn't mean there was an impact on outcomes.

But maybe having a forced conversation or having a certain type of, you know, group involved in the care, let's say, from a community health perspective, you know, those are the kinds of measures that we haven't previously tracked in terms of engagement that may ultimately be important to outcomes.

And then I want to second this comment about PRHOs [63], patient-reported health outcomes, and how nascent the data is in that space, but yet how important we think it is, and there have been some medical specialties,

63 Patient-Reported Health Outcome

including some that come before this panel, that have leveraged PRHOs and showed their impact.

So, I think that's an important place for us to look to try to see if we're providing high-value care, especially in these areas where cost avoidance is nearly impossible to calculate.

DR. MILLS: Yeah, I appreciate those comments and agree. I would pick up the thread that someone said that the ambulatory CAHPS survey is tired, not measuring the right stuff, and at this point, it's an activity and an industry.

It's not necessarily useful information, you know, for what happened 14 months ago by the time you get the results.

So, I also heard strains about all of the challenges of metrics, that it feels like, and again, Dr. Wiler probably can resonate with this. The metrics are so methodologically precise, but so difficult in the real world to implement that we're trying to be too smart, and sometimes we're letting

the perfect get in the way of the very good.

The average group leader, without hiring data architects and a team of fixed informaticists, you can't build the data systems that collect the information.

So, maybe it is process measurements and a bundle measure like we have bundled diabetes measures, a bundle of a combination of some semi-outcome and some process measures that capture more of the heart of coordination than anything does now.

DR. LIAO: Jeff, if you're reading Jay's mind, I think Terry may be reading mine. I was thinking the word CAHPS as he said it out loud, but, no, but I do really just want to underscore that point about drilling down the not.

And I think there are many reasons for it, but one as you think about precision is that even if you could resource it and get those measures, the ability to tie that back to any clinician, the reliability of that and the validity of it is really hard.

And actually you see that with the

CAHPS, right, where you say is that reliable in any way? We got it. We got what we wanted and we're not -- we don't have what we want, and so I think having some range there about what the measures should be, I think is important.

CHAIR BAILET: This is a great discussion. Let me just cover the last three here. We talked about research. Is there other additional information that is needed around this care coordination issue, including research questions?

I think, Jen, you brought up some research, needing research around this. Any other comments on that before we move to the next segment? Yeah, go ahead, Carrie.

DR. COLLA: I was just going to add like I've just been thinking about the different setting issue, that, you know, it's possible for care coordinators to be located out of lots of different settings.

And I don't think we have good research on if there's a way to coordinate across those settings too, like beyond the patients being discharged from the hospital.

Should that still be in primary care?

And I'm just thinking of research like comparing the care coordinators just being out of a primary care setting where you hope there's a longitudinal relationship compared to, you know, a transition manager at the hospital or something like that in terms of research too.

Because it seems to me that it may be that just having the care coordination out of the primary care could achieve those other things, but right now, they're not either like looped in or incentivized to do that.

CHAIR BAILET: Thanks, Carrie. I have two last points here before we wrap up. One is insights from all of us or the Committee on review of care coordination components for future PFPM proposals.

Is there anything that jumps out that we would like to see embedded in stakeholder proposals on the go forward based on care coordination?

DR. LIAO: I'd just reemphasize a point that I made a little earlier, which is

that primary to other ambulatory care, that transition, I think ostensibly it's covered under more quote "global" models like ACOs and others, but I think having some precision around that could be good.

DR. COLLA: I was just going to add, it's kind of building on my prior comment too, but if these are specialty models, is there a plan in place also to communicate back to primary care? --

CHAIR BAILET: Yeah.

DR. COLLA: -- and coordinate with primary care?

DR. FELDSTEIN: You know, and the other one, Jeff --

CHAIR BAILET: Go ahead.

DR. FELDSTEIN: It has to incorporate behavioral health, it just does --

CHAIR BAILET: Yeah.

DR. FELDSTEIN: -- regardless of what specialty it comes from for primary care.

CHAIR BAILET: Agreed.

DR. MILLS: I would add to all of that just this concept of not robust and

rigorous in terms of the research, but just operationally clinically robust because that's what the patients need, is linking the community resources.

I'm not so sure I'm totally bought off that an 18-page formal care plan is what makes the difference, but understanding that to your patient, their goal is to walk to the driveway and get the mail and back without having to stop to breathe.

That type of knowledge of the patient's concrete needs and desires, as opposed to you think it's about that they want to make their echo appointments and that sort of thing, it makes a huge difference, and so I'd like to see that type of activity more incorporated into the plan.

CHAIR BAILET: In the patient's words, Terry, right?

DR. MILLS: Absolutely.

CHAIR BAILET: Right.

DR. WILER: I'd like to comment on a charge that Dr. Nedza gave to the community and that's around more interspecialty collaboration

while thinking about these models.

I think there's an opportunity not only to do interdisciplinary care coordination, which would be focused on a lot, but I do think that the stakeholder community interspecialty collaboration, which we've seen in a couple of the models, but I think could be more expanded, is something where there's an opportunity beyond just primary care, one specialty as an example.

CHAIR BAILET: Thanks, Jen. All right, we're rounding, we're cresting the hill. The last one relates to the stakeholders themselves on potential insights that we can provide to them as they think about developing their proposals. Yeah, someone wanted to make a comment? So, that was the last one.

So, what kind of advice that we haven't already shared which we can incorporate in the report to the Secretary that we'd want to flash to the stakeholder community on, hey, if you're thinking about a proposal that we haven't already touched on, is there anything else that we'd want to add for their

consumption?

MR. STEINWALD: I'll offer this quickly. You know, we have three criteria that we have promoted to be the most important, and care coordination is number seven, and we might want to say something.

I don't know if we want to change the ranking, but say this is something we regard as very important, not that the other criteria aren't, but maybe we'd want to highlight that.

CHAIR BAILET: Well, that's a big point, and I guess we have the Committee on the line. Maybe, Bruce, we can make that more of a formal request.

We don't have to say it's a high priority item, or we could, but we'd maybe want to talk offline about revising our descriptions of the 10 criteria and where they rank and how care coordination sort of falls out.

Because one of the reasons we're having this theme-based meeting is because of what we've observed over the models that have come in around some of the soft spots around

care coordination, and so perhaps we need to revisit it.

I guess my feeling is we probably do, so thank you for bringing that up. How do others feel about that?

DR. MILLS: You're welcome, Jeff.

(Simultaneous speaking.)

VICE CHAIR CASALE: I think we've been at this for, whatever you said, five or six years now, and it is a good time to relook at what we think are the high priority ones. You know, I think there are more opportunities for physicians to participate, so I don't think it's been a priority.

So, you know, that may not necessarily be as much a priority as it was when we started, so, yeah, I think we should relook at all of that.

DR. MILLS: Yeah, I agree.

CHAIR BAILET: Kavita, did you have your hand up? I wasn't sure.

DR. PATEL: Just what Paul said, I completely agree, and if anything, just given the refresh on like, you know, thinking about

APMs, it might not be bad to take a look and also align it to some of the priorities that we know, not just CMS, but kind of the care space is interested in.

CHAIR BAILET: And I remember, Kavita, I think you were the architect, not in a vacuum, but you worked with the Committee. I think you led the charge in developing the Secretary's Criteria, not developing them, but incorporating them into our process --

DR. PATEL: Right.

CHAIR BAILET: -- if I remember, because there were more than 10 and we ended up with 10, and so.

DR. PATEL: Yeah, Bruce gets -- there's credit to go around, but, yes, and that was when we didn't really know what we were getting into, so it will definitely be more informed now.

CHAIR BAILET: For sure.

MR. STEINWALD: There's blame to go around too, so --

(Simultaneous speaking.)

CHAIR BAILET: Okay, so as we wrap

this up, I think this has been a great session. I think the panelists' sessions have been also incredibly informative, and I would like to turn to our colleagues, our ASPE colleagues and NORC who have been following every word, any input?

Any comments, Audrey, Steve, or Nancy, that you made listening in that you think we should do before we wrap up today's session or any questions you have of us that need clarification before we wrap up?

MS. McDOWELL: So, this is Audrey. I don't have any questions.

CHAIR BAILET: Thank you, Audrey.

DR. SHEINGOLD: From my perspective, I think, you know, we'll all have the challenge now like we did with telehealth of taking the incredible amount of valuable information we got today into a report like we did on telehealth, maybe a little quicker, that really boils it down to what's most useful for the Secretary and for the Innovation Center.

*** Closing Remarks**

CHAIR BAILET: Great, thank you for that, and I just want to thank everyone for participating today. These sessions obviously were originally designed to be in person.

That was the way the Committee functioned, and I miss that, and hopefully we'll have the opportunity to get back together soon, maybe in the September meeting.

It's still not clear if that's going to be virtual or not, but I just wanted to thank publicly my colleagues on the Committee and also the public for leaning in and providing your attention, and I know we'll get comments after the meeting.

We've explored many facets of care coordination today and how it relates to Alternative Payment Models. As I said this morning, we will continue to gather information on this topic through a Request for Input.

We're posting that on the ASPE PTAC website, a link that will be circulated through the PTAC listserv, so watch out for that.

Our next public meeting, as I said, is in September. We're excited for the next

theme-based topic, which is optimizing equity and social determinants of health in the context of Alternative Payment Models. We touched on some of that today.

I want to thank you all for taking time out of your day and your busy schedules, those leaning in and listening in, and also those that participated. I'm very grateful for our panelists as well. Please take care and be well, and the meeting is adjourned. Thank you.

(Whereupon, the above-entitled matter went off the record at 3:55 p.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

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Before: PTAC

Date: 06-10-21

Place: virtual meeting

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Neal R Gross

Court Reporter