PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

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PUBLIC MEETING

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The Great Hall
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

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Monday, June 12, 2023

PTAC MEMBERS PRESENT

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

STAFF PRESENT

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

*Present via Webex

A-G-E-N-D-A

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

9:30 a.m.

* CO-CHAIR SINOPOLI: Good morning, and welcome to this meeting of the Physician-Focused Payment Model Technical Advisory Committee, known as PTAC. My name is Angelo Sinopoli, and I'm one of the co-chairs of PTAC, along with Lauran Hardin, sitting here beside me.

Since 2020, PTAC has been looking across its portfolio to explore themes that have emerged from proposals received from the public over the years. After each theme, the Committee releases a public report to the Secretary of HHS[1] with its findings.

In March, PTAC released its report to the Secretary on optimizing population-based total cost of care models, and I encourage you to find it on the PTAC website.

Back in June of 2021, PTAC explored care coordination through one of the theme-based discussions, and care coordination has continued to come up at probably every one of

1 Health and Human Services

our public meetings since then.

Also given that the Innovation Center at the Centers for Medicare & Medicaid Services is focused on driving accountable care, PTAC is continuing to explore key issues related to the population-based total cost of care models. We decided to organize this public meeting around diving into how management of care transitions can be approved -- improved, specifically in the population-based context.

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

Before our first presentation of the day, we're honored to have opening remarks from Dr. Liz Fowler, the Deputy Administrator of CMS and Director of the Center for Medicare and Medicaid Innovation.

Dr. Fowler previously served as Executive Vice President of Programs at the Commonwealth Fund and Vice President for Global Health Policy at Johnson & Johnson.

She was Special Assistant to President Obama on Healthcare and Economic Policy at the National Economic Council. From 2008 to 2010, she also served as Chief Health Counsel to the Senate Finance Committee Chair, where she played a critical role in developing the Senate version of the Affordable Care Act.

Welcome, Liz.

DR. FOWLER: Thanks so much, Dr. Sinopoli, and welcome, everyone, and thanks so much for being here today. I'm sorry I'm not there with you in person this morning.

Before diving into today's meeting, I just want to take a moment and thank PTAC and all the speakers from the March meeting for the really valuable input from that session.

As I mentioned in March, the Innovation Center's specialty care integration team has been working on a specialty care strategy to drive better integration of primary and specialty care to serve those with chronic or serious conditions through our models.

And at the March meeting, the last time we were together, the team posed the following questions for PTAC's consideration.

What are the current challenges related to specialty integration and advanced primary care models and ACOs[2]? What strategies and approaches would best support increasing specialty care provider engagement in ACOs where specialists share accountability with primary care providers for providing high-value care and bearing appropriate financial responsibility for patient outcomes?

How should high-value specialty care be defined? And what are the appropriate performance measures for assessing specialty integration?

And I'm really pleased to support that a lot of the conversation and discussion at the March session is helping us to answer these questions. So just a round of thanks again.

Of course there's still a lot of outstanding questions to be answered as part of that strategy, but the March meeting was really immensely helpful, and we look forward to ongoing discussion.

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2 Accountable Care Organizations

And that's why I'm also looking forward to building on our previous sessions over the next two days as this focus is turned to improving care transitions management within population-based total cost of care models.

The topics outlined to be discussed are really right on target in my view: innovative approaches for improving management of care transitions across settings of care, financial incentives for improving care transition management, addressing care transitions in APM[3] design, and then also measuring care transition quality.

Staff from across the Innovation Center are live streaming the public session, and I look forward to hearing a report of today's robust and informative conversations.

Before closing, I just wanted to provide an update on the Innovation Center's new primary care model that we announced last week called the Making Care Primary, or MCP, model. The model is set to launch on July 1, 2024.

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3 Alternative Payment Model

The Making Care Primary model is built on the foundation of over 10 years of testing primary care models, the CPC[4], CPC Plus, and current primary care first models, to make advanced primary care available and more sustainable for smaller, independent practices serving a diverse set of patients to improve quality, health equity, and overall patient care.

Some of the distinguishing features of MCP compared to previous CMMI, current CMMI primary care models include first of all, an on-ramp for primary care providers and practices who are new to value-based care.

The model includes an explicit focus on smaller independent practices and safety net organizations, including FQHCs[5], many of whom are serving rural areas. And for eligible providers, the model will provide up-front infrastructure payments.

State partnership. Previous models have had a broad geographic scope, and MCP is focused on fewer states in a greater depth. We

4 Comprehensive Primary Care
5 Federally Qualified Health Centers

announced eight states participating in the model: Colorado, North Carolina, New Jersey, New Mexico, New York, Minnesota, Washington, and Massachusetts. And we're actively working with state Medicaid agencies to achieve meaningful multi-payer alignment.

These states have agreed to align with CMS in areas of quality measurement, data sharing, and learning supports and a move away from fee-for-service.

Third, a longer model test. So as all of you in the room know and on the line know, it takes time to demonstrate results and achieve transformation, and particularly in parts of the health system that have been historically under-resourced. And for that reason, we set the model to run for 10 years, compared to our usual five years.

And then finally, related to last March's topic, we are really looking at integration of primary care and specialty care as part of this model. The model includes elements and strategies to drive better integration of primary and specialty care to serve those with chronic or serious health

conditions.

And this includes supporting electronic consultations between primary and specialty providers and co-management for those with chronic conditions that require primary and specialty care to work together.

The model creates up-front financial support to practices, as I mentioned, to deliver whole-person comprehensive care. But it also creates a pathway for participants to adopt prospective population-based payments and gradually assume greater responsibility and accountability for their patient populations.

And it does this by creating three tracks with the expectation that providers will move up the track as the model progresses. The first track is building infrastructure and is reserved for participants with no prior value-based care experience.

And participants will begin to develop the foundation for implementing advanced primary care services such as risk stratifying a population, reviewing data, building out work flows, identifying staff for chronic disease management, and conducting

health-related social needs screenings.

Certain eligible organizations in track one might also receive a one-time up-front infrastructure payment meant to support investment in tools and staffing, needed to support care transformation.

Track two is really implementing advanced primary care. We expect participants in this track to partner with social service providers and specialists, implement care management services, and systematically screen for behavioral health conditions.

And then track three is really optimizing care and partnerships. And in this track, we expand on the requirements of track one and two by using quality improvement frameworks to optimize and improve work flows, improve care integration, develop social services and specialty care partnerships, and really deepen those connections with community resources.

We're planning on releasing more details in the coming months. Our application period will open later this summer with the release of the request for application.

And for more information on how we see the primary care model fitting in with our larger strategy, you can find a blog on this topic on the CMS Innovation Center's website.

It outlines our portfolio-wide primary care strategy and the goals to strengthening primary care infrastructure in the United States by really creating multiple pathways to support improved financing for advanced primary care, equitable access to high-quality primary care, and sustainable transformation across a wide variety of practices.

And the paper provides an overview of the Making Care Primary model, which is designed with this strategy in mind.

So I think that's maybe a good note to end on. I'll stop there and turn it back to Dr. Sinopoli. And thank you again for inviting me to join you today, and I'm really looking forward to hearing more about the care transitions and from all the speakers you have lined up.

*** Welcome and Co-Chair Update - Discussion on Improving Management of**

CO-CHAIR SINOPOLI: Thank you, Liz, for sharing all that. We look forward to hearing more about that over time. And we just want to say that we really appreciate how engaged CMS has been with PTAC, and we look forward to continuing to work with you and your team. Very much appreciate it.

For today's agenda, we'll explore a range of topics, including effective care delivery models and strategies that improve the management of care transitions. And how we can structure financial incentives and performance measures to incentivize adoption of these innovative approaches.

The background materials for this public meeting, including an environmental scan, are online. Over the next two days, we'll hear from many esteemed experts.

We have worked hard to include a variety of perspectives throughout the two-day meeting, including the viewpoints of previous PTAC proposal submitters who addressed relevant issues in their proposed models.

I want to mention that tomorrow afternoon will include a public comment period. Public comments will be limited to three minutes each. If you'd like to give an oral public comment tomorrow but have not yet registered to do so, please email PTACregistration@NORC.org. Again, that's PTACregistration@NORC.org.

The discussion materials and public comments from the June PTAC public meetings will all fit into a report to the Secretary of HHS on how to improve management of care transitions in population-based models.

The agenda for tomorrow -- for today and tomorrow includes time for the Committee to discuss and shape our comments for the upcoming report. Before we adjourn tomorrow, we'll announce a Request for Input, which is an opportunity for the stakeholders to provide written comments to the Committee on improving care transitions.

Lastly, I'll note that as always, the Committee is poised and ready to receive proposals on possible innovative approaches and solutions related to care delivery, payments,

and other policy issues from the public on a rolling basis.

We offer two proposal submission tracks for submitters to provide flexibility depending on the level of detail available about their payment methodology. You can find information about how to submit a proposal online.

* **PTAC Member Introductions**

At this time I'd like my fellow PTAC members to please introduce themselves. Please share your name, your organization, and if you'd like, feel free to describe any experience you have with our topic. First I'll go around the table, and then I'll ask our members joining remotely to introduce themselves.

I'll start. I'm Angelo Sinopoli. I'm a pulmonary critical care physician by training, presently as Chief Network Officer of UpStream. It is a value-based risk-taking organization.

We do support many rural primary care physicians in managing global risk in their practices. Prior to that, I ran a very

large network of 5,000 physicians across two-thirds of South Carolina, which as you can imagine was also very rural, and tackled a lot of these problems. So I'm very interested to hear our speakers today.

Next is Lauran.

CO-CHAIR HARDIN: Good morning, I'm Lauran Hardin. I'm a nurse by training and Chief Integration Officer for HC2 Strategies. I spent the better part of the last 20 years really focused on building care management and value-based payment with ACOs, MSSP[6], Pioneer, also BPCI[7].

And then have worked on model-building in partnership with states, government, communities, multi-state health systems. Really focused on populations who are disproportionately affected by health disparities.

I'll go to Lindsay.

DR. BOTSFORD: Good morning. I'm Lindsay Botsford. I'm a family physician by training and currently Market Medical Director

6 Medicare Shared Savings Program
7 Bundled Payments for Care Improvement

with One Medical. I'm based in Houston, Texas.

DR. WALTON: Good morning, Jim Walton. I'm a general internist by training. I currently am the president of my own consulting firm in health care. My background is a rural health care provider in Waxahachie, Texas. Health system executive for Chief Health Equity Officer at Baylor Healthcare System.

And I ran a large IPA[8] and ACO for about 10 years, and in the greater Dallas area, which included some smaller semi-rural spaces.

DR. LIAO: Good morning, everyone. My name is Joshua Liao. I'm an internal medicine physician based in Seattle at the University of Washington. There I also lead an evaluation research group that studies value-based payment models like ACOs and bundled payments, work with states, stakeholders, and decision-makers on value-based policy.

Outside of that, I also serve as Enterprise Medical Director for Payment Strategy, so implement models and work with our

8 Independent physician association

population health and value-based care teams on aligned strategies.

DR. PULLURU: Good morning, everyone. I'm Chinni Pulluru. I'm a family physician by trade. I'm Vice President of Clinical Operations and Chief Clinical Executive for the Walmart Health Omnichannel business. I lead our care provider entities, as well as clinical operations in clinics, telehealth, and social determinants of health.

Prior to that, I served to lead the clinical aspects of one of the largest provider medical groups integrated in the U.S. named DuPage Medical Group, now Duly Health and Care, and led a lot of their value-based care platforms end to end.

DR. FELDSTEIN: Good morning, everyone, my name's Jay Feldstein. I'm currently the President of Philadelphia College of Osteopathic Medicine. Trained in emergency medicine.

And prior to my current experience, I spent 15 years in the health insurance world, the last five running Medicaid plans in five states and have a lot of experience in fully

capitated and shared-risk arrangements. Thank you.

DR. WILER: Good morning. I'm Jennifer Wiler. I'm the Chief Quality Officer in the metro region for UC Health. I'm also co-founder of the Health Systems Care Innovation Center, where we partner with digital health companies to grow and scale solutions to improve outcomes for patients.

I'm a tenured professor at the University of Colorado School of Medicine, and I was a co-developer of an Alternative Payment Model reviewed by this Committee.

DR. MILLS: Good morning. I'm Terry Lee Mills. I'm a family physician, currently Senior Vice President and Chief Medical Officer at CommunityCare of Oklahoma, a provider-owned regional health plan offering commercial ACA[9] marketplace and Medicare Advantage plans on a fully capitated total cost of care basis.

My background is in rural primary care in south central Kansas. And over my career, I've practiced, operated, and led

9 Affordable Care Act

transformative APMs, including Medical Neighborhood, early BPCI, CPC Plus, Primary Care First, and multiple MSSP programs.

DR. KOSINSKI: I'm Larry Kosinski. I'm a gastroenterologist by training. I spent my entire career in private practice in the northwest suburbs of Chicago and helped build the largest GI practice in Illinois.

For the last 10 years, I've been focused on value-based care. And I'm currently the founder and Chief Medical Officer of SonarMD, a full risk company that is focused on disease management and -- care coordination and disease management in gastrointestinal diseases.

And I'm proud to say that the project Sonar, that started our company was the first PTAC-recommended physician-focused payment model back in 2017.

DR. LIN: Good morning, everyone. My name is Walter Lin. I'm the founder of Generation Clinical Partners. We are a group of medical providers based in St. Louis caring for the frail elderly in nursing homes and assisted living. It's often a very multi-

morbid population, and we do quite a bit of post-acute care work as well.

So the topic at hand, care transitions, is near and dear to my heart.

CO-CHAIR SINOPOLI: So thank you. I don't believe we have anybody online. I think everybody's here. So let's move on to our first presentation.

*** Presentation: Improving Management of Care Transitions in Population-Based Models**

CO-CHAIR SINOPOLI: Five PTAC members served on a Preliminary Comments Development Team, or PCDT, which has worked closely with staff to prepare for this meeting.

Walter, who you just heard from, led the PCDT participation with Jim, Jen, Lindsay, and Lauran. I'm thankful for the time and effort they put into organizing today's agenda and presentation. It was a lot of work.

We'll begin with the PCDT presenting some of the findings from their analysis. Additional background materials are available on the ASPE PTAC website. PTAC members, you'll have an opportunity to ask the PCDT any follow-

up questions after the presentation.

And now I'll turn it over to the PCDT lead, Walter.

DR. LIN: Thank you, Angelo. And before I begin my remarks, I do want to echo Angelo's thanks to the PCDT, the ASPE staff, and the NORC staff for the tremendous amount of work, not only putting together this presentation, but also in organizing the hopefully outstanding two-day meetings that we're about to have on this really important topic.

So just thank you for this, for all the hard work.

In terms of meeting objectives, the goal for this public meeting is to better understand how financial incentives and Alternative Payment Models can be structured to incentivize improvements in care transition management between settings of care.

To achieve this goal, we have invited a number of experts and national thought leaders to address how best to overcome barriers to improving care transition management through financial incentives.

Topics that will be covered include opportunities and barriers to improved care transition management, effective care transitions delivery model innovations and strategies, payment strategies that can be leveraged to improve care transitions management, and care transitions performance metrics that should be monitored for driving quality improvement, standardizing best practices, and facilitate benchmarking.

In terms of the agenda for this PCDT presentation, I will first discuss some definitions and background information related to care transitions. Next I'll present findings from an updated analysis of transitional care management services amongst Medicare fee-for-service beneficiaries recently completed by the ASPE and NORC teams.

This will be followed by a brief discussion on the components of an effective care transitions program. And finally I'll conclude with some thoughts that the PCDT team had on payment model challenges related to care transitions.

First, it is important to address

why PTAC is focusing on this topic. As Angelo mentioned, several of PTAC's prior public meetings have addressed issues related to improving care coordination, care delivery model design, and primary and specialty care integration in Alternative Payment Models.

Additionally, PTAC has deliberated on 28 proposed physician-focused payment models that met the Secretary's 10 regulatory criteria, one of which is Integration and Care Coordination. Many of these proposals described issues and payment design solutions related to improving care transitions management.

Thus, PTAC felt it important to devote a full public meeting to improving care transitions management through payment model design.

PTAC's working definition of care transitions is the movement of a patient from one setting of care to another, such as from a hospital to a post-acute care facility or to a patient's home. Patients often have not just one but multiple care transitions during an episode of care, and at each point, there is a

risk for patient harm and adverse outcomes if not done properly.

Care transitions management is the ongoing support of patients and their families over time as they navigate care and relationships amongst more than one provider, health care setting, and/or more than one health care service within the same or different facilities.

These services should include patient-centered interventions before, during, and after the transition that are tailored to the patient's acute condition, chronic co-morbidities, and social determinants of health factors.

The objectives of effective care transitions management are to, number one, improve quality and patient outcome and reduce patient harm. We also want to see improved patient experience through patient-centered interventions accounting for social determinants of health factors.

Thirdly, improve provider experience, ideally through the use of an interdisciplinary team to improve efficiency

and reduce burnout.

We also like to see improved population health by investing in infrastructure to coordinate care across settings, with a focus on equity and higher-risk populations, such as racial and ethnic minorities, older adults, individuals who are duly eligible for Medicare and Medicaid, and individuals with limited English proficiency.

And finally, but very importantly, reduce spending by decreasing avoidable readmissions and ER[10] visits and increasing healthy days at home.

Components of an effective care transitions management program include screening and risk stratification to identify high-risk patients; thorough medication reconciliation to reduce harm for medication errors; communication in collaboration with the patient's health care team, caretakers, and family; timely follow-up visits; and patient and caregiver education.

Foundational to an effective care

10 Emergency room

transitions management program is the complete and timely transfer of health information from one setting of care to the next. Intuitively, the more settings that a patient receives care in, the more difficult it is to achieve this goal of accurate health information transfer.

And as a result, the more likely an adverse patient outcome or a medical error will occur. At the risk of oversimplification, this is not dissimilar to what happens in the children's game of telephone, in my mind.

This slide depicts an idealized example of a care transitions journey for a patient after a stroke. The patient unfortunately suffers a life-changing stroke with functional or cognitive deficits and is admitted to the hospital for treatment.

Once treatment is complete, the patient is stable -- and the patient is stable, he or she is discharged to a post-acute skilled rehabilitation facility, followed by discharge home after achieving their goals of care. The patient initially may or may not receive home health services after a discharge home.

And after completion of this episode

of care, the patient receives ongoing outpatient care in the community from his or her PCP[11] and specialist.

Now, in this idealized example, no medical errors in any of the patient's care settings occur, and health information is transferred seamlessly, accurately, completely, and in a timely fashion to achieve perfect handoffs between each setting of care.

The patient also develops no complications during this episode of care and is able to proceed linearly to progressively lower levels of care without any setbacks.

As we all know, a patient's care journey is often far from this idealized example, and in fact may look more like this. This diagram depicts the many different destinations the same stroke patient may be discharged to. Example settings in this diagram are not intended to be exhaustive.

The light blue boxes in this slide show the linear path demonstrated in the prior slide, while the dark blue boxes show other

11 Primary care provider

potential destinations the patient may be discharged to.

Also note that at each stop along the patient's episode of care, there is a risk of readmission to the acute care hospital, which may start the patient's whole care transitions journey over again.

There are literally hundreds of different permutations a patient's episode of care can take, and each stop along the way requires active care transitions management with effective and timely transfer of health information with goals in order to optimize the patient's health outcomes. This is why care transitions management is so difficult.

From a payment model perspective, patients frequently are treated in multiple care settings by multiple providers. These relationships may not be accounted for under existing attribution approaches, which tend to focus on the provider furnishing the plurality of care or the provider furnishing care during an anchor event or procedure.

Next, I'd like to present some findings from an updated analysis of

transitional care management services among Medicare fee-for-service providers recently completed by ASPE and NORC teams. I am actually very excited to share some of these new findings that I know will help shape the discussions with our experts over the course of our ensuing two-day meeting.

First, some more background. This slide provides an overview of Medicare enrollment. In 2021, there were approximately 64 million Medicare beneficiaries, of which 58 million had both Medicare Part A and Part B.

The first pie chart shows that a bit over half of all Medicare beneficiaries were in traditional Medicare as opposed to Medicare Advantage. The second pie chart shows that all the beneficiaries in traditional Medicare -- I'm sorry, the second pie chart shows that of all the beneficiaries in traditional Medicare, 57 percent were not in a value-based arrangement like an ACO.

In other words, in 2021, over a quarter of Medicare beneficiaries were still in traditional fee-for-service Medicare. Although this number is expected to shrink over time, it

is still quite sizable and thus highlights the importance of proving care transitions management for Medicare beneficiaries in both value-based arrangements, as well as traditional fee-for-service Medicare.

So why is it important to focus on care transitions management? Put simply, overwhelming evidence has shown that care transitions interventions are associated with substantial cost savings without reducing access or quality.

For example, the care transitions intervention, a patient-centered coaching intervention, has been associated with 22 percent lower total health care cost at six months.

The University of Pennsylvania's transitional care model was also associated with up to a $4,000 lower average total care cost per patient at six months. We are pleased to have Dr. Mary Naylor, who designed this model, as a subject matter expert during this meeting.

In 2013, Medicare introduced two

TCM[12] billing codes to reimburse providers for assisting patients during the transition from an approved inpatient to a community setting of care.

To bill for these codes, a provider has to, number one, communicate with a patient or caregiver within two business days of discharge. Number two, make medical decisions of moderate or high complexity. And number three, have a face-to-face visit within seven or 14 days, depending on the patient's complexity.

We are pleased to have Dr. Robert Zorowitz, a coauthor of the original TCM codes, as a subject matter expert during this meeting.

Now, prior studies have shown that uptake of TCM codes has been slow, possibly because of the relative cost of providing transitional care services versus the financial incentives of providing these services.

There's also been a documented lack of interoperability between electronic health records, making TCM services time-consuming and

12 Transitional Care Management

challenging. And there have also been eligibility and co-insurance requirements that may be a barrier as well.

A March 2022 descriptive analysis conducted for PTAC examined the use of TCM codes in 2019, which was six years after these codes were first introduced. This analysis found that less than one in five potentially eligible Medicare beneficiaries received TCM services, as evidenced by the billing of these codes.

Larger practices were more likely to bill for TCM services. Practices that were affiliated with an ACO were more likely to bill for providing TCM services. And similarly, practices that were affiliated with an ACO billed for higher proportions of their beneficiaries who were potentially eligible for TCM.

The major takeaway from this study was that Medicare TCM services were likely not provided to many fee-for-service beneficiaries who might have benefitted from them.

Now for the exciting new news. A new June 2023 analysis, hot off the press,

examined the impact of the use of these TCM codes on outcomes during the two-year period of 2018 to 2019. Let me first give some background on the study methodology.

The unit of analysis was episodes that began from a qualifying discharge that was eligible for TCM services after an indexed short-term acute care hospitalization and ended 60 days after discharge. Results were compared for beneficiaries who received TCM services within 30 days and a similar comparison group that did not receive TCM services following discharge.

The headline is that this new analysis found that those beneficiaries who received TCM services within 30 days had statistically significant lower hospital readmission rates, lower total cost of care per episode, and more healthy days at home.

There was a significant decrease of 13.7 percent, or almost $1,000, in the total cost of care per episode during the 60-day period following discharge.

This analysis provides further evidence that TCM services as delivered in the

real world setting as opposed to an idealized academic study are also associated with positive patient outcomes, including substantial cost savings.

Taken as a whole, these two analyses by the ASPE and NORC staff teams show that, number one, Medicare TCM services were likely not provided to many fee-for-service beneficiaries who might have benefitted from them. Number two, practices that were affiliated with an ACO were more likely to bill for TCM services.

And number three, use of these services within 30 days of hospital discharge was associated with significant improvement in outcomes.

I invite our audience to think through the implications of these findings and also very much look forward to discussing these implications with our experts over the next few days.

I'd like to now turn our attention to components of effective care transitions models from the PCDT environmental scan on this topic.

So the good news is there -- that from a clinical perspective we have ample evidence that care transitions management program works. This slide shows four examples of care transitions delivery models which have been extensively studied in the literature.

These include the transitional care model from the University of Pennsylvania School of Nursing, Project BOOST from the Society of Hospital Medicine, Care Transitions Intervention Model from the University of Colorado School of Medicine, and Project Re-engineer Discharge, or Project RED, from the Boston University Medical Center.

This list is not intended to be exhaustive by any means, but the key takeaway is that effective, evidence-based transition -- care transitions models are in use but unfortunately have not been widely implemented. The question for our experts is how can payment model design help close the implementation gap between best evidence and current practice around care transitions?

This slide illustrates some selected facilitators of care transitions management,

which include collaborating within and across organizations, tailoring services to patients and caregivers, and generating staff buy-in. Successful care transitions delivery models leverage interdisciplinary team-based care to coordinate care and community services across different settings of care.

They facilitate complete and efficient transfer of information, as previously discussed. They also encourage effective communication with the patient and caregivers, both in person, as well as telephonically or remotely.

These models also tailor comprehensive patient and caregiver education and their -- and promote their active involvement in care planning.

And of course, staff buy-in and prioritization of care transitions services is critical to the success of these models, given the many competing interest providers face, limited resources, and the need for timeliness of provision of these services for them to achieve maximal impact.

What are some care delivery

challenges related to improving care transitions management? They include communication breakdowns; unplanned discharges from the hospitals; disparities in care transitions management resources; insufficient health information infrastructure, technology, and data analytics; gaps in access to post-discharge care, particularly in rural and underserved areas; limited patient awareness of care coordination staff and services; workforce availability and staffing turnover. And perhaps most importantly in my view, lack of accountability, particularly in the traditional fee-for-service Medicare model.

So the way the PCDT team has thought about enabling effective care transitions is to establish effective policy goals and payment models, such as increasing accountability and optimizing financial incentives. This is detailed in the first dark blue box.

In our vision, this will serve as the catalyst through which care transitions delivery processes can be transformed. The second box, the middle box, which will ultimately result in improved quality and

health outcomes, as detailed in the third box.

Now, the focus of this public meeting is the first box. We feel that by getting policy goals and payment policies right, delivery processes will be optimized, and quality in health outcomes will be achieved downstream to that.

Finally, I will conclude my remarks with some care transitions payment model challenges. Let's start by first acknowledging that there are many payment models in play that support care transitions.

From less risk to more risk, these include the Medicare TCM services which I just described; Bundled Payments for Care Improvement, or BPCI, advanced model design; Accountable Care Organizations; and finally, Medicare Advantage.

In addition, many current and prior Medicare programs encourage effective care transitions management through payments and penalties. These include the Hospital Readmissions Reductions Program, or HRRP; the Skilled Nursing Facility Value-Based Purchasing Program, or SNF VBP; and Community-Based Care

Transitions Program, or CCTP.

Suffice it to say that Medicare has extensive experience in payment models supporting care transitions. It is also true that there is much variation in care transitions outcomes, both quality and financial outcomes, between different payment models and even between different organizations in the same payment model.

The goal of this public meeting is to hear from our experts on how to make payment policy recommendations to better achieve optimal care transitions outcomes across the board, both under fee-for-service, as well as value-based models.

This slide provides an overview of payment model challenges related to improving care transitions management.

These include limited and/or conflicting financial incentives for providing care transitions management activities, especially in the traditional fee-for-service setting; determining accountability for care transitions quality and spending when multiple providers are involved from multiple different

settings; establishing an optimal degree of flexibility in participation requirements related to care transitions management and structuring financial incentives for participating providers; and identifying meaningful performance measures to evaluate the quality of care transition management activities.

The following slides will provide additional details on each of these payment model challenges.

From a limited and/or conflicting financial incentives perspective, there are currently limitations on who can provide TCM services. Often TCM services are focused solely in the primary care provider realm, especially from a billing and reimbursement perspective. Whereas in reality multiple specialists, as well as a wider interdisciplinary team, might be involved.

There are also issues regarding the cost of providing TCM services versus the available reimbursement for these services, especially under the traditional fee-for-service setting. There are pressures to reduce

lengths of stay in hospitals and post-acute care facilities and to discharge patients to less intensive settings of care, as well as to reduce readmissions.

And finally and very importantly, under fee-for-service, Medicare TCM reimbursement is not tied to outcomes.

In terms of assigning accountability for care transitions, in theory there's really no accountability for outcomes or spending under fee-for-service Medicare. Beneficiaries who are not attributed to a value-based program may experience worse management of care transitions and have poor outcomes related to care transitions, as suggested by the recent ASPE analysis.

Multiple providers may also contribute to a patient's care transitions journey. And attribution based on plurality of services or first touch may not account for all the contributing providers.

As an example, a patient who receives joint replacement surgery might be in an attribution approach based on plurality of services, and thus may align to a primary care

provider, but not to the hospital or post-acute care setting involved in their surgery or rehabilitative care.

Similarly, under a first touch approach, a patient might be attributed to their admitting provider but not to their discharging provider or primary care provider, who can also influence a patient's quality of care and financial outcomes.

Even under value-based models like ACOs and Medicare Advantage plans, participants can address accountability for care transitions by sharing quality performance data or distribute shared savings or losses amongst participating providers, but they are not required to do so. And so performance information is often limited, even in these settings of care.

With respect to establishing optimal degree of flexibility, patient-centered care may necessitate different approaches to care transition management, such as for patients with multiple chronic conditions, with high or rising risk, with conditions requiring acute or chronic management in underserved areas, or

with issues in access to care.

The patient panel mix may vary substantially amongst providers in regions, which should be taken into account. Requirements around provision of evidence-based services in order to receive add-on payment versus the ability to use add-on payment to provide tailored services based upon a patient panel's needs should be addressed.

From a measures and metrics perspective, there are a lot of examples out there already around the possible care condition performance measures. These include care process measures, such as medication reconciliation, communication about discharge information, utilization measures such as ED[13] visits, avoidable hospital readmissions, post-acute care utilization, and home health visits.

Spending measures such as total cost of care and setting-specific spending measures. And health outcome measures, such as mortality, frailty, change in functional status, receipt of follow-up care, and healthy days at home.

13 Emergency department

And finally, patient-reported outcomes, such as patient experience with care.

Examples of technical issues affecting implementation of meaningful performance measures in general are well known, and I won't detail them too much here, except to say from a high level, these include balancing specificity and usability.

This includes sample size issues, which affect low-volume providers, as well as some condition-specific measures. Data collection burden, capturing patient-reported outcome measures, can often be burdensome but are very important. Defining person-centered goals and indicators.

And there's also some question about the applicability of absolute versus relative skills for providers serving certain different populations.

So some options for addressing these previously discussed payment model challenges include sharing benchmarked financial and performance data in a timely manner, especially performance data that can affect predicted algorithms and risk stratification.

These might include transitional care management utilization rates, 30-day readmission rates to the hospital, ER visits, Medicare spending per beneficiary metrics, and healthy days at home.

Payment design features that shift risk to providers in the traditional fee-for-service environment could also encourage the wider implementation of care transitions activities by tying TCM payments and/or bonuses to outcomes. The whole idea of shifting fee-for-service providers to risk-based relationships is essential to value-based care.

Creating models of care that support care transitions innovation include funding non-physician roles, expanding the SNF three-day rule waivers and skill in place programs, and more recently, Hospital at Home programs.

And finally, defining and disseminating care transitions best practices include things like understanding the role of interdisciplinary teams; studying transitional care performance under bundle payments, ACOs, and Medicare Advantage to learn best practices and disseminate them; and also learn from the

rollout of Medicare Advantage's transition of care metric.

Ultimately at its core, the journey to value-based care involves increasingly tying patient outcomes to payment. Over the next few days, PTAC hopes to learn from our invited experts on how to better do this for the important area of care transitions management to improve care transitions not only for the Medicare fee-for-service population, but also under value-based care models.

We'd also like to hear from our experts on why they think providers in value-based care organizations perform better care transition management services than fee-for-service providers.

With that, that concludes my remarks, and I will turn it back over to you, Angelo.

CO-CHAIR SINOPOLI: Good, thank you, Walter, that was a great presentation and sets us up very well for the next two days. Appreciate that and all the work the PCDT members put into it.

We only have a few minutes left, but

before I open it up to PTAC members in general, I just wanted to see if the PCDT members had anything to add to that presentation.

If not, then do any of the PTAC members have any questions?

CO-CHAIR HARDIN: Walter, that was an excellent presentation. Such a wonderful foundation. I was very intrigued when you began to talk about creativity and TCM models and addressed one recommendation of funding non-physician roles in care models.

I'm curious what trends you saw in that in review of the evidence. And then also how could that potentially impact longitudinal care, which we've seen is a real benefit for consistency and quality?

DR. LIN: That's a great question, and I'll -- I'd like to open it up to my PCDT members and ASPE staff as well. But I'll take a first pass at that.

So in terms of funding non-physician roles, I think one of the things that we saw clearly in our environmental scan is the key role the interdisciplinary team plays in successful care transitions management

programs. That being said, under fee-for-service management, there aren't very many funding mechanisms for non-physician roles.

And so I think that is an area ripe for exploration. And perhaps one of the reasons why ACOs and other value-based care payment models perform better in care transitions outcomes is because of their ability to fund the non-physician roles.

CO-CHAIR SINOPOLI: Any other questions? If not, I want to -- go ahead, go ahead.

DR. KOSINSKI: Excellent presentation. I really enjoyed it. You covered it in detail.

Your study that you presented at the beginning showed the positive effect of an organization that has accountability in improving transitions, lowering costs, improving quality. I struggle with the opposite end, the number of readmissions to hospitals that occur without one claim-based encounter between the discharge and the readmission.

It's a lot more common than we would

imagine. And you know, it's great that we have a positive outcome, but we really have to focus on those negative ones. It's a big problem.

DR. LIN: Yeah, Larry, thank you for that. I agree, it was sobering to see the ASPE and NORC analysis that as recently as 2019, less than one in five eligible Medicare beneficiaries received these services that have such a big impact on both quality and financial outcomes.

And it was also very interesting that beneficiaries in risk-based models like ACOs received more services than fee-for-service models.

And so I think in my view, ultimately the answer is to shift more and more fee-for-service providers to value-based arrangements. I know that is also a CMS/CMMI goal by 2030 as well, that 100 percent will be in some sort of value-based relationship.

But in the interim, there's still a significant number of traditional fee-for-service beneficiaries who are not receiving the benefit of transitional care management services. And we really look forward to

exploring the reasons why with our experts and potentially coming up with some innovative solutions over the next two days that we can -- so that we can make recommendations to the Secretary.

DR. WALTON: Yeah, Walter, I'd like to comment. I think that, you know, kind of following what Larry was talking about, that the barrier for primary care physicians to actually participate in value-based arrangements has really fallen over I would -- my experience, four, five, six years.

And it's drifted downward where it's fairly easy and pretty low-impact because there's enough infrastructure organizations to provide the wraparound support that lowers the burden to do that, to be a primary care doctor in a value-based arrangement and be successful.

The whole theory of moving the money, you know, for a doctor, from here to there and as a mechanism, right, as a mechanism to say we want you to take on these new things and we want you to focus on these new activities in addition to running your business. And the reason -- we feel so

strongly about it, we're going to put that money right over here.

I think that what you're suggesting with TCM, right, I think is a right approach, which is move the TCM payments, you know, maybe even increase them somehow so that doctors are going to go, okay, not only will I do that work because it saves money and reduces the readmissions, it improves quality, right. I'm going to do that work, but I'm going to do it through an organization that gives me support so that I can actually optimize the care of my patients.

I think that kind of gets to the payment model that we were advised. So thank you so much for -- I think, if I'm interpreting correctly, I may be misinterpreting, but that's how -- what I got.

CO-CHAIR SINOPOLI: Chinni.

DR. PULLURU: Thank you, Walter, and the entire team. This is an excellent presentation.

I wanted to highlight one thing that you talked about with barriers that I think, you know, I'd like to double-click into,

insufficient health information technology infrastructure and data analytics.

I feel this is so foundational to our ability to do this in any, sort of in any construct. And one of the things we had in my old world was when we tried to form a high-performing post-acute network, we had the hardest time getting people to get us feeds, their ADT[14] feeds on admission discharges or any sort of information in order to be able to react to it.

So the question is, how do you see that being able to be enabled better, given some of the barriers that are there? Because it seems like it's so foundational if you want to go into fee-for-service infrastructure.

DR. LIN: Yeah, Chinni, I don't have an easy answer to that. This is a huge problem and well known. But I think especially acute in the transitions of care role because of the importance of having health information at the time of the care transitions visit. And so I look forward to exploring that with our

14 Admission, discharge, transfer

experts.

CO-CHAIR SINOPOLI: So we only have one minute left, Lee.

DR. MILLS: Thank you, Angelo.

I'm going to, Walter, return to something Jim was saying which just has really struck me that, you know, one of the drawbacks to some of the advanced models are just that they're very complex to operate. High data needs, high analytic needs, high infrastructure needs, and they're just very, very hard, especially for rural providers to have that type of infrastructure.

What we have here in the analysis from ASPE and NORC about TCM codes is incredibly powerful. It's a specific single service providing the most valuable piece of most advanced practice models, which is the transition of care, managing, if you will, the white space in the health economics of the org chart, is incredibly powerful.

And it showed that just that single service, managing that transition, saves money, prevents hospitalizations, et cetera.

And so I was just wondering,

listening to Jim talk about it, I -- less, you know, one-fifth of eligible beneficiaries get this service. Let's do more of that, let's not overthink it. Almost, you know, it takes, it's going to take a lot of thought about this.

But it's almost like there's a method here. We could use TCMs as a bridge to its own upside shared savings model. Just doing the service if you show that you reduce outcomes, you get part of that savings back. Just wondering.

CO-CHAIR SINOPOLI: Totally agree, Lee. Appreciate all the conversation and the presentation, again, Walter. And thanks to the PCDT for putting all that together.

We're going to take a quick break now until 10:40, and at 10:40 we'll come back and hear our first panel discussion. Thank you.

(Whereupon, the above-entitled matter went off the record at 10:31 a.m. and resumed at 10:41 a.m.)

*** Panel Discussion 1: Improving Management of Care Transitions from Facilities to the Community**

CO-CHAIR SINOPOLI: Welcome back. Earlier this morning, we had a great presentation from Walter and the PCD team that shared their presentation around care transitions. And it is going to be the topic for the rest of today and tomorrow.

And now I am excited to welcome our first panel discussion. At this time, I will ask our panelists to go ahead and turn on their video if you haven't already done so. Thank you.

In this session, we have invited three esteemed experts to discuss improving management of care transitions from facilities to the community. After each panelist offers a brief overview of their work, I'll be asking them questions.

PTAC members, you will have an opportunity to ask our guests follow-up questions as we go, and I encourage your participation.

The full biographies of our panelists can be found on the ASPE PTAC website along with other materials for today's meetings. I will briefly introduce each of our

guests and their current organizations and give them a few minutes each to introduce themselves.

First, we have Dr. Karen Johnson, who is Vice President of Practice Advancement at the American Academy of Family Physicians. I will note that AAFP submitted a proposal to PTAC in the past. Karen, welcome. Do you want to introduce yourself?

DR. JOHNSON: Sure. Thank you very much. Good morning, everybody, and thank you for the opportunity to be part of this important discussion.

I am, as you said, Karen Johnson, and I am here on behalf of the 129,600 members of the American Academy of Family Physicians and other primary care physicians and teams essential to facilitating smooth transitions that result in better outcomes, including improved equity for patients.

I currently serve as Vice President of the Practice Advancement Division, which works on payment practice and career-related policies and education on behalf of our members.

My comments today are also informed by a wide range of perspectives -- can you go to the next slide, please, I apologize, thank you -- by a wide range of perspectives I have gained through my work as a benefit consultant to self-funded employers. Back to the last slide. Oh, sorry, sorry. I'm misreading the slide. It's early on a Monday, folks.

I worked as a benefit consultant to large self-funded employers in union trust. I helped plan payment strategies, including primary care and value-based payment design. And also I was privileged to work on a number of multi-stakeholder data-driven improvement initiatives.

Next slide, please. So from a primary care perspective or really any practicing physician perspective, there are really a couple of essential ingredients in successfully supporting care transitions.

One is that you have to know the transition is taking place to activate your team and your resources. And secondly, you really have to be equipped with the level of resources needed to support that patient

successfully through their transition whether that is within your practice or whether that is a resource that is needed in the community that you are there to facilitate and support engagement with on behalf of your member or on behalf of your patient, excuse me.

Unfortunately, barriers to this happening continue to persist.

CO-CHAIR SINOPOLI: Karen, we think we've lost you there. Can you hear us?

DR. JOHNSON: Continue to get in the way of primary care practices receiving timely and actionable information about their patient population, one of the core principles represented in the AAFP guiding principles for value-based payment which were adopted as policy by our membership in 2022.

And when we talk about solutions for care transitions specifically, it is important to recognize that any successful improvement initiative must be embedded in a complex maze of policy and practice considerations to have meaningful impact.

We know that the typical primary care physician caring for Medicare patients may

coordinate care with as many as 229 other physicians working in as many as 117 different practices.

When one considers the number of disparate EHR[15] systems, each implemented as we know in its own unique way, the challenges to information sharing through that mechanism are really strong.

So given the visibility that payers have into the overall patient's care journey, we believe they play a really important role in this multi-layered strategy.

How they choose to approach their role can be a help or a hindrance as practices frequently contract with seven to 10 or more payers. If each payer, whether public or private, sets its own, quote, solution for ensuring physician practices receive timely and complete information, it may look like a very elegant solution from the payer's point of view.

But when viewed from the perspective of the primary care practice, their elegant

15 Electronic health record

solution has the potential to be very disruptive to internal practice work flows and at cross- purposes with their primary aim of really ensuring high-quality care for their members.

So finally while information is essential, and you will hear that reflected in the discussion that we have today, the primary care practice's ability to activate, to actually act on that information, is compromised if we continue to rely exclusively on an undervalued fee-for-service payment for primary care.

Essential to primary care practice's ability to be part of the solution to the very complex problem laid out so well by Dr. Lin and the team that supported him is increased investment in primary care.

This increased investment must include population-based payments that provide sufficient funding and the flexibility to invest in the teams and the resources they need to best address the needs of their patient population.

We are so pleased to have this topic

on PTAC's agenda and appreciate being included in today's discussion. Thank you.

CO-CHAIR SINOPOLI: Thank you, Karen. I'm looking forward to some discussion around that.

Next we have Dr. Scott Berkowitz, who is the Chief Population Health Officer and Vice President, Johns Hopkins Medicine. He also serves as the Associate Professor of Medicine and Cardiology at the Hopkins School of Medicine. Scott, please introduce yourself.

DR. BERKOWITZ: Good morning. Thank you so much for the opportunity to join you all today. I really appreciate it. Can you please move to the next slide?

So I'm Scott Berkowitz as mentioned. I'm a general cardiologist, but I'm also the Chief Population Health Officer and Vice President of Population Health for Johns Hopkins Medicine.

By way of background, I've been at Hopkins for about 20 years now, for the last three in the role of Chief Population Health Officer. And predating those efforts, I was involved in helping to stand up our Accountable

Care Organization and some of our efforts with post-acute care collaborative development, as well as a program we had in partnership with CMMI to develop the Johns Hopkins Community Health Partnership, which was one of the HCIA[16] innovation awards.

In late 2020, we launched the Office of Population Health to standardize, coordinate, and deploy population health activities and services in a strategic and data-driven way, really with a focus on enhancing value and reducing disparities.

There are five key functions related to high-value care that the Office of Population Health seeks to support. Those relate to health system coordination on system-wide population health projects, program leadership for population-based care contracts, programs and grant awards, clinical services to support our patients in optimally managing their health and social needs and, of course, with a need to focus, one of our principle areas of focus has been around high-utilizing

16 Health Care Innovation Award

and high-risk patient populations, developing of a data analytics platform to enable data-driven support and performance management across various health system and entity population health matters.

And in terms of population health, the way we've organized ourselves relates to delivery of clinical services, community health, administrative services, as well as analytics, population-based analytics.

Next slide. So Johns Hopkins Medicine is headquartered in Baltimore, Maryland, a $10 billion integrated global health enterprise and a leading academic health care system in the U.S. It includes over 40,000 full-time faculty and staff, operates six academic and community hospitals, four health care and surgery centers, more than six ambulatory surgery centers, and 2.8 million outpatient encounters per year. Plenty of background to be shared if it would be helpful.

Next slide. So what we're here today to talk about today relates to care transitions. And I will suggest that increased patient complexity and reduced system capacity

are really important components of that.

Our patients require transitions of care from the hospital, as well as from other locations that address post-discharge clinical needs by also addressing social determinant of health issues. Growing patient complexity has complicated this transition.

I oversee the ambulatory care management, behavioral health, and the other elements of that cross-functional care team. I don't directly oversee the inpatient care management teams, but we partner together across the enterprise related to care that is delivered.

In terms of efforts that are involved in addressing this from a transitions perspective and work that we've done related to J-CHIP[17] and other areas, the bundled hospital discharge strategies allude to some that Dr. Lin and team had mentioned in the preview about some of these components, including risk screens and tools; interdisciplinary care rounds; patient family education; medication

17 Johns Hopkins Community Health Partnership

management; primary care handoff; emergency department management and protocols; and just overall transitions of care support, such as transition guides, a patient access line, as well as other areas.

Next slide. The Office of Population Health has a cross-functional care team, which includes care management, behavioral health, community health workers, and pharmacists which work together and partner. And we seek to identify patients through analytic mechanisms, as well as provider referrals and to try to connect them, particularly at the time of hospitalization, but also when they're not hospitalized to support improved management of those patients in seeking to understand and address their needs.

And as also mentioned, one of the things that Johns Hopkins Medicine is also engaged in is related to a post-acute care collaborative development facilitating discharge to SNFs. And there has been significant evolution through COVID related to these types of partnerships and working on our

care continuum efforts.

So the partnerships and the continuum and the way in which we help navigation of patients through the continuum, I think, is another important area which will come up today.

Next slide. That's all I have. Thank you.

CO-CHAIR SINOPOLI: Thank you, Dr. Berkowitz. Next we have Dr. Robert Zorowitz, who is the Regional Vice President for Health Services for the Northeast at Humana. Bob, welcome. You can share your slides.

DR. ZOROWITZ: Sure. If you can go to the next slide. So, yes, I am Regional Vice President for Health Services for the Northeast of Humana. Humana, as you know, is one of the larger providers of health insurance, particularly Medicare Advantage.

As Regional Vice President for Health Services for the Northeast, I oversee utilization management and all clinical activities from Maine down to Maryland. We provide Medicare Advantage plans to all of those markets.

My background is I am a graduate of Albany Medical College. And I am boarded in internal medicine and geriatric medicine, as well as hospice palliative. Prior to my current position, I spent many years in clinical practice at the office of a hospital and a number of years working in nursing homes, as well as medical director of hospice and home health agencies.

I think germane to this particular talk, I have been the American Geriatric Society Advisor to the AMA[18] CPT[19] editorial panel since about 2003 and helped draft the transitional care management services CPT Codes 99495 to 99496 about 10 years ago or so.

I'm going to – if you can go to the next slide. I'm not going to go over this because actually a lot of this was covered in the presentation just prior to this. This is a summary of some of the evidence of transitional care models. And I wanted to just include this in the slides because it was studies like this that informed our development of the codes,

18 American Medical Association
19 Current Procedural Terminology

mainly the work of Eric Coleman and Mary Naylor.

You can go to the next slide. It's not time for the break. Sorry. Is my appendix there? I do have in the appendix the text of the transitional care management codes. It's not necessary that you see them.

But what I wanted to mention, just because I know this is part of the discussion, and as you know, the TCM Codes 99495 and 99496, while utilized, have had a rather slow uptake and have not been used as often or as frequently as we had hoped.

We did draft them based on the evidence mainly of Dr. Coleman's and Dr. Naylor's work. And we tried to jerry-rig the components in their research that they showed evidence for effectiveness into the format to make a Category 1 CPT code family as per CPT Category 1 requirements. So I wanted to give that background.

Remember that these are physician-based codes. These codes were rather unusual at the time in that they involved not only physician work but also the work of physician

supervised clinical staff. And they were essentially global codes over a period of 30 days from the date of discharge, which at the time was rather unusual.

We modeled it somewhat on the ESRD, end-stage renal disease, codes, which were 30-day codes, as well as looked at the rehospitalization metric from CMS, which was a 30-day rehospitalization, and that's why the 30-day global period was chosen.

And in order to use these codes mainly for patients that really needed them, we confined them to those that would require moderate or high-level complexity and decision-making.

We've already talked about in the prior presentation that the uptake has been rather slow. But there are other models that can be, I think, jerry-rigged into these codes. They do leave a lot of room for different types of models so long as according to CPT, they are under physician supervision.

And I think I will leave it at that, and we can talk about other models and other issues as we go on. Thank you very much.

CO-CHAIR SINOPOLI: Thank you, Bob. That was very helpful from all three of you. And we're looking forward to this conversation because I think the PTAC Committee realizes how important and possibly underutilized transitions of care is and what an impact it could have at least from the literature we've seen. And so we're really looking for your perspectives on this as we go through the rest of the morning.

And I'm going to ask my PTAC Committee members, colleagues, to put their name things up when they are ready for a question. I'm going to start out with one question. And then I know we'll have a lot of questions from the group.

So given the importance of the transition in care processes and sometimes how complex it can be, who do you all feel should be primarily responsible for managing those transitions across the continuum if there is a single primary person responsible? And if there is, what provider would that be in your opinion? I'm going to start with Karen on that.

DR. JOHNSON: Thank you, Dr. Sinopoli. I want to do just a sound check first because I understand I was cutting out a bit in my introductory comments. And I hope that you're hearing me. It looks like the team is telling me in the background that I'm coming through now so that's good.

So, you know, I think from our perspective, you know, we certainly understand and believe that the primary care physician plays a really central and important role in the ongoing care of patients, and so therefore I think there is an important priority in engaging them early in the transition process, giving them full information as I mentioned previously.

We see that as one of the most systemic barriers also called out earlier by, and I may have pronounced this incorrectly, I apologize if I do, by Dr. Pulluru, in her comments about just receiving notification. So you can't be responsible for something you're not aware of that is happening.

But I think we believe also that every provider or physician or other clinician

involved in the care of that patient plays a really important role. And sometimes that is just tapping the primary care physician on the shoulder and making sure not only that they know the transition is happening, but they also receive full information. So a warm handoff as opposed to an alert in many situations can go a long way in facilitating that accountability.

But while we think that, again, the primary care physician, family physicians, and others in this role play a really important and central role in the ongoing care, I don't think that diminishes the responsibility for others in the transition process to be really active participants in the engagement of that primary care team.

CO-CHAIR SINOPOLI: Perfect. Bob?

DR. ZOROWITZ: Thank you. I would tend to agree with Karen. I do think that transitional care management is a team effort.

I do think because of the clinical complexity of these patients that it should be overseen by a physician or a non-physician practitioner such as a nurse practitioner or physician's assistant.

But as you know some of these models, for instance, the care transitions model may be led by a nurse. But, of course, the physician is going to have a critical role. In Project RED, there is a virtual patient advocate. Now that's actually a discharge planning model that is complementary to transitional care models.

But I think it's important to underline the fact that there are really important leadership roles that don't necessarily have to be filled by a physician. But I think that the clinical complexity in synthesizing information and working together with the team in coming up with a coherent and consistent transitional plan, I do think requires the clinical skills of a physician.

CO-CHAIR SINOPOLI: Scott?

DR. BERKOWITZ: Yeah, thank you. I agree with both of Karen and Bob's comments, and then ideally the primary care provider is the leader of that work. But I do believe it is a team-based approach and a team-based model. And having strong care coordination, care management team members that can help

support the provider in working top of license and helping to work with them to support those needs across the continuum, I think is really important.

One area that I alluded to in my earlier comments relates to multi-disciplinary rounds. And at that time when a patient is hospitalized, there are physicians, and all of the different types of support staff are participating in a unified discussion around those patient's needs and ensuring that they are being advanced through the care continuum towards discharge and with appropriate follow-up.

So I think that's another example of where team members working together and facilitating connections between inpatient, outpatient, and other teams that is patient-centered is particularly important. And as those patients move from hospital to next a facility, whether it's a skilled nursing facility or other facility or back into the home, we need to be mindful of the different needs, constraints, and challenges that may exist within those care settings to support the

needs.

And while there may be more resources available in a hospital setting, there may be fewer available in some post-acute care settings, but then that transition back to community-based care and primary care is nonetheless important. And it's just a matter of making sure that that continuity can be maintained.

CO-CHAIR SINOPOLI: Perfect. Thank you for that perspective. Larry, I think you have a question?

DR. KOSINSKI: I do. And I guess it should be best addressed to Robert, but any of you can comment as well. In today's complex environment for inpatient care, patients are not being taken care of by one physician. There are multiple specialists involved in just about every admission to a hospital today.

Also the physician that is taking care of the patient for primary care versus each specialty is most often not the one that is seeing the patient in the outpatient setting since we have hospitalists, and we have now specialty hospitalists.

So the transition of care is one that requires transition for more than one specialty. Certainly, I welcome the need for the primary care doctor to have a TCM code. But I can see a need for it in the specialties as well.

So my question, Robert, is at CPT, why did you limit this to just one provider to be able to bill for a TCM code?

DR. ZOROWITZ: Do you have an hour? So let me say that the TCM code has to be – can only be submitted by one physician. However, that does not necessarily have to be a primary care physician.

I do think that part of the TCM services that are involved in the code involve coordination with specialists. So the physician or the clinical staff would have to, as part of transitional care, be in contact with the specialist.

The other thing I wanted to mention, and I think is really important, because transitional care really begins with day one in the hospital and with discharge planning and doing an assessment of what that patient's

function is, what the patient's behavioral health issues are, what kind of resources they need, what kind of social determinants of health deficits?

And going towards discharge, getting them ready for discharge and then providing a meaningful discharge summary, which is often very perfunctory and devoid of a lot of good content for the primary care doctor if the primary care doctor is not the one taking care of the patient.

The primary care doctor then would be armed with enough information with clinical staff to be able to perform medication reconciliation, identify the specialist that the patient needs to see and use clinical staff in order to coordinate that. And that would include speaking with a specialist and making sure everybody is on the same page.

It is a lot of work. I understand the point that a specialist may also have a stake in this and may perform some of these tasks. But I think that the one physician who is going to submit this code should be the one along with clinical staff and the team in

coordinating everything and putting together the transitional plan. I hope that answers the question.

DR. KOSINSKI: It does, but that's clearly not what's happening in the real world.

DR. ZOROWITZ: I don't disagree with you. It's very difficult. And I think one of the reasons you see slow uptake of the code is that it is very difficult to put together the organizational structure, the culture, the training, and the commitment in order to provide this kind of service which is complex.

CO-CHAIR SINOPOLI: Karen or Scott, do you all have any additional comments?

DR. BERKOWITZ: I'll just reiterate Bob's comment about the importance of good communication across teams and the importance of specialists and being a part of that broader care team structure and process.

Within our hospitals and other care teams, we have some patients where specialists play an increasing role based on patient complexity and the needs of those patients, whether they are cardiovascular, such as myself, or behavioral health or other areas of

importance.

And so I think it's good to think broadly about that and to recognize the important roles, although as I answered the last question, I think primary care is suitable to be the quarterback. I think there are situations where increasing roles of the specialist can be really important and to managing the complexity of those patients and to positioning them for success as part of a broader care team.

DR. ZOROWITZ: If I can just say one additional word --

DR. JOHNSON: Yeah, I would just --

DR. ZOROWITZ: -- I'm sorry. I'm sorry. I hope I didn't interrupt.

DR. JOHNSON: That's okay. Go ahead.

DR. ZOROWITZ: The TCM codes were really conceived as part of CPT physician fee schedule. It's not the only way to pay. In value-based arrangements, you're going to have a lot more latitude to develop different models. So if you're talking about getting specialty involvement and having specialists be

part of the team, you have a lot more flexibility in a value-based arrangement to do that than you do with the narrow structure of CPT codes.

CO-CHAIR SINOPOLI: Karen?

DR. JOHNSON: Yeah, so I was going to say almost exactly what Dr. Zorowitz just said, which is that I understand that the question was about the TCM codes per se. But I think the relatively low uptake of that code, I think as interpreted by the study Dr. Lin cited, that was an indication that the services were not being provided.

I think based on what we hear from our members, many of the services that constitute components of TCM are really being delivered but not being billed by that very specific code. And that's why I think at the Academy what we are really leaning into is this idea that we really do have to move away from fee-for-service payment, whether it's a more comprehensive code like TCM or some other very specific code, toward more population-based payments embedded in a value-based payment structure.

So that's the piece, I think. Because I do think Dr. Zorowitz's point about how complex and difficult this is is true. And how it's delivered in any given geography or practice setting may look different based on the needs of the population and the resources that exist in the community to support those practices and their patients. So the flexibility of the population-based payments outside of the fee-for-service sort of requirements for documentation and coding are really, really important.

CO-CHAIR SINOPOLI: Thank you for that, Karen. Jen, you had a question?

DR. WILER: I want to thank each of our presenters. But my question is for Dr. Berkowitz. As you described, Hopkins is a multi-inpatient facility health care network, including academic and community practices, and you practice in a pretty unique state with regards to population-based payments.

So my question for you is what is working well with the current payment model around population-based payments in this transition of care space? What is not working

well? What is good care that is not being incented? And what might be some perverse incentives that you are currently seeing in this space?

DR. BERKOWITZ: Sure. Thank you very much for the question. By way of background, I'm sure many who are participating are aware, but Maryland is what's called an all-payer state through an arrangement that exists between the Health Services Cost Review Commission and CMMI through a waiver that's been in place for decades to make it what's called an all-payer state, meaning the cost for a hospitalization for Medicare is the same as Medicaid is the same as commercial. However, that may change month to month. So the cost of a hospitalization may be one amount in one month and then changed through a rate setting process the next month.

Part of the reason it's been constructed in this way over time was to enable further planning related to coordination in this way. And the idea since all patients are discharged, it's nice to imagine a way in which you can think about all payers and from that

perspective.

Part of the evolution in Maryland has been that there has been enhanced focus, I would say, on the Medicare side and the Medicare side having a total cost of care framework. Because a lot of the oversight is of the hospital side, but they've been able to implement a total cost of care metric and to start to think about what that looks like more broadly across Medicare and to try to move in that direction.

So what I would say is one positive is the potential to continue and the opportunity is to grow to be able to become increasingly all payer with respect to that and to create services and opportunities. A lot of the services that I describe for our Office of Population Health come from what is called the Maryland Primary Care Program, which is analogous to CPC+, and it started with Medicare and enhanced revenue to support investment and care coordination teams. And as we have talked about, it takes a village to do that.

And the support of that has been primarily, as I mentioned on the Medicare side,

is opportunity over time to be able to take that more broadly. And I think that that's a really exciting opportunity. As a state, we're not quite there yet. We're on a journey. And so I think that that's positive in terms of the flexibility and what that allows you to do and create over time.

Part of the opportunity, I would say, is inherent in some of the complexity that I just described, which is that, you know, the ability to have changes such that you can reduce utilization, reduce hospitalization, and that can end up translating to an increase in cost though the math is sometimes challenging to fully understand and how it then changes such that the pricing for hospitalizations, for example, can change.

And so I think that that's hard sometimes for frontline workers to truly be able to wrap around if you're trying to develop strategies and approaches. It's really important to understand the framework with which you are operating under. And I think there is a lot of good work that's being done to help to support that, but it can be

challenging at times to fully wrap your arms around what can seem to be a change based on utilization versus cost that may not be aligned in the way that it might be in other additional payer-based models.

And it can be sometimes harder to fully win hearts and minds, I think, if clinicians don't fully understand more around what's trying to be achieved there. But really focusing on the key goals and what we are trying to do for our patients to support quality and reducing avoidable utilization and how that produces improved health is important. And I think there are opportunities that are created through a lot of hard work and collaboration to have gotten us to where we are today.

I hope that was responsive. I'm happy to elaborate further.

CO-CHAIR SINOPOLI: Bob, Karen, anything to add to that? Okay.

DR. ZOROWITZ: Not for me.

CO-CHAIR SINOPOLI: All right.

DR. ZOROWITZ: That was very good.

CO-CHAIR SINOPOLI: Lauran, you had

a question?

CO-CHAIR HARDIN: Excellent presentations. Very helpful so far. I am interested in asking you about health-related social needs and health equity and how our relationships in the community impact the way that you look at build of partnerships, potential shifts in payment, and also structures that are creating effective relationships in the places where people spend most of their time, and what roles and disciplines are emerging as key partners in delivery of effective care transitions?

DR. JOHNSON: I would be happy to jump in on that one first if that's okay with my panelist friends. Such a great question and so important to really -- all aspects of care but especially these care transitions, which we know are so often hindered by a person's social circumstance, whether that's a lack of care support at home or an inability to [inaudible] meds or to get to the follow-up services and care that they need.

So we, you know, believe that all physicians at all points along the spectrum,

everyone should be attended to in an individual's health-related social needs and probably looking at it through the lens of care that they are delivering at any point along the process. But know that primary care physicians, given the longitudinal and trusted relationship that they have with their patients, have the most visibility and insight into what those health-related social needs are.

I would say there were a couple of points that I would want to make sure that I think are really important. One, it goes back to the sort of common theme of information sharing. I think for us to collect that information and not to share it in a secure and safe manner with other physicians and care teams that the patient has selected as their trusted partners in their care journey would be a mistake.

And I think that building mechanisms for doing that is really important. So as that information is collected at different points in my care journey as an individual, I want to make sure that all of my -- those that I trust

with my care are receiving information to help them help me in the best way possible. So I think that's one aspect of it.

I think the other aspect of it that we think is really important is that no physician, whether primary care or other, should be held accountable for addressing social needs, complex social needs, when the resources to do so don't exist in the community. That's not to be built into the health care payment. It is to build social support.

I think to connect to social supports in the community is a really important aspect of the role that all physicians play, but especially primary care physicians. At the AAFP, we are strongly in support of community-based infrastructure that helps community-based organizations build strength as a network that can support and facilitate addressing health-related social needs identified in the health care ecosystem. So the idea of a community care hub where that information -- where that resource exists to facilitate really effective and community-centered and patient-centered

interactions we think is essential to moving us forward from where we are today.

CO-CHAIR HARDIN: Scott and Robert, did you want to add?

DR. ZOROWITZ: Sure. If I can add to that. It is a real struggle to identify resources to address food insecurity, housing insecurity, transportation insecurity, and other social determinants of health and find organizations that can provide it and connect patients with those organizations and pay for it.

I can tell you that many payers, us but not only Humana, most of the Medicare Advantage payers are looking for ways of identifying organizations that can provide connections with agencies and other organizations that can address social determinants of health.

One nice thing about value-based agreements is it does give you some room to provide -- and even if it's a fee-for-service arrangement, payers are interested in finding ways of connecting patients with resources to address their social determinants deficits.

This is not easy, but I believe that it's necessary. But, again, I believe it starts in the -- you know, if someone is in the hospital, part of that discharge plan needs to include identifying those social determinants and if possible, identifying ways of addressing those before discharge and then communicating that in the discharge material. I don't want to say discharge summary because that's usually a perfunctory narrative. But the discharge material from the hospital should be more comprehensive if it's going to a primary care practice that did not admit the patient.

If that information is there and a lot of these connections are already jump-started, I think it makes it a lot easier once the patient is out in the transitional period to make those connections. But, again, this is a very complicated process.

DR. BERKOWITZ: So I'll just add -- I appreciate the comments by both of my colleagues and really appreciate the question because you are absolutely right. At the heart is that social factors have a huge impact on patients' health and our ability to provide

care delivery for these patients. And I think that it's been studied before, and it can be a really sizable important part of that role because if they don't have certain issues that may be addressed related to their social factors, then they can't really focus on other clinical factors that they need to be able to have addressed, and so you need to be able to think about them holistically.

This directly impacts on the way that patients move through care delivery towards other care settings. Like for example, you are trying to appropriately manage a patient and then preparing them for discharge through a screening process, and then that patient may have certain needs that are related to these factors which may directly impact on their ability to go to a next of care facility, to be able to get the supports that they need. And so this can be really critical to be able to understand that and to be able to have enough of those supports.

We are fortunate through some of the initiatives I mentioned through the Maryland Primary Care Program to get some funding, which

is called HEART[20] funding, which is specifically related to health equity to support some of these needs. And we've been able to help match both for transportation and some food insecurity issues to be able to support some patients with this.

But this is not necessarily for all patients, again, as we're talking about if a patient is in particular programs. And when you are talking about areas that are, you know, critical, like housing or things like that, we may not have solutions for how to help settle some of the social issues like that.

And so what I think is equally important in a dialogue around this with all of the esteemed colleagues who are in the room and participating in this is, how does everyone work together in a multi-stakeholder and collaborative way? Some of these are public health-related issues. Some of these require local, municipal, city, state, other supports and arrangements and partnerships to solve these issues, or even to make continued and

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move them in the right direction absolutely requires people working together.

That doesn't mean that health care providers and teams and plans shouldn't be partners in that because they absolutely are, and I think something that we are really working hard on. But recognizing just how important this is and how overarching it is and continuing to think about broader stakeholder solutions to that I think is really important. And I would be happy to elaborate on that further.

CO-CHAIR HARDIN: Thank you. Really valuable perspectives.

(Simultaneous speaking.)

DR. JOHNSON: Can I do one quick follow-up on that?

CO-CHAIR HARDIN: Sure.

DR. JOHNSON: Yes. So I really appreciate all the comments from Dr. Berkowitz that is sort of the shared -- this is a problem begging for a shared investment solution model. And the multi-payer and multi-stakeholder approach to that I think is so important.

I just wanted to call attention to

one of the initiatives that the AAFP has been participating in and thinks is really important around this community care hub concept that I mentioned. And it is the partnership to align social care, which is really focused on the build-out of the community-based organization network in communities.

So most community-based organizations are not equipped to receive referrals from 10 different payers and 40 different practices, but they might be equipped and resourced to engage with a central mechanism that is built with attention to their needs and their capabilities. So I just want to underscore that point of shared investment and multi-stakeholder engagement as such an important path forward here.

CO-CHAIR SINOPOLI: This is Angelo. My question is kind of tangential to this conversation because I'm interested in your perceptions around transitions to home from the hospital as opposed to going to a SNF for those patients that have complex needs. As we know now, the path of least resistance a lot of times is your hospital is just to discharge

them to a SNF.

And so I'm curious what are your thoughts about how we can improve care at home, not necessarily just traditional home health, but what does care at home look like, and can you comment around how to -- know some innovations around that and how we can fund that differently than we're doing today? I'll start with Scott.

DR. BERKOWITZ: Happy to comment. I really appreciate the question. It is important to think about that transition. That is likely the most common transition, is a patient being discharged from the hospital to home.

And one of the cornerstones that I would suggest is that communication is really key. We've talked on this call so far today about discharge summaries. We've talked about communication between care team members. We've talked about many other areas of communication.

We've also talked about the fact that considering the discharge to home is really something that needs to start at the outset of the hospitalization really from the

very beginning, bringing together a multi-stakeholder team to think about and assess appropriately what that patient's needs might be post-discharge and to be able to bring together the stakeholders to work to facilitate that, knowing that sometimes that might take a little bit of time and planning to bring together whether it's rehab needs, whether it's home care needs, as you mentioned, whether it’s support for particular disease type conditions if you will, like heart failure follow-up, post-acute primary care visits, things of that sort.

And so as I mentioned a little bit earlier, one of the things that we do is we have a focus on sort of a bundle of discharge strategies that is hoping to sort of engage around all of these areas, one of which relates to sort of a risk screen or a tool to help anticipate what those needs are.

One that was mentioned, I believe earlier, was ESDP, early screening for discharge planning. And there's also an activity measure for post-acute care which helps folks to understand what the activities

might need.

There are also embedded flags in the EMR[21] which can help you to understand and anticipate who might have higher risks or higher needs that you can really be working around. Then you bring together that interdisciplinary round which is really for us is usually daily to focus on these different issues to make sure that you are able to communicate well within the team and prepare.

Education is key with patients, families, caregivers, and different tools to help to support that. Medication management, the idea of getting as much as possible, trying to make sure that these medicines can be in a patient's hands before they leave.

And there is a lot of complexity around medicines and different medicines which can be really higher-risk, you know, and I see that in my practice, a patient who comes in on 20 medicines. And even if I have help there, I know how much complexity there is in terms of those medicines and planning around that.

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That primary care handoff, and we probably have all seen in different ways some strain relating to access and capacity there, and so what does that look like? In some places, we've been able to have what's called an after care clinic to support some immediate handoff needs related to that.

We work with the emergency department and transition guides through some of the models that you alluded to earlier in the presentation, things like transition guides, patient access line, phone calls to people to make sure they were able to get their medicines and the follow-up, as well as other social work and referrals.

And so I think that those are some of the different strategies that can connect in particular. And I would also just add, and bringing back to something that I mentioned earlier in the social context is the importance around behavioral health and substance abuse challenges and other issues regarding behavioral health needs and really trying to connect around that because that can have such an important impact. And these numbers and

frequencies have really increased so dramatically through COVID. And we really need to make sure that we're helping to address those patients' needs to help them get to the other clinical supports that they need.

And so those are, what I would say to your question, is sort of an aggregate of some of the areas that we need to work on together and ensuring that those resources can be provided across a multi-disciplinary, cross-disciplinary manner for those patients as they are transitioning from a hospital into a home.

CO-CHAIR SINOPOLI: Karen or Bob, anything to add to that?

DR. ZOROWITZ: Yes. You know, I think that the age-friendly health system by definition addresses much of this by identifying the major domains that are necessary to address in order to effect a safe and timely discharge, mobility, mind, medications, what matters most to the patient. This includes things like social determinants of health.

And as a member of the American Geriatric Society, we like to add a fifth

pillar in there, polymorbidity because many of these patients have multiple morbidities that interact with each other and make it even more complex to manage them.

When discharging patients, it may be necessary to provide some services besides referring them back to their primary care doctor. They might need -- home health, for instance, doesn't include a physician necessarily or a nurse practitioner visit at home. And that may be something that is necessary in the short run before the patient is able to get back to the office.

And it may even provide better support than just going back to the office in that a clinician going into the home can see for themselves what are the barriers to maintenance of health in the home? Are there medications stuck in the medicine cabinet that were not previously identified?

So I think that we need to have a much broader view of what kind of discharge services would contribute to an effective transitional care plan. And this is not all obviously included in just performing the TCM

CPT Code. This is really having a much broader view.

It also depends, I want to add, on the organizational structure. So I think Dr. Berkowitz is very fortunate to be in a highly developed integrated health system. And that allows the use of resources that may not be available to a small practice or even to one of these larger network practices that are growing more and more every day. And that allows for more integration and communication, whereas independent practices may have to find ways of communicating and creating partnerships with other organizations in order to provide the services necessary.

CO-CHAIR SINOPOLI: Karen, you might be on mute. Karen? We can't hear you. You might be on mute.

DR. JOHNSON: Hello?

CO-CHAIR SINOPOLI: Yeah. We can hear you now.

DR. JOHNSON: Okay. So the comment that I was going to make is that -- sorry about that. A couple of points that I want to underscore that have already been made.

One is that discharge planning starts when the admission begins. And so that initial notification to the primary care physician at the point of admission is so important. They not only need to begin to activate and engage within their care team, but they can also inform the care that happens in patients or in other care settings based on their knowledge of the patient, particularly around health-related social needs given their degree of knowledge and understanding of the patient is so high.

In terms of transitioning out into home, access to just the basic essentials that they need in terms of medication and equipment that often comes with the transition and care, sometimes those are complicated by things like prior authorization that get in the way or delay care. So thinking about how those are eliminated at those critical moments in the patient's care journey are important considerations.

And then also we talked a little bit about staff and the robust staff required. This challenge that we're all having around

staffing adequately to meet just our organizational needs in terms of taking care of patients, whatever that setting is, is real and probably not easily solved by any single policy.

But we know that payments and just being able to offer competitive wages to those folks who do the daily work of taking care of patients in transition, home care workers, aides, and others is really essential and critical to making sure those resources are there when we need them.

CO-CHAIR SINOPOLI: Thank you for that. I think we had Lee next and then Lindsay. Lee is passing. Lindsay?

DR. BOTSFORD: Thank you. I think, Karen, you talked a little bit about this in your opening remarks so I would love to hear further on your perspective and I think also from Dr. Zorowitz. But as payers, PCPs, ACOs, or other risk-bearing entities try to improve outcomes at care transitions, the risk of duplication of efforts is very real, I think especially as we think about older adults, patients with complex chronic conditions. Good

intentions lead to confusion. I see this especially in my older adult patients.

How can payers and other stakeholders that are trying to improve outcomes at care transitions be incentivized to work together as opposed to duplicating efforts and risking confusion for patients?

DR. JOHNSON: Okay. I'm back now. Sorry.

CO-CHAIR SINOPOLI: Now we can hear you, yes.

DR. JOHNSON: I'm doing a workaround here on my technology issues. Thank you, Dr. Botsford, a really great question and one that we are really looking at closely given the high level of activity we have seen from payer-directed care.

So, again, I think very well intentioned resources put in place to care for their members. The complication as we know that creates is from a -- when you look at it from the primary care practice perspective, that may mean seven, 10, or more different sort of interventions across their patient population depending on who the payer is to

keep track of and pay attention to.

So I think we -- so we keep that payment model, the value-based payment model, that sort of is really clear about who is accountable for what and making sure that those payment models are sufficiently resourced to provide care teams again with the flexibility but also the level of resources they need to care for their patients is essential in moving us forward.

I will say though that one of the things we are observing in at least some of the payer behaviors around some of this is an increasing recognition that the patient's primary care physician relationship in the community is paramount to their ongoing sort of improved outcomes for their member population.

So, again, going back and forth between who is the patient and who is the member, it's the same person, but we look at them differently depending on the organization we are representing and working for.

We have gained increasingly that payer to recognizing that relationship and proactively reaching out to primary care

physicians and advising them when they have engaged with a vendor solution, and we see a really great number of vendor-driven solutions.

But when there is a vendor solution in place to care for a unique population or a very specific need for those members, we are seeing increased communication from the payers to the physician practices, which we applaud and appreciate. I think it does not solve the problem that you are talking about, which is the patient is often left out of that communication and therefore confused as to who is doing what on their behalf.

So I don't know that we have all of the answers to how to effectively solve that. But I do think that beginning to sort of be more explicit about what role the physician and their care team is expected to play under the payer's payment approach versus the care that they are delivering is really important.

But again, we believe that the care belongs in the primary care practice with the physician-led care team and that the payment models that support that delivery model that are those that we need in place today.

DR. ZOROWITZ: I'd like to add to that because I think that was a very perceptive response. From the payer's perspective, you know, a payer has multiple, multiple practices in hospital systems and other practitioners. Some of them are capable of performing these activities. Many of them are not.

The payers are very interested in seeing these services provided because they know it improves care. And, of course, they are interested in reducing costs.

If it was aligned that payment, particularly value-based payment, supported those sorts of activities, and the practice had the economies of scale and the information systems and the communication channels in order to perform those services, the payer wouldn't have to do it. The payers are doing this in order to fill in the gaps that many practices cannot fill.

And I think at the larger practices that we've seen that can provide these services, it is not necessary to fill it in. But those are few and far between. And I think as payment models, incentives, and the

organizational structure of the practices evolve, I think you're going to see the movement of those activities more to the practices because as Karen says, I think that's where it should reside.

The payers, remember, don't have the clinical information. They have claims information. They have some clinical information if they have hospital records because of utilization management. But mostly they are dealing with claims information. It's the practice that really has the real important clinical information and knows the patient.

So I think that down the road as these payment models evolve and as incentives and metrics align with them and the practices develop the organizational structure and infrastructure in order to support these activities, that's where it's going to reside and that's where it should reside.

DR. BERKOWITZ: So great --

DR. JOHNSON: I'm going to jump back in here real quickly if I could. Do you mind? I just want to underscore one thing. Thank you, Dr. Zorowitz, for that. And also, working

in the health plan environment previously myself and really trying to solve for this from a health plan perspective, I do think that ability to sort of be adaptable and flexible as a payer organization in scaling what you do based on this capability to the practices is an important solution in the long run. I think we are probably a long way from getting there.

But the one point I really wanted to make here is that we talked a lot about communication between, you know, care settings, the different clinicians, physicians, and others who are caring for patients and how important that communication is, I cannot underscore how important the communication is between physician practices and the many payers that they engage with.

Equally important, and we find physician practices to often be confused about who is doing what on the payer side. And so I just think that is another aspect of this that is a really important ingredient in the overall picture. Sorry, Dr. Berkowitz.

DR. BERKOWITZ: No, those are all great comments. I really, really appreciate

that and appreciate the question. The only thing I would add is that as we think about this, especially as we are evolving collectively to more value-based arrangements is trying to consider the opportunities for harmonization from that perspective. And I say that knowing fully that patient populations may be different and different payers may support different patients in different ways.

But I can tell you on the provider side, practice side, or hospital side or otherwise, and patient side that patients can sometimes find it a little bit frustrating if they walk into a doctor's office and if they are on Medicare, they can get this, but if they are Medicare Advantage, they get that, or if they change this, they can get this, and the measures that might be looked at from the provider side might be different.

So to the extent that there is opportunity and partnership related to that between the provider and payer and an embracing of engagement of providers in that work, there may be opportunities to have the provider with the care manager partnering with the payers

rather than each payer having their own care manager servicing that site.

So again, this is a continuum. This is a partnership. This is a not one-size-fits-all but recognizing the opportunity for the practices increasingly as they are capable to take on that opportunity and to partner and to be thoughtful regarding the data and the care services, I think, is a really valuable opportunity as we continue to all move in this direction.

CO-CHAIR SINOPOLI: Perfect. Thank you all for that. Chinni?

DR. PULLURU: Thank you, everyone. This has been alluded to previously by all of you, but I wanted to crystalize it a little bit more. So I'm a core operator at heart. And when we think about these things, the cost to do this -- in order to be able to do this with the administrative burden, you have to staff in a way that adds at least a few hundred thousand dollars to your operating cost for a typical practice.

So if you think about that, it automatically rules out small to medium

physician primary care groups that can own it. So then it leaves entities that are large clinically integrated networks like Johns Hopkins or my old group that can fund that. And they have the data infrastructure and EMR basis in order to be able to get that sort of instant information in order to make it happen and get to outcomes, or you have to be in a total cost of care value-based care platform.

And in the Medicare world in order to do that, you're in Medicare Advantage for the most part so it rules out fee-for-service methodology in order to be able to effectively do it. So it's almost like what comes first, the chicken or the egg, right?

And so, you know, what are your thoughts on the fundamental structures of payment methodology that can incentivize a small to medium physician group in order to be able to put the infrastructure in place, to get the communications, to get the ability to get this out of the gate?

And if you think large swaths of this country are not covered by groups that are large clinically integrated networks or

entities that can do Medicare Advantage at scale, I would love to hear your thoughts on that.

DR. ZOROWITZ: If I might, that is probably the most difficult question we have had so far. You know, when the TCM codes were devised 10 years ago, and remember it was 10 years ago they were devised, and CPT is very slow to revise code descriptors. So the TCM codes have remained pretty much the same as they were when they were first approved 10 years ago.

But the idea behind the codes was not that they were to be used once in a while. It was really sort of a way of jerry-rigging in a fee-for-service environment a capitation sort of structure. You know, it's a 30-day capitated payment that includes all clinical staff services plus a face-to-face visit and a phone call and a medication reconciliation.

And the idea was that this would -- that and the chronic care management codes would incentivize practices to develop the infrastructure in order to provide them. And, again, there is that chicken versus the egg.

I think the issue is can small -- and not only can small and medium-sized practices provide transitional care services, but can they manage population health in general, which requires the information systems and infrastructure and organizational structure in order to manage a large panel of patients?

And I know that, you know, some practices will join IPAs, independent practice associations, or they may associate with MSOs, with managed services organizations, in order to achieve economies of scale even though the practices themselves are relatively small.

So I think there are ways of doing it. But, you know, I struggle myself to understand how a small independent practice is going to be able to practice population health without having some sort of economies of scale. And I'm sure they do a great job individually with the patients that they know intimately, and they can take care of them and, you know, deal with them on the phone, and they may even make home visits, but in order to really manage a population, I think it does require some economies of scale. And some of these other

types of organizational structures may be necessary in order to effect that.

DR. JOHNSON: Yes. I agree with Dr. Zorowitz. This is the hard question. It's how do you do this because that chicken and egg continues to baffle us, I think, in terms of solving to this end payment.

That's a reflection of the fact that we have been undervaluing and underpaying primary care for years. And so we have the problem that we've created for ourselves as a system, that if we care about primary care's role, it can be corrected with adequate payment.

And I think a course correction particularly for small and independent practices is merited. We were so pleased to hear from LaSalle this morning and see the announcement about their new payment model. Of course, that's just a limited number of states, but an important step in the right direction.

I do think the evidence around independent practices and their ability to improve outcomes is strong. Under value-based payment, I think we've seen it. We know that

recent report from Wakefield, the actuarial consulting with the MSSP really underscored that, you know, we know primary care is important. And we know that more primary, more primary care visits, leads to lower total cost of care, more shared savings.

They also saw a difference, though, between those primary care practices that were independent versus those that were a part of a larger health system. The improvement was even greater for those in independent practice.

You know, some of that had to do with natural sort of financial incentives. But we also, I think believe that has a lot to do with a lot of what Dr. Zorowitz just alluded to. Independent practices close to their patients know them, know how to help support them throughout their care journeys, and are just really good at that.

So I think, you know, the kind of prospective payment that we are advocating for in value-based payment for primary care that works well would require some sort of additional up-front incentive for those who are not there today that need to invest up-front

and don't have the capital to do so, which is becoming increasingly challenging in our consolidated, ever consolidating primary care market.

Does it mean that those practices don't have the ability to earn that back or those who are making those investments? But we think that those are really, really important and also believe that there is some discernment that practices need to do around what they should be building on their own versus where they need to be part of a broader sort of shared investment model with others, whether that is other practices in an IPA or through an MSO or some other mechanism.

DR. BERKOWITZ: I will just add that I agree with my colleagues around the recognition that this typically requires some level of investment to get started and that there can be different complexities based on the background.

A piece that I will add to this that may be different just by virtue of, as I started to allude to earlier within the Maryland model, I will just say with the

Maryland Primary Care Program, the penetration across the state right now is very high across primary care practices, including small and independent groups. And there is financing that is provided through that program. There is complexity related to that in terms of how that ultimately links back to the total cost of care model. So I don't want to say that it's just sort of in a vacuum. But what it has done is it has allowed for investment for small practice, medium or larger practices to support those needs, to get off the ground related to that and to have a recognition of what that looks like and to provide structure around that.

So I think as you are considering models, it is certainly one thing to consider among the different types of models that you are thinking about and the revenue that supports that initiative.

CO-CHAIR SINOPOLI: Thank you. I think we have time for one or two more questions. Walter, do you want to go next?

DR. LIN: Thank you. And I also wanted to just add my thanks to the panelists.

They've been really helpful in terms of your insights and perspectives.

You know, one of the goals of this public meeting is to try to make recommendations to increase the focus on care transition services through payment model recommendations. And I wanted to circle back to some of the comments that were made after the PCDT presentation by my fellow colleagues, Lee and Larry, in terms of just noting that the slow uptake of the TCM code use and the benefits that such use brings.

And this question is primarily to Bob, but I would love to hear Scott and Karen opine as well if they have comments. But especially since you were one of the drafters of the original codes, I'm wondering if you have any thoughts about why the uptake has been so slow? And then a follow-up question is how can we increase uptake of these codes as a proxy for use of -- focus on these services?

I know Karen said that a lot of times providers are doing these services without billing these codes. But I think it is probably a good proxy and wanted to see if you

guys have any thoughts about how to improve uptake of these codes.

DR. ZOROWITZ: Yeah. I think there is -- you know, in geriatrics we talk about syndromes being multi-factorial. And I think it is multi-factorial.

Number one is that a lot of physicians are not familiar with CPT, and they don't know that the codes exist or they don't own a CPT book, they have never read it, and they don't know what these codes entail. That's the simplest answer.

I think because of the fragmentation of the health care system, the difficulty in identifying patients that are being discharged, in communicating with practices, and practices developing the organization and infrastructure in order to do this or even to know how to do it because I'm not sure that physicians are necessarily trained to do this.

So I think there is a whole variety of reasons. I've seen small practices, large practices, integrated health systems using these codes. So I don't think it's necessarily closed to even smaller practices, but they need

to know it exists. They need to know how to do the code, and they need to plan and get the skill set.

I also think that hospitals can help. I'm really intrigued by Project RED, which is cited in the presentation, which is a very robust approach to discharge planning and would give a big jumpstart to transitional care planning were that information then transmitted in a timely fashion to the primary care doctor.

It's not exactly analogous, but when I was working in nursing homes and I would be ready to discharge a patient, I would write these very, very lengthy discharge summaries and discharge instructions and medications, and I would ask them, who is your primary care doctor? Call them. What's your fax number? And make sure it was faxed to them upon discharge. And I would give them a copy and say bring this just in case they didn't get it.

I don't know what kind of assurance hospitals, you know, create in order to make sure that the doctors that these patients are going to have to follow up with get all the information they need in order to follow up and

create that transitional care plan.

So I think multi-factorial, I think it begins in the hospital. I think it is skills, training, and just understanding the structure of CPT.

CO-CHAIR SINOPOLI: Karen?

DR. JOHNSON: Yeah. So it's a great question, and I think that -- I wish I could see the room, all of you right now, because you're mostly physicians, and I would love to ask how many of you really want to be coding experts because I don't think that's what you went to medical school for.

And so I think this idea that physicians are going to somehow drive adoption of this code per se is maybe some flawed thinking because I think physicians really want to take care of patients.

And so I think about who our members are and how they are -- there's the room. It's like magic. But, you know, more than 70 percent of our members today are employed, and half of them are employed in large health care organizations, hospital or health system owned.

Very few are really primary care

centric. Just 24 percent of our members are either specialists or sole owners or their physician practices. Those are the folks who are really driving how their EMR is structured and set up, and do they bill for this code or that code, and is it easy or hard to document that in a care encounter to actually bill for the code?

These compass organizations that have acquired primary care practices as part of their sort of model of care delivery may or may not be focused on the new code that comes out for primary care at any given moment in time.

I think we also know from our members that there has been some inconsistency in how private payers have adopted this code over time. I think while we see improvements there, we know that there was a lot of variation in that sort of in the early years so maybe the incentive to implement that code was not as strong.

But I also -- yeah. So I think those are some of the things that are the challenges that we see that would prevent adoption of the code per se.

I guess one other thing I would add though, there is a practical consideration here for those where the code is on the radar, we understand, we think it's important, we really should be billing for it, but we can't afford the staff to do the work that is required to bill for the code. So that gets back to the chicken and egg conundrum that we just talked about that I think is a real and persistent problem.

CO-CHAIR SINOPOLI: Scott.

DR. BERKOWITZ: Yeah. Really helpful comments from my colleagues. I will just pick up on the last point that Karen raised. And I haven't heard this really focused on as much, and it was around workforce and support care team members.

I think the colleagues in the room are all very aware that the workforce considerations have been really significant emerging from COVID in terms of what the impact of that is for nursing and other support, whether it's in the hospitals, whether it's in post-acute care facilities or other facilities.

So we have this situation where patient complexity is growing. The role of social determinant of health factors is growing. The role of psychosocial, psychologic behavioral health needs is growing.

The ability to move patients from one area of care to an appropriate next level of care is based on the patient being ready from a clinical medical perspective or otherwise and also being able to have a location for them to go to that's appropriate for their care. And so all of those elements directly translate into the ability to have the right type of staffing to support patients in those needs.

And so for example, one challenge that we've seen at times in some of our urban hospitals particularly is that there right now may not be sufficient capacity in post-acute care facilities to be able to take these patients based on their needs because they are multi-morbid or they have dialysis needs or they have other types of needs.

And if those patients can't get taken to a next level of care, they end up

remaining in the hospital longer than may be optimal from a care perspective, you know? Every day that you are spending in the hospital that you don't need to be in the hospital is not optimal, yet those patients can't go home. They need to go somewhere else, but there may not be a somewhere else available.

So I think as we're thinking about this, and we're thinking about these payment issues, I don't want to also lose sight of the workforce connectivity to this, to what this means from a cross-continuum model of care and being able to support those needs in the workforce pipeline to ensure that those other elements of the care continuum can help to support the needs of those patients as well.

CO-CHAIR SINOPOLI: Perfect. Thank you. Jim, did you have a question? We have a couple minutes. Okay. Good. Yeah, we would all like to thank all three of you for joining us this morning. This has been very insightful. Your perspectives and actual life experiences dealing with this day in and day out have been eye-opening and will help us formulate our letter to the Secretary.

So, again, I just really want to thank you. And I think at this time, the Committee will take a break, and we will be back at about 1:10 so thank you again. Bye-bye.

(Whereupon, the above-entitled matter went off the record at 12:04 p.m. and resumed at 1:12 p.m.)

*** Listening Session 1: Relationship Between Payment Features and Care Transition Innovations**

CO-CHAIR HARDIN: Good afternoon and welcome back. I'm Lauran Hardin, one of the co-chairs at PTAC. And in this session, Relationship Between Payment Features and Care Transition Innovations, I'm pleased to welcome three experts who have experience with how payment features can encourage some of the innovations we've been discussing today.

You can find their full biographies posted on the ASPE PTAC website along with their overview slides. I'll briefly introduce our guests and give them a few minutes each to share an overview of their key takeaways. First, we have Ms. Cheri Lattimer who is the

executive director at the National Transitions of Care Coalition [NTOCC]. Welcome, Cheri. Please go ahead.

MS. LATTIMER: Thank you so very much. Hello, Committee. Good afternoon to you or if you're in my part of the country, it is still good morning. I'm on the Pacific Time zone. And thank you for allowing me to just share a few thoughts around care transitions and payment features.

As we talk about really the next slide, the role of transitions of care, I don't think there's anything new here other than I think many of us find that having been addressing some of these issues for the last 20 years, we still are struggling with that transition from one health care provider or setting to another. Often related to just communication and the sharing of information, I always think about the saying that Dr. Eric Coleman shared with us at one of our first meetings in 2006. The transitions of care is not about an individual. It is a team sport.

And today when we talk about team sports and transitions of care, we have to talk

about the teams between each level of care, between each communication point. Those barriers we see are still the barriers that were identified in 2006 working as the National Transitions of Care Coalition, system barriers that often lead to poor communication, not being able to share information. It's not timely. It's not presented in a format. It's not complete.

Or clinical barriers where we are not sharing and communicating with providers at each level of care. The transfer of information often is delayed. Lots of times, there is duplication of ordering of medications.

And of course, at our patient level barriers are still health literacy and understanding of not only the health illness that they're dealing with but just the care coordination that is required across the continuum of care. The next slide is one that I think really highlights what we're talking about in that in the center of all that we do is our patient and their caregiver, their identified caregiver. Yet they move through a

huge continuum of care, as you can see.

And in that continuum of care, that sharing of information is not with just one provider. It is multiple providers, multiple levels. And the more medically complex the patient's diagnosis is, the more that we see this transfer of not only the patient and family to a different level of care but through multiple individuals.

The next slide very quickly highlights -- this was developed by NTOCC. And this was just revised in 2022 to really highlight some of the things that we have accomplished but still need to consider. If you look at these areas around designing transition, you'll notice that many of them are included in the national quality strategy, in CMS' framework for care coordination.

And yet we are still struggling to highlight some of these. I think among those is around our medication management and services and coordination. We're talking about not only having good physician provider involvement but pharmacy involvement where it isn't just about reconciliation.

It is about counseling. It is about education. It is about coordination. It is helping families and patients really ascertain the medications that they need and understanding what some of these transitions, from such as acute care to post-acute, can actually mean around medications that were ordered at the hospital and yet may not be followed through in the post-acute component based on formulary changes.

Transition planning, which is so important and so timely, and information transfer. We are still dealing with 40 to 45 percent of the time, primary care physicians don't even know their patient was admitted to the hospital. And if the patient would call, that would be the first notification, and they would not have the information from that transfer.

So there are a lot of areas that are really key to identifying and really helping us understand the coordination that is needed, not only in communication but also around reimbursement for the services. The next slide I wanted to just highlight very quickly, a key

piece that the National Transitions of Care Coalition has really been working towards is really understanding that the assessment process that is needed is a culmination of the three areas where we see huge gaps and barriers around the physical health, the mental health, including the substance use disorder, and the social determinants or social needs of health. To assess one without the other often leaves a gap and barrier.

We call this the triune because it is really important that we highlight some of these factions and that we really understand the correlation in treating the whole patient and the family caregiver through this process. So let's talk just very quickly about what are some of the reimbursement gaps and barriers that our providers, our patients, their family caregivers, and some of our payers are actually identifying. The next slide, please. We often, as I said before, find the timely notification information to providers at that point of discharge and transition is delayed.

Now I do want to highlight that where we have Accountable Care Organizations

and inclusive services with physicians, we see better notification. But in our Medicare and Medicaid fee-for-service world, this is often a significant delay in really identifying the needs for the patient. The coordination between the specialist and the use -- and the PCP and the use of the TCM codes is often confusing and sometimes is not used at all because only one provider can bill.

And so when I look at transitions of care and the NTOCC looks at transitions of care, we understand that our very medically complex patients aren't going to see just one provider. A stay in the hospital and a transfer of that patient, transition of that patient to either home or post-acute often is going to involve several specialists plus the primary care. And as I said before, oftentimes our PCP is not notified about that admission.

Some providers are still talking about the reimbursement codes don't cover the administrative costs, the documentation, and billing, plus the services that are being provided. Timely access and appointment to PCP specialists for follow-up care, depending on

where you live geographically today in the U.S., that may be very, very difficult, especially if you are not and haven't identified a primary care or a specialist. If you are in a rural area, that timely access is probably going to be even more difficult.

I live in the northern part of Arizona in a small community where access to primary care physicians is often delayed. To get a new appointment to a primary care in the area I live in is often eight weeks to two to three months before you can get that appointment. So if those core coordination issues are not identified, then there are definitely delays, and there will not be consistency of treatment.

We talked about the TCM codes used only by one provider during the 30 days after discharge. And I think there is oftentimes confusion among providers who should use those codes. Medication reconciliation and management, not just reconciliation but management, also really requires our pharmacist's support.

But oftentimes, we don't have the

pharmacist in this equation and especially in these transitions. Transition follow-up with patients and their family caregivers at discharge is often not clearly identified. And if we haven't done a good assessment around do they have transportation, are they connected to the physician, do they have an appointment before they go, that confusion can only grow.

I did talk about how the TCM and the CCM[22] code coordination is not -- what I want to say, prominent. Since one provider must use these codes, yet we ask a care team among the various levels of care to really interact. So we're not talking about just one individual or one specialist.

I think of clients such as the one I will just share with you who is a diabetic, has cardiovascular disease, is obese, has pulmonary issues, and was just identified with cancer. When we think about the number of providers that will be involved in this individual's care as we coordinate care, it is key that we understand that these codes don't really

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coordinate the collaboration of these teams across the board. Patient assessments need to include all aspects as we talked about.

And I do want to highlight that the TCM codes versus fee-for-service, as I said before, in ACOs, IDSes[23], value-based payments, this is often seen to be used more frequently, still not to its full extent. But in the fee-for-service world, this is really difficult, especially when electronic health records are not connected with independent physicians. And accountable care providers who can bill for TCM and CCM since that is limited to physicians, DOs, and advanced practice nurses.

This, again, has a limit to it. So I'd like to leave you with just a few suggestions as I close. The next slide highlights some of those for your consideration to look at -- can we enhance the TCM codes so that it does support more than one provider?

One of the things we talk about is the hub provider. When a patient is medically complex, have we decided that the hub provider

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is a PCP or a specialist? Whichever that is, there should be that code for the TCM. But there should be a secondary code.

If the PCP is the hub provider but a specialist is involved, then the code needs to support both coordinating care. We also need to look at can we ease the requirements for billing? And to enhance CCM after TCM is, should we look at developing a bridge code for the handover from TCM to CCM coordination and expand those CCM codes for more than one provider so that we are really supporting collaborative practice and care coordination as a team across the continuum of care?

I cannot stress enough how our medically complex patients get lost in a lot of this process. And especially if we're going from acute care to post-acute care to then home, to rehab, back to this hospital, this care coordination really needs to be tied with some type of coordinated reimbursement. I would like to suggest we look at integrating pharmacists in part of the CCM reimbursement.

I'm going to skip to that last one real quick to talk a little bit about

collaborative practice agreements. We're hearing from those individuals, pharmacists, and often case managers who are working under collaborative practice agreements that often these are not structured. The individuals doing the service and the work are really paid less than those that are doing the administrative billing.

And that's another point to really look at. Do we need to structure some of these differently? I'd like to also recommend an additional expansion of providers of care from our pharmacist to registered nurses with bachelor's and certification in case management that are able to help coordinate this.

We do not have enough providers, especially in the rural areas, to be able to provide these services. And that expansion would help us not only support patients but to be able to give the quality of care that patients deserve no matter where they are in the United States. I also recommend that we really look at how we can support advanced practice nurses, especially in these rural and underserved what we call medical deserts that

can really provide because sometimes it is an advanced practice nurse and a pharmacist that are the only key folks that are available.

We do hear from our pharmacists that in some of these rural areas, the pharmacist may be the first contact for primary care. I want to thank the Committee for allowing me to share these thoughts. And I look forward to your questions after the presentations. Thank you.

CO-CHAIR HARDIN: Thank you so much, Ms. Lattimer. That was really a valuable presentation. Committee members will have time for questions after the third presenter is finished. So please write down your thoughts. And I'm going to next go to Dr. Diane Sanders-Cepeda, the senior medical director at United Healthcare Retiree Solutions. Diane, please go ahead.

DR. SANDERS-CEPEDA: Thank you. And thank you all for having me today. It's a wonderful experience. I want to talk about the relationship between payment features and care transition and really delve into some innovation. So if we go to the next slide.

Our focus today will be to address barriers, impact in care transitions, really talk about the infrastructure and challenges that we see across the post-acute long-term care continuum and consider some innovation such as provider partnerships and innovations around care delivery. When -- if we go to -- thank you. As we are looking at this slide, I really wanted to showcase what the true landscape is when we talk about post-acute long-term care and that continuum.

It really does focus in on those members as they're moving out of the hospital to those different post-acute care settings which are inclusive of acute in-patient rehabs, long-term acute care hospitals, our home health, and where I'm going to focus today, the skilled nursing facility. When we think about the long-term care settings, that we are often delivering care that could include the more traditional nursing home which is still within the skilled nursing facility, that assisted living model, and definitely care in the home. So we wanted to make sure when we're talking about this that we're really looking at how do

members and patients move across this continuum?

What services are available to them and really think about those challenges. What the previous presenter presented was really those issues around the transitions of care. And I think we all feel that.

We are all experiencing that. And what we noticed in the post-acute long-term care space is those patients coming into this space are often sicker, requiring more needs and more services. So if we move to the next slide, one of the challenges that we're seeing with our nursing facilities are around not only where they're located.

There can be an intense amount of variability. If I'm talking about a facility that's in a suburban population versus urban or rural, the hospitals that they are surrounded by, those places where we're looking at who are they serving, where are they admitting from. That has a huge challenge, not only because it could mean variability among the payer source but just in access and what they're dealing with as far as those social risk factors that

may be impacting certain populations over others.

And then I'd like to mention the competitive landscape. If we think back to the slide where we're looking at that whole landscape, there are a lot of people competing for these residents, these patients as they come out of that acute space. So when we're thinking about that pressure on the skilled nursing facility in particular, they are competing with other skilled nursing facilities, acute in-patient rehabs, and sometimes those long-term acute care hospitals for that same population.

And then where I want to dwell a little bit on is the payment models. What we are really seeing and thinking about as we are looking at how do we support and really delve into the challenges that our skilled nursing facilities undergo? Really have to think about how do these facilities get paid?

When we talk about this, a lot of people assume that it's really that Medicare Part A benefit that's supporting these buildings. But most of the dollars for our

nursing facilities are coming in from Medicaid dollars for that long-term care component. So when we look at how the Medicaid payments that vary truly state-to-state and how much a facility may be reimbursed, it can vary county-to-county as well.

And so that is a part that a lot of SNFs are having trouble with. There's also now we're seeing more Medicare Advantage beneficiaries similar to the program that I work in where they pay differently. They require different levels of authorization.

Those pre-authorization processes may lead to delays. And those are things that our facilities have to deal with, as well as different models like the institutionalized special needs models and the institutional equivalent special needs programs that exist now. Those programs actually do have a benefit too, and we'll talk about that as we move through the presentation.

Where I would like to go is really into the barriers. So it was mentioned a bit as we're thinking about those transitions of care what barriers and what resources are

needed and what do we try to overcome. When we're looking at the skilled nursing facility space, we do know that there are a ton of lack of resources, one being bed availability.

This is changing on a day-to-day basis, depending on the staffing that we may see, depending on those shortages in those areas. And from different areas in the country, we're going to see different needs. For example, the urban population versus the suburban versus the rural, we are having very different challenges when it comes to staffing.

And I have staffing shortages up there. And if you look at that graphic, what we've seen is that as the health care sector was rebounding following those early months in the early years of the pandemic, we saw that we had rebound in most of the health sectors except for the nursing facility and those residential cares. This is what we're still dealing with.

This is the problem that we're still having. In addition, there still remain technology challenges such as the fact that our EMRs do not speak to each other, and we can't

share data back and forth between acute care hospitals. And it really becomes a challenge when so much of all of the information being shared is still on paper or via fax.

The fourth thing I have, and I have questions around it, because there's a lot of variability. I used to say as I assessed facilities with the SNF that I once worked with that if you saw one SNF, you saw one SNF. So from building to building, location to location, even if that facility is part of a chain, we are still seeing huge variability in the way they are doing their -- executing all their daily processes, interacting with their staff, interacting with the clinical staff.

And I think that what we are often not appreciating is how the clinicians are in those facilities as well, the role of the medical director in those buildings. So all of that becomes an issue that we have to then overcome when we're talking about nursing facilities. If we're looking at -- if we go to the next slide, looking at how we're utilizing transitional care management and those codes that we have available, I will say that when

we're thinking about this population of providers who care for residents and patients in the skilled nursing facility, that there's a lot of variability when it comes to utilization of TCM codes.

What we find often is that this is more -- something more around the ACOs and those value-based care models. A lot of the independent clinicians, they don't understand or have the time to utilize these codes. So even though this study that was out of the Journal of American Medical Association, looking at the findings from 2013 to 2018, saw that there was an increase.

If you look provider to provider, you'll see that those increases were really around those entities that have a larger structure and are able to organize a code and understand that coding differently than those independent practitioners. If we go to the next slide, I want to just share when we're thinking about where do we need to go and how do we provide innovation in this space, one thing is around the provider partnerships, thinking both of the provider as the clinician

and as the SNF. We are able to look at how do we incentive and partner differently with these facilities?

Those models of care such as the I-SNPs[24] and the IE-SNPs[25], they do allow for more of an incentivized structure, where a facility can be bonus. Providers can build differently. There can be different engagement, even to the point of one of the more popular features of our public health emergency where we had that 72-hour stay waived for SNPs.

Under those care models, they already do that waiving. So that was not something that was taken away. When we look at providers, I think that this becomes something that on the value-based care side, a lot of Medicare Advantage plans have done really well in thinking about how do I partner and provide incentives beyond the transitional care management coding to providers who are actively doing the process?

So one thing that we've been able to implement for both those providers who are par

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25 Institutional Equivalent Special Needs Plans

and non-par is incentives around quality. So looking at do you have coordinated discharge with the patients that you're serving? How frequently are they back into your office after a discharge? And those things.

But none of that works without care coordination. So to the point made earlier, there needs to be extensive care coordination and delivery of care in order to get to a point where we are getting that person who's been discharged from the hospital back in front of their PCP. And what we've seen, especially after an SNF discharge, is that it's very disconnected.

So providing care coordination, whether it's a nurse or a social worker, helping that member as they're moving through that journey, navigation where we're looking at their medications and doing a full assessment of their medications because we know that there are so many variabilities between the formulary at the hospital, the formulary at the SNF. That becomes a vital component where we're thinking about how do we innovate in this space? Something that I've been able to really

design and lead with: our in-home care services and support.

We know that when patients come out of the hospital, come out of the SNF setting, they may have -- they may be in need of things as they experience functional declines. A lot of things that drive a person back to the hospital are not just, oh, I didn't take my medication. And maybe I didn't have the ability to pick up my medication.

So what other services can we do to make sure we're helping that person in their home as they're transitioning back into their home? I do believe that if we're going to talk about social risk and doing assessments on social determinants of health, I need to stand up something to support that. And what we've been able to stand up is really post-discharge meal delivery into the home.

In 2022, we had 12,000 members. And we were able to deliver over 344,000 meals to them in that post-discharge period. So really looking at how do I get in front of those social needs and risk so that we can get that member or that patient healthy and keep them at

home and out of going back to the hospital? And I will stop there and just thank you for this opportunity, and I look forward to your questions.

CO-CHAIR HARDIN: Thank you so much, Dr. Sanders-Cepeda. Another really interesting presentation. I'm sure our members will have many questions for you. And finally, I'd like to introduce Dr. Diane Meier who's the Founder, Director Emerita, and Strategic Medical Advisor of the Center to Advance Palliative Care. Welcome, Diane. Please go ahead.

DR. MEIER: Thanks so much. It's really an honor to be here. I appreciate the invitation. I'm a boarded geriatrician and palliative medicine physician on the faculty at the Mount Sinai School of Medicine and also work with the Center to Advance Palliative Care. Next slide, please.

What I want to focus is the subset of high-cost, high-need Medicare beneficiaries who have serious illness. And just so that we're all on the same page, this is the definition of serious illness: A health condition that carries a high risk of mortality

and either negatively impacts a person's daily function or quality of life or excessively strains their caregiver’s.

So you see here that in this definition, it doesn't say anything about prognosis. It says high risk of mortality. Next slide, please. So I noted in the materials that were sent to me in preparation for this session, the repeated use of the phrase transitions to palliative care, comfort care, or end-of-life services, which falsely equates the three terms and yields the opposite of the intended result.

That is it drives patients and clinicians away to the extent that palliative care is conflated with comfort measures only or hospice care or end-of-life care. It leaves the table of the treatment options for that patient. Palliative care as defined by Medicare is specialized medical care for people with serious illness, focused on providing relief from the symptoms and stress of the illness.

It is an added layer of support working in partnership with other providers and

is provided at the same time as curative and life prolonging treatment. Nothing in this definition includes stopping treatments. And access to palliative care is based on patient need, not on their prognosis. Next slide, please.

And again, here's the CMS definition with a graphic showing over time patients' need for and the varying ratios of disease-directed therapies and palliative care. It's showing that palliative care is delivered at the same time as disease-directed treatment. Next slide, please. So here's an example from the Bundled Payments for Care Improvement in a sub-acute rehab setting where I'm sure you are well aware, a high percentage of sub-acute rehab patients die within six months, 28 percent within one year.

And this is a quote from the person who is running that bundled payment program there. They used an embedded palliative care consultant within their sub-acute rehab. And she said, the only way we were able to sell the idea of the embedded palliative care consultant to clinicians was that it's not giving up and

it's not end-of-life. Next slide, please.

So what many people are not aware of is that the majority of high-cost, high-need patients are actually not dying and are not near the end of life. In fact, only one in 10 of the highest-cost, high-need patients turn out in retrospect to have been in the last year of life. Half have short-term high-needs.

So for example, someone who has a coronary artery bypass grafting and then is discharged and returns to reasonably good health. Or someone who has a kidney transplant and then is discharged and returns to reasonably good health. Forty percent, the next largest group, have persistent high cost year over year.

And that group is characterized by cognitive impairment, functional impairment, huge family caregiver burden, symptom distress. And if we impose a prognostic criterion in there, we miss that entire 40 percent group and a big chunk of the 11 percent as well. Next slide, please. So untreated symptom distress increasingly drives emergency department and hospitalization use.

And these are data on cancer ED visit primary diagnoses within the top 10. Twenty-seven percent of cancer ED diagnoses were for pain. And in the 10 years between 2012 and 2019, there was a 100 percent increase in the number of patients with any illness visiting an ED because of pain.

And you can understand why people visit the ED because of pain. What may not be so clear is that the rest of the system, primary and specialty care, just doesn't know how to manage it and doesn't manage it. Next slide, please. This is a patient I've been taking care of for 11 years. Her name is Debbie, and I have her permission to use her image and her story.

When I met her, this was her when I met her. She was a hairdresser who had been recently diagnosed with multiple myeloma, went through a successful bone marrow transplant which was complicated by severe and disabling nerve injury pain. Next slide, please. So she eventually reached palliative care after she was in the emergency department four or five times for disabling pain.

Somebody finally called a palliative care consult. She was having depression, functional decline, inability to work, social isolation, lots of suffering, multiple 911 calls. And one of the things that was most painful to her was that each time she came to the ED with this pain, she was labeled as a manipulative drug seeking patient. Happens a lot to Black and African American patients.

Once palliative care got involved, we were able to control her pain. Took a while to get it under reasonable control. She was able to return to work part-time.

She has 24/7 access to our team. So if the pain is getting worse or some problem arises, she can reach us. She has an ongoing relationship with us. We see her about once a month.

She sees her hematology team maybe every quarter or every six months. Because we are an interdisciplinary team, she gets support from our social worker, our chaplain, our yoga and art therapists, none of which are reimbursed on the fee-for-service billing. And she has not once made a 911 call or been back

to the ED in the last 10 years because the system is now -- what we're providing is matched to her needs.

And she is not dying. She does not have a recurrence of her myeloma.

Next slide. So integration is what we're seeking for palliative care, not a transition from curative care to palliative care.

Most serious illness is chronic. Most people with serious illness are not dying. And in case you need reminding, nobody is interested in dying, and everyone wants treatment that might prolong their life or improve its quality.

And this is especially true for minorities who have traditionally been excluded from care in our health care system and for whom the suggestion that they might not want life-prolonging treatment anymore is perceived and experienced as a racist exclusion. Next slide, please. Alternative Payment Models implicitly incentivize palliative care but not explicitly. And many providers have been very slow to connect the dots.

And this is a Health Affairs paper from 2019 that looks at the number of steps that APMs have used to try to manage their high-need, high-cost population. You can see the vast majority of them identify the high-need, high-cost population. Many fewer, under 20 percent, are doing routine advanced care planning.

Same, many fewer, have 24/7 access, telephone access for their patients. Only about 20 percent have hospital-based palliative care routinely available. And even fewer have routine availability of community-based palliative care.

So even though these people are at risk, and taking risk, they have not utilized this proven strategy. Next slide, please. So my point again, the great majority of these patients are not dying. The goal should be early identification of these patients, 90 percent of whom are not in the last year of life.

And the population includes about 80 percent of Medicare beneficiaries who are hospitalized. Most skilled nursing facility

and long-term care facilities would be eligible. And in primary care, it's about 10 percent of the total patient population that would fit this criterion. Next slide, please.

So these are the criteria for palliative care needs for screening. And you will note that diagnosis is not listed here. I have lots of patients with lung cancer who are working full-time.

They do not need palliative care right now. They're functioning well. They feel well. Their disease is under control. But these factors are consistently valid predictors of high utilization and repeated utilization, functional and cognitive impairment, symptom distress, caregiver distress, frailty, social drivers of poor health, psychiatric and substance use disorder, comorbidity, and recurrent utilization, hospitalization, and ED visits.

Those screening in should have mandatory palliative care consultation and/or co-management and quality measures that reflect and incentives that reflect the proportion screened and referred. Next slide, please. So

the barrier between high-value care transitions and palliative care is precisely this misconception that conflates palliative care with comfort measures or end-of-life care. It is the surest way to reduce access to palliative care, is to conflate it with end-of-life care.

And as you know, discharging patients from hospital to post-acute, sub-acute rehab without prior clarification of achievable goals for care is often a very low-value care transition. Seventy percent of patients with cancer discharged to a sub-acute are dead within one year. Sixty-four percent of patients with stroke discharged to sub-acute rehab are dead within one year. In the other non-cancer groups, it's about 25 percent.

And that's where you see these articles on rehab to death because the sub-acute rehab is paid more, the more rehab it provides, even if the patient is dying. Next slide, please. So our recommendations are that we use the new NQF[26]-endorsed patient reported

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outcome measures, patient experience of feeling heard and understood, and patient experience of receiving the desired help for pain as measures of the patient experience with transition management. We recommend explicit requirements and payment incentives for screening for and referral to palliative care from the ED or during hospitalization.

And that we start requiring access to palliative care specialists and screening for needs in all relevant settings. Next slide, please. And in case you think that's just not something CMS can do, it did it with left ventricular assist devices. CMS requires the presence of a palliative care specialist on an LVAD[27] team.

None of us know how they came up with that idea, but they did it. And there was no objection to it, and it is happening across the country. So why not in other settings? Next slide, please.

So the main takeaway is that a strong evidence base indicates that palliative

27 Left ventricular assist device

care delivered from the point of diagnosis well before a patient is near the end improves quality of life, reduces caregiver and clinician burden, and reduces avoidable utilization. In contrast, linking it to hospice or end-of-life results in markedly reduced and delayed utilization, both because many of these patients are not dying. So they shouldn't be shifted to a care program for the dying.

And because nobody wants to be so labeled, and people want to live as long as they can. So we need to stop linking palliative care to transitions away from traditional treatment. And we need to add mandatory screening for palliative care needs, referral, and inclusion of specialists in the care of those who screen in as high-need, high-cost. Next slide. Thank you.

CO-CHAIR HARDIN: Dr. Meier, that was incredibly helpful. Thank you so much. We're going to turn next to an opportunity to ask questions. We have until about 2:40.

I'll start us off with one question, but PTAC members, if you have a question you'd

like to ask, please turn your table tent with your name upright, and I'll call on you as those questions arise. So one thing that's really important as we look across settings and care transitions is really the integration of health equity and health-related social needs.

And each of you have touched on that, but I'd like to give you each an opportunity to go a little bit deeper. If you are going to make recommendations to this group about what should be considered as essential in addressing health-related social needs, what recommendation would you have for the group? And whoever would like to go first can start.

DR. MEIER: Well, if no one else is ready to start, what I will say is that the most valuable member of our team is our social worker. And Medicare fee-for-service doesn't enable support of those people. Without a social worker, we cannot reduce utilization no matter what we do medically or spiritually or from a nursing standpoint. If we can't find safe housing, if we can't organize transportation, if we can't figure out a way to get the meds paid for, that patient is going to

show up in the ED because that is the only place that has to take care of them. And the failure to recognize the essential role of social work in addressing social drivers of ill health is one of the key faults in the traditional Medicare program.

MS. LATTIMER: This is Cheri. I couldn't agree more, Doctor. And we not only see the value of the social worker in these instances but of the certified case manager, be it nurse or social worker, who really understands the need for coordination and resource.

And unfortunately in most cases, they are not paid for either. And so they are often looked as a cost center rather than a revenue center. And yet in the long run, they help improve the quality, the consistency, and are the advocate for that patient and family caregiver. So the National Transitions of Care Coalition has pushed forward heavily with social work and nursing involved in case management and in these social needs to address them because, again, I will quote a favorite of mine which is Dr. Coleman. He said 50 percent

of his readmissions at this point in time are often related to the social needs assessment that wasn't done rather than to the clinical care plan that was developed.

DR. SANDERS-CEPEDA: So I definitely will pile onto both of those comments about social workers and the need that we have in our skilled nursing facilities and across the post-acute care continuum. I think that one of the advantages that we've been able to really look at on the payer side is how to stand up some of those things where we do have more social support and caregiver support being delivered to those members of those programs. But what I would ask and recommend is for us to think a little bit broader and really look at what is driving the outcomes and look at where the members -- rather the beneficiaries of Medicare fee-for-service, what are their needs in their community?

How are we addressing those needs? Because if I have someone who's living in a food desert -- and we can tell. We can go to -- look at what's going on at the level of the ZIP code.

That data is available to all of us, but how are we utilizing it? How do I send a person home to homelessness? And then if I admit them into an SNF, what happens thereafter?

I think those are the bigger questions that we need to be asking. We need more boots on the ground. So we definitely need more licensed social workers in the nursing facilities doing this work.

We need to support it better. You know, I think I can speak for my own experience of always being in the social worker's office because we had those difficult cases where we were trying to discharge a person. And we had no -- we knew there was no caregiver support in their home.

We knew that within three days if we didn't get this setup correctly, they will be back in the hospital. I've been able to go into a person's home to do a home visit and see that their refrigerator is empty, see that their home lacks security, that they are tripping over items. Yet I can't get anyone to come in and do the cleaning. And that support

that they may need that doesn't seem like it's medical, but in the geriatric population, becomes very critical to keeping a person in their home and keeping them safe.

CO-CHAIR HARDIN: Thank you so much. Valuable comments. So I think Larry, you are first.

DR. KOSINSKI: Well, my question is for Cheri. And everybody on this Committee knows how happy I was to hear you say that we should be able to pay multiple TCM codes. But you didn't mention PCM[28] codes. And so you talked about TCM and CCM. But since the beginning of last year, a specialist can bill for a PCM code which only requires one chronic illness. Could this be a solution for the specialist to help coordinate their component of care in a post-hospital admission period?

MS. LATTIMER: I think that the application of the PCM code is at this point still somewhat misunderstood. When you apply it, when you don't apply it, and to what patient versus the patient that may fall under

28 Principal Care Management

the TCM and the CCM. I think what we often hear is the confusion around these codes and the integration of how these codes might work together. So there definitely needs to be some clarification on that.

I do honestly believe that the application of the PCM code could be expanded when you have that patient that has multiple specialists plus the primary care. I do get concerned on who is going to be considered the hub. Who is the one that is going to really have the full oversight of what we see?

I go back and I look at programs that CMS has put in. And you can see the program by disease state. So it still is siloed by that disease state.

How do we integrate that when your patient has five of those chronic diseases integrated and coordinate that? Who takes that responsibility as hub versus the specialist? And how is that really couched in reimbursement?

I wish I could give you an answer that I think is the best thing since sliced bread. But we constantly talk about this at

NTOCC. We do know and I do want to stipulate that as a provider care team across these continuum of services, we have not used our pharmacist as we should, which helps coordinate this multi-poly-pharmacy issue that we have.

And they have under their medication management services a broad breadth of services that can be integrated. And so as we talk about TCM, PCM, CCM, I encourage you to look at it. How do we incorporate that pharmacist as a provider of care in there for this specific aspect?

And I know in some cases that is somewhat threatening to individuals. But we're at a point where the shortage of our providers is so great across the board in primary care, in our pharmacy case management. And I'm going to say this because in health equity, I believe this.

We need to have the cultural and racial representation in our workforce to work with our patients and their family caregivers. It's one of the reasons I love the health care worker that is in the community because oftentimes they are able to relate to this. So

I know I kind of went on the one side. But in answer to your question, I do think PCM gives us an avenue. And I think we need to see how we can incorporate that and integrate it with TCM and CCM across our care teams.

CO-CHAIR HARDIN: Dr. Meier, Dr. Sanders-Cepeda, did either one of you want to also comment?

DR. SANDERS-CEPEDA: I support what Cheri said.

DR. MEIER: Yeah, we agree.

CO-CHAIR HARDIN: Excellent. We'll go next to Angelo.

CO-CHAIR SINOPOLI: Thank you. So this has been a great conversation. And what I visualize seeing here looking at the three of you as you talk, you really described a very integrated model between the three of you in a very complex matrix of care for very complicated patients. And what I'd like to ask and maybe starting with Dr. Meier is in what you all have described, how specifically do you partner with and integrate with primary care physicians or do you?

DR. MEIER: So in the ideal world,

very regularly. So we're a health system that has an electronic health record that has a chat function. And we are constantly updating one another between the multiple specialists who are caring for our patients, our palliative care team, and the primary care doc.

And that sometimes daily communication through Epic Chat has revolutionized the ease of communication because it doesn't have to be synchronous, right? We don't all have to be on the phone at the same time. And it really makes a huge difference.

Where it breaks down, of course, is when the person we're trying to communicate with is not in our system. And many of our patients are getting care all over the place. Or if the patient is in a facility, those people are not -- I don't know if health policy can fix that brokenness of electronic communication around health care. But it is a major barrier to controlling --improving quality and controlling cost.

DR. SANDERS-CEPEDA: So I can jump in next. I'll say that from where I sit is a

little different. We have now 1.8 million retirees as part of our group Medicare Advantage plan.

And they are across the country and the Virgin Islands, Puerto Rico, and Guam as well. So there is a lot of diversity in around who we are providing care for, as well as the providers. The way our infrastructure is set up, we are trying to not only identify those primary care physicians from the members of the program.

But any information that we're getting in, where it identifies that this is a person who is working as a provider in our plan. We're then trying to get in front of them as far as meeting them in their offices, going out, doing virtual visits, and working with them to become part of what we call an incentive program where every time they're meeting these quality metrics, we are including them in that bonus that we make it from meeting that Star measure. So they are also incentivized.

We've been doing this now for over five years. And it has worked very well in

those markets that we serve. We still though see those barriers around people not being attributed to any primary care physician who you may find when they initially meet, they go to the emergency room. So one of the programs that we stood up is really trying to get in front of that person and get them a virtual visit, at least if not, an in-person visit with a primary care provider within seven days of that presentation to the emergency room.

CO-CHAIR SINOPOLI: Cheri, I'm interested in your insights.

MS. LATTIMER: I'll just add what I think is probably pretty -- what do I want to say -- easily identified today as we look at this care coordination. As I had said in my presentation, when we see ACOs and IDNs[29] and Medicare Advantage plans, we see better coordination. We are struggling, and there's just no doubt about our primary care physicians in a fee-for-service world who are independent physicians being inclusive in all of this care, in notification, in trying to coordinate.

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I can share my age with you all by telling you that when I first went into ambulatory practice back in the early '70s, it was general practitioners. And believe me, they were the hub. They were the coordinator.

They did everything. The doctor I went to work for was a surgeon and delivered babies across the board. We don't have that today.

So to try and coordinate these individuals is difficult. I do believe, though, that by incentivizing the impact of value when coordination is given when patients are in the hospital and transition to that next level of care to that primary care physician, especially if they are linked and they have identified them. That is key in the fee-for-service world of starting to try and pull this together.

In the rural areas, it's going to be more difficult. But our primary care physicians that work with us often are linked to, as I said, ACOs, Medicare Advantage. But those that are independent constantly structure with that communication about their patients.

DR. SANDERS-CEPEDA: And if I can jump back in for a minute just as a person who came from that independent practitioner role being a geriatrician in the community that I served, it was difficult then. It remains difficult when you're doing that assessment and getting that information from the hospital system. If it wasn't for trying to get in front and making sure every person who came into my office knew if you go to the ER, I want to know, and, like, really being supportive, that we wouldn't know.

We wouldn't know until we either got a call from the hospital if I was on staff and could admit that patient. If I wasn't on staff, I wouldn't know until they were discharged and coming back into my office. And the fact that it still exists in that manner is really distressing. I think it's an opportunity beyond the ACOs and Medicare Advantage.

There needs to be an opportunity for fee-for-service Medicare as well to really think about what do we need to do so that these patients who are now in the emergency room then

being admitted to the hospital to an SNF, home with home health, coming into their PCP office three weeks later, know and can get that information because that becomes a huge barrier, in trying to get information from five different sources. It is a redundancy that I hope that we can solve for. But I will say that in the lifetime of my practicing, has not been solved for yet.

CO-CHAIR SINOPOLI: Thank you for that.

CO-CHAIR HARDIN: And next we'll go to Jen.

DR. WILER: Thank you so much for your presentations and really engaging conversation. I have a two-part question, and I think I'm going to direct it first to Dr. Meier. But I'm curious to your thoughts on both.

And I'll give you my two questions together. The first is, Dr. Meier, you recommended payment, some recommendations around incentivizing high-value care regarding payments. And that's around both the process of screening and then ultimately access, which

I interpret as intervention and treatment.

So I'd like to give you some space to describe a little bit more your or the panelists' thoughts around how to incentivize this high-value care around a team that is provider, nurse case managers, social workers, and I assume probably a pharmacist would be added to that team. Is your vision payment would be for the ambulatory space, the in-patient space, facility, provider? Could you just give a little bit more clarity around how to create those incentives regarding payments?

And then my secondary question will be then around -- I think there's lots of recognition around how important this service is. But I will tell you, at least in my own community in the Rocky Mountain area, there's a huge recognition, but there's a lack of workforce to deliver this care. Although we may have a process for screening and identify patients, it’s screening to nowhere potentially.

So you can talk a little bit about workforce issues and innovative care models you've seen. And again, I'm going to tie that

back to payment. How do we incent those innovative care models where there may not be access to the support and resources? Thank you.

DR. MEIER: So I'll start with the latter part of your question, which is that since we don't incentivize use of palliative care, we have a workforce problem. We don't have any workforce problem with orthopedic surgeons. We have tons of them because we incentivize the work of orthopedic surgeons.

We disincentivize the work of people in palliative medicine. And that's a policy fix. It's not an advertising problem. It's -- if people can't make a living, if they can't work with a team because there's no reimbursement for the team, it becomes -- you're asking people to be Mother Theresa.

And there are a lot of Mother Theresas in the field. But that's not a scalable model, right? And that's what we're relying on right now.

In terms of models that identify, there are some bundled payment models and several others that embedded palliative care

consultation in their model and attribute their success in improving quality and reducing cost to that embedded palliative care consultant or team. So when the incentives are right, the payment incentives and the quality measurement incentives, and when people are incentivized to use palliative care as a mechanism of improving value, they will. It's really just -- it's both the carrot and the stick.

We want you to -- a good example is the Commission on Cancer added a requirement for access to palliative care about 10 years ago. The number of palliative care programs in the South and Southwest of the United States increased by 300 percent within a year because there was an accreditation requirement. We don't have an accreditation requirement for palliative care anywhere in the Medicare system.

The only place that it's required is in LVADs. But it could be required much more broadly. When it's required, the resources will be applied. But it isn't required anywhere. The fact that palliative care has grown as much as it has despite a complete lack

of policy incentives for it to do so is a measure of how desperately needed it is. And that health systems have invested money they're not getting back on fee-for-service and supporting these teams.

DR. SANDERS-CEPEDA: I would just add that the evidence is there for why we need palliative care solutions. I think what has always been distressing is that sometimes it's regulated to, like, a box that's being checked. And it needs to be so much more than that.

If you look at cost-benefit analysis ratios, and I could bore you with utilization spreadsheets. But when we see active engagement, active delivery of palliative care services, we see that the cost go down. It is a proven model, a proven care delivery service for how to manage complicated patients.

And it should never start at the end of life. It needs to start, like, at the beginning of that diagnoses. And we see the benefits when we do that.

DR. MEIER: We need some help from government to get the flywheel moving.

MS. LATTIMER: I think also that

helps support the work that we require in palliative care is to look at codes that pay for the care team. Jennifer, you identified the care team as you went through. Maybe it's truly identifying and mandating that is the care team that needs the basic -- let's call it the basic care team. You can add to that.

But the basic care team needed for that service. And that the codes are around that team working together rather than as one provider in that team has to do all the billing and everybody else has to do the service. We need to go beyond a single provider to the broader breadth of care teams that deliver this type of care, whether it's transition, care coordination, PCM. We need to think about it in the team concept rather than the individual. I hope I said that right, Doctor.

DR. MEIER: You did, brilliant.

CO-CHAIR HARDIN: Did you have another layer you wanted to add to that, Jen? Or did that answer your question? Jim?

DR. WALTON: Sure. I had a question to the entire panel. If we were to kind of wave a magic wand and have a global payment

like we do as the example was used a moment ago of orthopedic surgeons. And there was a model for global payment of a total joint.

If there was an equivalent global model for palliative care-led TCM activities and that was rolled out, if that was developed, would you think there's the cost that we've discussed here today that you all have illustrated, the cost of having that complex interplay of services in connection to the PCP, would that cost be covered by the savings? And is that information available? We could do the -- is the actuarial horsepower available to evaluate?

Like, what you would say, this is what this would cost and we would divide it by this many patients based on capacity. Would that generate enough savings? And has that been kind of -- is that in the literature I guess is what I'm probably asking. And if it's not, how would you construct that?

DR. MEIER: So the answer is yes, it's in the literature, whether it meets CMS' criteria for adequacy of data. I will tell you that the great majority of Medicare Advantage

plans contract with palliative care vendors. So they believe in it.

There are these private for-profit palliative care vendors, many of them that are getting a per member, per month payment from the MA[30] plan. So MA plans are boding with their feet on palliative care. Traditional Medicare has not done anything to incentivize access to it.

So the question is, what's the standard for making that decision? And is the data standard so unreachable that we'll never get there? And that's perhaps a worry.

And the other issue with a care transition or a care management payment model is that it has to be worth the squeeze. And it hasn't been within fee-for-service Medicare. It's a huge amount of administrative hassle, and the payment is not meaningfully equal to that. So it depends a lot on what the payment is.

DR. SANDERS-CEPEDA: I would add that to your point, Diane, we're doing that.

30 Medicare Advantage

That is something that we're actively doing when we're thinking about the cost-benefit analysis. What is the cost versus the benefit of taking care of a patient and being proactive and engaging that patient proactively with palliative care services?

We've recently invested in a home-based medical care model that is going to be able to deliver that palliative care eval and then treatment in the home because we know that if we want to keep a person out of the ER, we need to be managing them appropriately. And if you're not thinking about all of their symptoms and the challenges that they may have, those palliative care needs, that you're not doing that appropriate management. Time and time again we've seen that model work.

It is the basis of the I-SNP model that we support through Optum. It is the basis of the IE-SNP models that we support as well. And so on the Medicare Advantage side of it, if you're looking for that data of how to do it, there's a lot of resources that the Better Medicare Alliance has put forth as far as studies that been done to show that this does

work.

Now every Medicare beneficiary should not be on a MA plan. So where we need to figure out is how do we make this work in the fee-for-service world? We are utilizing a lot of resources on the fee-for-service side.

And the reward for taking care of a person who is sick on the fee-for-service side is to get another encounter billed. And as long as that is the reward, then we're going to still see the same outcomes. So I think it really behooves us to be innovative in the way we're thinking about how do we pay the providers if we're forming a team?

What does that look like? And how do we pay them more for the value that they're bringing instead of just that encounter with those codes? And however many codes you can get on that one encounter so that I can beef up that claim. That is not going to get us to a place where we will see the outcomes that we're seeing on the Medicare Advantage side.

DR. MEIER: Absolutely.

MS. LATTIMER: I would agree with what both Diane and -- I'm sorry, Dr. Meier had

just --

DR. MEIER: We're both Diane.

DR. SANDERS-CEPEDA: We're both Diane.

MS. LATTIMER: I was looking at this. I'm, like, okay, they're both Diane. But I can't stress enough where we are with the fee-for-service. But I also want to take what Dr. Meier was saying that palliative care shouldn't be transition. It should be an integration into that.

And maybe that is a way to really look at that in the fee-for-service world is that it isn't just a handover or a handoff. It's an integration into the care coordination model. But it is a team model that we look at and that we identify.

I know that fee-for-service is so much more difficult. But the fact is that there is extreme cost in that fee-for-service because it is rewarded by encounter rather than really by the value added or the coordination of the team that is done. So I just encourage us to really look at that and question. I mean, I think it's time to question why can't

we change some of these things that in transitions and care coordination we've been talking about for a number of years.

CO-CHAIR HARDIN: Very helpful. Larry?

DR. KOSINSKI: I just have so many questions today. I just -- I have to say, though, before my question, this has been a fabulous panel. I've learned a lot from each of you. Thank you very much.

My question is about care coordination. And each of the three of you have alluded to it or mentioned it directly in the course of your statements today. And I live in the care coordination world in my real life.

And it is very difficult to get a health plan to give us a value-based care program around care coordination. It's not easy. And so I guess I'm going to direct my question, even though all three of you can answer, I'm going to go to the payer representative, Dr. Diane Sanders-Cepeda. And tell me in the absence of a value-based arrangement, how do you compensate a provider

group for care coordination?

DR. SANDERS-CEPEDA: That is a great question. I think that we have been able to stand up those type of relationships where we are looking at what that provider group may be delivering around care coordination. But what I think we've leaned into because we do understand how difficult it is on the provider side to do that.

What we were able to lean into is incentivizing that provider group in the model that we have where we are sending out our quality field manager to their office to be with their practice manager and look at, okay, these are all the things that they're doing to bring value. Here are all the gaps of care that they're closing, the amount of recommendations that they're doing that are in line with how we are closing and addressing those Star gaps. And then incentivize them with a check that goes directly to their office.

We're actually standing up a pilot in Georgia around Z-codes because we want to be able to make sure we're getting up front and

identifying any member with a social need who is at social risk. Teaching the primary care physicians, those are codes that we know they're not the most attractive of codes. But they tell us something where you're coding them.

But we understand that the value of that code is low on the radar. So we want to incentivize you directly and incentivize your staff for going through the social determinants of health screenings that we are trying to develop for the population. So in that way and working directly with those provider groups, we know they don't have to be an ACO to do that.

We're just looking for groups who are enthusiastic and willing to do that type of work and lean in with us. Now what may or may not happen, their structure may change, and they may become an ACO with us thereafter. But when we're looking for partners for innovation.

We're just looking for enthusiastic providers. And we want to make sure that we are equipping them with that incentive -- those incentives. The other thing that we've been able to do is really have them link up with the

care coordination that we are delivering on our end as part of our standard program because we, like I said, time and time again, have seen the value of doing that.

So when we have a group who's providing it, we don't want to disincentivize them. We want to reward them. But then also link them with our teams so that we know how to navigate the care for that individual together.

CO-CHAIR HARDIN: Walter, you're next.

DR. LIN: This has really been a great panel. It's kind of taken a different direction than I had anticipated. But just super valuable information and perspectives.

At first I was going to ask about our panelists' perspectives on how should palliative care be reimbursed under fee-for-service? I think it's clear that there's huge value for palliative care in value-based payment model. But under fee-for-service, though, palliative care takes often a long time. And the financial savings is often in the avoidance of care, how you value chemotherapy that was never given or dialysis

that was never undertaken because of the palliative care consult.

But I just don't know how Medicare does that. I mean, how does Medicare in the traditional fee-for-service world somehow value palliative care the way it should be valued, the way that Medicare Advantage is valuing it because Medicare Advantage is taking full risk and getting payment on the back side or decreasing costs on the back side and able to apply the savings to palliative care? So that was my original question. I have another question. I'm not sure we'll have time, though.

DR. MEIER: Well, right now, fee-for-service Medicare does not incentivize palliative care except insofar as it reimburses hospitals through the DRG[31]. So hospitals are highly incentivized to reduce length of stay, reduce complications. Palliative care is extremely helpful in helping hospitals prevent those long complicated hospital stays that block beds and cost them money.

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31 Diagnosis-related group

So to the extent that hospitals are incentivized by hospital mortality, readmissions, and length of stay and complications, hospitals across the country, 95 percent of hospitals with more than 200 beds have a palliative care team because of those financial incentives. Not because there's any JCAHO[32] or other accrediting body requirement. There still is not.

And I think that's appalling for hospitals and other entities that there's no mandate that palliative care be available in hospitals. That would help a lot if there was one. But the outpatient setting, it's just Part B, right, and Part B evaluation of management codes. And some care coordination and some TCM, but you can't make a living for sure, and you can't pay for your team.

And this is what really makes me nervous is that many of my colleagues are going over to work for MA plans or MA vendors and leaving the fee-for-service system because they literally can't support themselves. And some

32 Joint Commission on Accreditation of Healthcare Organizations

health systems are not investing adequately. So that's a huge risk to traditional Medicare that the workforce is going where they can make a living wage.

DR. SANDERS-CEPEDA: I can jump in, too, and I probably talk from the different perspectives. But to Diane's point, if the only thing that I have available on the fee-for-service side is what the 99497 type of code, that E&M[33] code and maybe billing a prolonged service code. That doesn't really speak to how you're incentivizing someone to do this work.

I think that we -- I don't think that -- I think there's opportunities to be more creative outside of just the way we're coding. It may take a different structure. But it doesn't have to only exist in the Medicare Advantage space.

And I know -- I think what I was thinking about making a transition, it was really about trying to design clinical programs that actually solve problems because of that

33 Evaluation and management

frustration where I can see 40 to 50 people a day. But trying to get the staff paid and trying to get myself paid out of that was very burdensome and very taxing. And if you're trying to practice geriatric medicine, it's impossible to see 40 or 50 a day.

So I think that when we're thinking about those care models that can work, how do you take some of the learnings from a Medicare Advantage plan and then build up these programs like we've described today? It's not an impossibility. It just means that we are looking at valuing that group.

If there's a group who becomes the hub that Cheri talked about, and they are doing this work, how do you pay them for the work that they're doing? I think it just becomes about being creative and realizing that cost avoidance, as was mentioned, is very valuable. Not only to the overall quality of that person's life, it is also valuable if you're thinking dollars and cents and how much money is wasted by the time we get a person to the end of their life.

And that last six months where we

know that their quality takes a nosedive, and we are now spending all this money, they're going to -- having multiple transitions in a month, and no one is having the hard conversations because we don't seem to have it until we're really at the end-of-life, when we should've had those conversations and really thought about this three years before -- four years before. And Walter, I might have gone on a soapbox. Sorry about that.

DR. LIN: No, I was just going to say note to ASPE staff. This might be a broader topic to pursue in the future.

CO-CHAIR HARDIN: And I think we'll go to Angelo next to wrap it up.

CO-CHAIR SINOPOLI: This may be a short question. I'll start it out to direct it at Cheri. So there's been a lot of concern about patient co-pay related to CCM billing and a lot of that being a barrier to access the CCM.

Are you experiencing the same thing? And have you figured a way to get around that? Or are you doing Part B waivers? Can we talk about that a little bit?

MS. LATTIMER: We actually hear from our providers that that often can be a game stopper right in the very beginning if we're telling a patient that they have a co-pay under Part B for the CCM. I think we tend to forget that many of our seniors are on the fixed income of Social Security. And when you have to talk about a co-pay, it is a real disincentive.

There are issues around waivers as you know in the fee-for-service for that. NTOCC has submitted comments back to CMS asking that that be taken away. It is my understanding under the Medicare Advantage plans, there is no co-pay for the CCM which, again, encourages us to use these things under our Medicare Advantage or our ACOs or IDNs but tends to stop us in the fee-for-service.

As long as -- and this is heartfelt for me -- as long as fee-for-service is the more you do, the more you get paid, we are on an uphill battle to really make this work which is one of the reasons I think all three of us said maybe it's time in the fee-for-service world to really look at a team concept on how

we might be able to bill for that based on a team. I also think, in all honesty, we need to expand our ability to provide that through providers.

As I said, an advanced practice nurse with a nurse, social worker, pharmacist is able to provide a lot of this care. And it doesn't always have to fall on the shoulders of the MD and the DO. I just think we keep making these administrative burdens so great that the administrative side of the code versus the payment is the deterrent right there.

CO-CHAIR SINOPOLI: Thank you. Anybody else have any comments?

DR. MEIER: Enthusiastic agreement.

DR. SANDERS-CEPEDA: Right there with you.

CO-CHAIR SINOPOLI: Perfect answer. Good.

CO-CHAIR HARDIN: This has been an excellent discussion. We appreciate each of your really important contributions to this. We'd like to welcome you to stay and listen to as much of the meeting as you can.

We'd love to have you on. Right

now, we will take a short 10-minute break until 2:50 Eastern before moving into our first listening session. Thank you so much for the rich dialogue.

(Whereupon, the above-entitled matter went off the record at 2:39 p.m. and resumed at 2:52 p.m.)

CO-CHAIR SINOPOLI: Welcome back, everyone.

In planning this meeting, PTAC wanted to prioritize hearing from those with frontline experience managing care transitions within value-based care. To that end, we invited four experts from across the country for this panel. You can find their full biographies posted on the ASPE PTAC website along with their slides.

At this time I ask our panelists to go ahead and turn on your video, if you haven't already. After all four have introduced yourselves, our Committee members will have plenty of time to ask questions.

We'll start with the introductions first.

* **Panel Discussion 2: Provider Perspectives on Payment Models for Incentivizing Improved Management of Care Transitions**

CO-CHAIR SINOPOLI: First, we have Dr. Charles Crecelius, who is the medical director of post-acute care at BJC Medical Group.

Welcome. And please begin, Chuck.

DR. CRECELIUS: Thank you very much for having me. I have to admit I am just retired and will be going back into clinical academic work.

In my previous role I've just left, I was the post-acute medical director for BJC Medical Group, which is basically the private practitioner arm of Washington University and Barnes-Jewish Hospital.

In that role, I've been helping case management, in placing patients from the hospital into nursing homes, and helping with the transitions from nursing homes out to home care and back home.

I have 35 years of nursing homes, clinics, and hospitals, five years in more

administrative work.

In my past iterations, I'm the past president of AMDA, which is the National Society for Post-Acute and Long-Term Care. Was the Medical Director of the Year, Public Policy Chair. And I work on the fee-for-service side on the AMA Relative Value Update Committee to assist in determining appropriate values for Part B services performed by physicians.

Are we going to go to the next slide to summarize or? Thank you.

The heart of my points today, communication and improving treatment in place.

After the last talk I'm going to have to add a brief comment about advanced care planning. Communication barriers in transitions is a big problem. Nursing homes and hospitals, private doctors often have entirely different EMRs. And we are not at a point yet where we can seamlessly relay information across EMRs. We are far from it still at this time.

We've worked on our system to produce a reliable continuity of care document to serve as a discharge summary from skilled

nursing homes. Hospitals are pretty good at putting out a good discharge summary. They have the capabilities of the typical EMR systems.

Nursing homes, however, are in entirely different world. They do not get nearly the financial support from the federal government when we went to electronic health records and, therefore, they have a much less robust system that frankly does not talk well with other systems.

And, in fact, when you're discharged from a nursing home, there is normally not a good discharge summary. We use a continuity of care document. But that document isn't always able to be translated by other EMR systems. There is a mapping or translation problem.

So, currently my area, in St. Louis, only one of the three major nursing homes' EMR has any ability to translate information back into hospital records, otherwise we're stuck with paper. And if you've ever worked in a nursing home, you get people from the hospital with about 200 pages, and you send them out with about 100 pages of information that's

disjointed and not always in a good format.

The second point I want to bring up today, improving treatment in place. The best transition is no transition. And, unfortunately, about 22 percent of patients from the skilled nursing home go back to a hospital setting during their stay.

While value-based medicine does have penalties for that in place, fee-for-service really is still at a point where it doesn't have much value, doesn't have much of an impact yet. And in particular because in the PHE[34], those penalties were not enacted.

But we've had several projects trying to keep people treated in place. I was the medical director for one CMMI project. We did show substantial reductions in avoidance of transition back to the nursing home. Unfortunately, this project used several different sites with several different methodologies of achieving this. And the whole project did not reach statistical significance.

However, the two most closely to

34 Public health emergency

ours would be Indiana University. It showed significant results in reducing hospitalization by treating in place. Very simply, if somebody is developing sepsis, I can get an antibiotic started within less than an hour.

If they go to the hospital it's five hours, and you're even sicker, on a good day.

One last item I did not put in here but I need to put in my two cents worth after hearing the others talk earlier, particularly Dr. Meier, our system is very invested in advance care planning. And it's really goals of care we're trying to get to.

Physicians tend to think of code status -- full code, no code, limited code, am I going to shock you heart enough? Goals of care are more significant than that. What am I trying to achieve for this patient in their current status?

It can be simple as an 88-year-old female saying, I want to get to my granddaughter's wedding. After that, I don't care.

Sometimes it's, obviously, more complicated.

Currently at our hospitals now, if you take the 20 percent sickest patients in the hospital, and the hospital gets an alert to tell them this patient is very ill, likely to return, or likely to have an adverse effect in the next year, you need to have a palliative care conversation, goals of care conversation, or have palliative care see them to do this. Or, ultimately, write why are you not getting it?

That program in our hospital system has resulted in a 20 percent change to post-status. That was not our intent. Our intent was to get goals of care listed in a particular section of the chart that people could see going forward. But we did see an immediate effect both on that, on our ICU[35] length of stay. Our ICU length of stay in people who have undergone this is about 20 to 30 percent shorter as a group than those who have not had this conversation.

So, transition involves more than just going from one place to another,

35 Intensive care unit

obviously, which we talked about on the other session. It involves a lot coordination, right timing, and right communication.

So, I'll hand it over to the next person.

CO-CHAIR SINOPOLI: Okay, thank you.

DR. HERMAN: Good afternoon. I'm David Herman and I -- Go ahead.

CO-CHAIR SINOPOLI: Okay. Next we will hear from David Herman who is the chief executive officer of Essentia Health.

Go ahead, David.

DR. HERMAN: Well, thank you very much.

I have the privilege of being the chief executive officer of Essentia Health. And you can see our footprint there.

We are primarily a rural health care provider. But we began our shift to value in 2005 when we first entered our first value-based contract. This led us to become an early adopter of dual risk-side models within the Medicare Shared Savings Program and Minnesota's Medicaid Initiative called Integrated Health Partnerships.

Currently we have 23 value-based programs with both government and commercial payers, with more than 200,000 attributed lives. And we truly believe, and our data supports that, is that it's been said that value-based care can't be implemented in rural America, that it just doesn't work. In our experience we found that it really is the only thing that does work.

And several weeks ago three of my colleagues and I had an opportunity to spend two hours with the Health Finance Subcommittee of the Senate Finance Committee in Washington, D.C., and provided about two hours of testimony just on this topic.

And I can provide the link for anybody who is interested in seeing that.

In order to be able to deliver that, we have had to become essentially a vertically integrated health care system. So, we have about 15,000 colleagues, 14 hospitals, 77 clinics, with almost 80 percent of our revenue coming from outpatient services rather than in-patient services.

In order to be able to manage, and

better manage, and better plan those transitions of care that Charles just talked about, we also have six long-term care facilities, six assisted living facilities and independent care facilities.

In some of the appendix material that I've shown is that EMS services in rural America are very challenging as well. And we literally have to pick up and own EMS services to provide that transportation.

We have also been an early adopter of telehealth services. And we were fortunate in setting up the infrastructure to do that and making it part of our strategic plan. When the pandemic hit us, literally in March of 2020, we went from several hundred video visits a day to over 3,000 video visits a day, and still maintain a footprint of well over 1,000 of those today.

In a rural footprint as you see there, the transportation and other challenges make it difficult. And what we have tried to do during this transition is not to take the in-office experience and move it to the home, but to determine what are the suite of services

the patient really needs, and then leverage that home location to provide better, more rich information to help our patients on the journey to wellness.

We firmly believe that each of our patients does not want to buy health care services. Each one of our patients wants to be healthier and avoid the health care services.

Next slide, please.

But rural health care is distinctly different than urban or mid-urban health care. And that red circle there is our service area in Minnesota. And the demographics of that service area are the same as our service area in Northern Wisconsin and the State of North Dakota.

In general, patients have lower household incomes. They are certainly older. They have less education and more health concerns.

At our flagship hospital here in Duluth, Minnesota, more than 30 percent of our in-patients on any given day have a diagnosis of diabetes, not necessarily as their admitting diagnosis but certainly as a comorbidity.

Distance to care is certainly greater. We have some of our patients the nearest medical facility, whether it's a doctor's office, an emergency room, or an urgent care center, is 90 minutes one way from their home. And when they're back at home, they're relatively resource-poor.

They are generally living in food deserts. They have extremely unreliable broadband connectivity.

We have advocated with the State of Minnesota and the federal government over the last 10 years to improve that. And it has improved. Yet, many of our patients for their telehealth visits still rely upon cell phone or landline services because they don't have the bandwidth from broadband connectivity to be able to do that.

We still have some very small provider practices here with a distinct lack of specialty services.

So, the challenge with our patients, knowing that it's not easy for them to access acute care services, is turning our service rather than as to acute care service that

initiates the care, turning our service into longitudinal service that keeps them healthy and requires them from needing that care.

What we have found as we have done that, that it's not practical nor proper to differentiate the way we care for patients based upon their enrollment in a value-based program. What we do is we stratify our patients based upon their clinical and social needs rather than by payer. We find that to be most effective, and certainly most equitable.

The approach that we've adopted and that we've designed around our patients creates a model of care delivery that's as standard as possible because we need the footprint to be able to do that, but as unique as necessary to meet the needs of our patients in our communities.

So, as we've made that shift, we have found that nearly 40 percent of our health system, rural health system revenue flows through value-based programs. And we actively continue to grow that share.

What allows us to do that, is we have a strong clinical information technology

infrastructure, we are in Epic from front to back. It allows us to understand our patient populations and screen for not just the social determinants of health but the social characteristics that affect their health outcomes.

In 2022, more than 144,000 of our patients completed our health-related social needs screening. And more than 20,000 of our patients identified at least one social need related to food insecurity, transportation insecurity, or financial difficulties.

We then try to partner with our communities to help provide those services. Yet, what we sometimes find is that leads us on a road to nowhere, that in many of these rural communities we don't have those services, so we work as a health care system to be able to do that.

We are proud to do this. We believe this is the best way to do that. I'm looking forward to the conversation this afternoon to determine how we can work better together to reduce some of the barriers -- some of them payment and some of them regulatory -- that

allow us, that are keeping us from taking the next step on this.

CO-CHAIR SINOPOLI: Thank you, David. That was actually fascinating. I'm looking forward to hearing more about that.

Next we have Jenny Reed, who is the senior vice president of value-based care at Baylor Scott & White Health.

Jenny.

MS. REED: Hi. Good afternoon, everyone. Thanks for having me.

I lead Baylor Scott & White Health Quality Alliance, which is a clinically integrated network of 8,500 providers across a geography the size of the State of Virginia, which makes us the largest not-for-profit health care provider in the State of Texas. Over 700 facilities. For context in transitions of care, only about 50 of those are hospitals, and all the rest are various post-acute providers across our geographies in order to serve the locations of our members.

We provide value-based care services for about a million lives. And I've spent the first 10 years of my career -- my background is

in social work, I'm a licensed clinical social worker by education and training -- spent my first half of my career in acute care case management planning transitions for folks, and observing all the challenges, many of which my colleagues have already described.

Although I would say Dallas-Fort Worth is the opposite of rural health care, and I look forward to learning from Essentia, our challenge is more in that we have an abundance of health care providers. And so, trying to maintain continuity in an environment where there's a different provider on pretty much every corner is the challenge we face in a metropolitan area.

I heard a statistic at one point that one-eighth of the home health care in the United States of America existed in the State of Texas. So, connecting the dots longitudinally for patients has been a huge challenge for us to overcome over the 10 years that the Quality Alliance has been in existence and managing value-based populations.

On the next slide I'll describe a little bit more detail.

We have participated in Medicare Shared Savings since 2017. Began taking downside risk in the second half of 2019. And have earned the most savings for the past two years, nearly $300 million.

There's about 130,000 members in that population. And the learning that we have in managing those has been quite a bit of opportunity, one of which is how we keep folks in a network.

Primary care is a great quarterback when you can get patients connected to them. Really, again, with the abundance of providers in any given geography, being able to manage within a network as opposed to I heard someone mention regulatory challenges, patients having access and choice, how we start to balance choice with quality of care and continuity of care, is a challenge I think we'd love to work together with this Committee, CMS, others, on solving.

We know that when we can keep folks within a network that has visibility to all their care needs and all the care they're receiving across locations, we see better

outcomes.

When we first started in 2017, we had about a 40 percent network utilization, meaning those patients' care was visible to their primary care providers. We've increased that to about 80 percent of the patients in our Medicare Shared Savings Programs have been with us for two years with the same primary care provider, in the same network. And we believe that is paramount to how we've been able to achieve the savings that we've achieved for both CMS and to reinvest in the programs.

What we do with our shared savings is reinvest in an additional programs, both digital and face-to-face type of solutions, innovative solutions to provide better care to those Medicare patients over time.

Comprehensive care management is one of the things that we do. So, I mentioned being an in-patient case manager at the beginning of my career. We've built longitudinal case management.

We know in our Medicare populations that those patients who engage with that program, we save about $83 per member per month

on average. But for those with chronic conditions, more like about $1,200 per member per year, which across a system the size of ours is a considerable savings for all of those involved.

We've seen our readmission rate reduced, acute hospitalizations, et cetera.

One of the things we did in the readmissions space with our earnings is invested in a digital care coach. I am a firm believer that there are lots of things we can do electronically. The only way we're going to successfully manage these programs is if we create non-people-oriented solutions, and how we use our data better across time, because we need to reduce the total cost of delivering health care in our country. That's the only way these models will be sustainable.

So, we have reinvested our savings in a digital care coach that helps folks manage their transition to home, and can escalate to a human interaction, as needed.

We've seen our post-acute care utilization reduced quite a bit as well by implementing better methods to determine what

level of post-acute care is needed, by working with those providers, again, balancing choice with high-quality providers and implementing ways for patients to make informed choice about which providers they're going to work with when they leave our hospitals. And we've increased our continuity of care there as well.

We've also reduced our length of stay in skilled nursing facilities by working directly with the skilled nursing facility staff, again transmitting data, doing advance care planning, making sure the plan we put together in primary care travels to the hospital, travels to the post-acute care provider so that patients, families, physicians, care team are all on the same page about goals of care and what needs to happen in the various different care settings.

So, I am a huge advocate for longitudinal total cost of care models that incentivize innovation and allow providers to reinvest in a new way of delivering health care across our markets.

And I look forward to the discussion today.

CO-CHAIR SINOPOLI: Great. Thank you, Jenny.

Next is Dr. Robert Wachter. He's a professor and chair of the Department of Medicine at the University of California, San Francisco. Bob.

DR. WACHTER: Thanks so much. Thanks for the opportunity to speak today. And I've enjoyed the prior three discussions, and agree with a lot of what I've heard.

I think the next slide is just the one my mother sent in about my bio. And won't spend much time on it other than to say that my day job – if you could turn to the next slide, maybe not -- my day job is I chair the Department of Medicine at UCSF, so a very large academic health system, about $6 billion a year, increasingly networked health system in San Francisco. And have about a thousand physicians in internal medicine in my department.

Other than that, my perspective, I think I was asked to take on the hospitalist perspective. I coined that term now 30ish years ago, and it became the fastest growing

field in the United States. So, most of the in-patient care in the country is delivered by this specialty that didn't exist 30 years ago called hospitalist.

So, we have a very much central perspective on the challenges of in-patient care.

I've spent a lot of my career thinking about patient safety and writing about it. I've also spent the last 10 years or so thinking a lot about digital transformation. And endorse the comments you've heard already that we're not going to get to where we need to get to without focusing on some digital solutions that we don't have today.

And I think particularly, I think it was Charles' comment about the importance of interoperability. We spent $30 million helping to digitize hospitals and doctors' offices but did not digitize the post-acute world. And that has created a huge voltage drop between when patients are hospitalized now in essentially 100 percent digital systems with electronic health records, and then they go to other settings where they don't have that. And

so, it's a strategic and systematic flaw in the system.

And I'll just go on to the next slide to just kind of talk about a few of these issues from the perspective of hospitalists.

And let me just say and give you a little bit about my own personal perspective at UCSF. Our hospital, like a lot of big academic hospitals, certainly in urban settings, tends to run very, very full. I think we are seeing some change in the marketplace where the big players in many markets are full, and the small to mid-size hospitals tend not to be full. And we have a few hospitals in San Francisco that are 50 percent full, while we're 110 percent full.

And, obviously, talking about strategic alliances between those two, those two groups all the time.

But the fact that we are full creates powerful incentives for us to move people through the hospital system as quickly and safely as possible. And sometimes that involves trying to send them to post-acute settings.

And sometimes it involves -- and it really hasn't come up so far but I think it's important to raise the point -- it involves thinking about whether they can be cared for safely at home from the beginning. So, do they really need to be in a hospital or could they be cared for in a Hospital at Home model?

Let me just say a word about that now. I find Hospital at Home to be incredibly interesting because the original articles talking about the value of Hospital at Home, that in fact it can deliver care that is as good, if not better, than care in the hospital, at often half the price, the original article supporting that premise came out at about the same time that my article supporting hospitalists came out in the late '90s. And within five to 10 years, there were 50,000 hospitals in the country, but essentially no Hospital at Home programs.

And even now, 30 years later Hospital at Home remains a fairly fledgling model. And that, I think is largely because of the regulatory and payment challenges. The hospitalist model, once people believed it was

a better mousetrap, there weren't any major regulatory or payment issues to overcome. And it very quickly became the dominant model for in-patient care.

Whereas, Hospital at Home even today in California the -- as we think about making a major investment in Hospital at Home, we still worry about how long is Medicare going to be supportive of the model, will the rug be pulled out from it? And as long as there is that uncertainty, I don't think Hospital at Home will achieve its potential.

And I think its potential is very, very large. I think probably 10 to 20, maybe even a little higher percentage of patients who are currently in hospitals could be cared for in home settings with digital augmentation if the payment and regulatory signals were clear. And right now they're still kind of murky. And as long as they're murky, we see the companies that are in that space are all a little bit uncertain in terms of their future.

So, I think in some ways that may be one of the more important things that can be done by the federal government, which would

send a clear and unambiguous signal supporting Hospital at Home, both in terms of payment and regulatory changes.

The other issues I've put up here are the three kind of pet peeves for hospitals and hospitalists. And, again, from our perspective we're taking care of patients, many of whom, I'd say the vast majority of whom needed to be in the hospital for a period of time, maybe independent of the Hospital at Home question, but could potentially be discharged to the next level of care.

And we find in many, many cases they could be. But they can't be because there is simply not capacity in the skilled nursing facility or long-term care facilities. And capacity is sometimes they don't have the space, sometimes they don't have the nurses, sometimes the payments that they're going to be getting are not attractive enough for them to want to take a patient.

And the result is a hospital like mine tends to be very full, which leads to an overfilled emergency department because the patients can't get out of the ER to go

upstairs. And the entire system sort of breaks down.

So, one pet peeve is the three midnight rule, which increasingly seems antiquated, not the right call to make patients stay in the hospital for multiple days in order to be eligible for skilled nursing facility payment.

Another is just a hospital issue, which is sometimes we have long-stay patients that we cannot send any other place, and we don't get compensated for that.

And the third, which is a theme I think you've heard from others, is I think the world is a better place if we can come up with better bundled care models that provide the appropriate incentives so that we can work together with post-acute facilities to try to figure out the right place for patients, and all of us get compensated in the right way.

Right now in San Francisco we still have a lot of our patients who are under fee-for-service models where the incentives aren't aligned to get the patients to the right place at the right time.

So, I'd say those are the main things that I wanted to bring up. But very much want to endorse some of the comments of my colleagues and take, particularly on interoperability. It's absolutely going to be vital that we figure out a way of wiring and digitizing the post-acute environment and connecting the hospital and the post-acute settings.

And it's very clear, if you look back at 2008-2009, prior to that, 10 percent of hospitals had electronic health records, and five years later, 10 percent did not. And that took a federal investment of $30 billion. It wasn't a huge investment to essentially digitize a $4 trillion health care system. And, obviously, we didn't get it perfectly right, but I think it's created a foundation for much, much better, safer, and ultimately less expensive care.

I think the fact that we left nursing homes out of that at the time is understandable. But now would be a good time to figure out how to digitize the rest of the system and to connect all the parts.

So, I will stop there. And thanks again for the opportunity.

CO-CHAIR SINOPOLI: Thank you, Bob.

At this time I'll remind the PTAC members that as you have questions if you can flip your name tent over so we can recognize you have a question.

All four great presentations. And all four, obviously, very successful health systems. And it's obviously taken you all a while to get there.

And so kind of part of that question is how do we get the rest of the country where you are, and then how do we allow you all to continue to improve?

And so, to kind of get some of the conversation for this afternoon flowing I'd like to go back and just kind of get you all to identify what did you see as your barriers to get where you are today, both from a payment and regulatory standpoint? And how did you overcome those?

And kind of where are you today, and what kinds of things do you still see that we need to overcome to continue to move forward

and to grow value-based care across the rest of the country?

And I'll start with Dr. Herman.

DR. HERMAN: Thank you very much. Some really good information here today.

I think the first thing, the thing that was holding us back, we were Medicare Shared Savings, but we were Track One. And when we looked at what it would take to get to Track Three, when you sit down and talk with your finance people, you talk with others, the first thing they're going to say is, well, you're going to lose money on this.

So, I think it really requires a commitment from leadership, which we did in this organization where we said if you tell me we're going to lose $4 million, then let's book the $4 million and find it someplace else, but let's make the commitment to do this.

I also believe people talk about having a foot on the dock and a foot in the canoe. You're just going to, here in Minnesota, we just get in the canoe. We don't spend a lot of time on the dock.

What you're going to have to do is

you're going to have to decide to treat every one of your patients that way to do that.

I do think that if you're a smaller provider, small numbers can really doom you to be successful in this. I think you have to do something different for smaller providers than you do for an organization like ours that's $3 billion. We have the numbers where we can show the differences. We can show how we've made a difference, how we've saved money.

But if you're in a small rural practice where you have a panel of perhaps 5,000 to 6,000 patients, one very ill patient is going to skew your finances in the wrong direction or it will show that you're not really saving money when, in fact, you are saving money.

What we also believe is that of course the unit cost of health care is incredibly important. Yet, decreasing the overall burden of disease is beneficial, both from a cost standpoint and from a population health standpoint.

So, what we try to do is make investments in the community while we can, and

then continue to move that going forward.

From a digital health standpoint, and I mentioned this in my Senate testimony, there are so many barriers around telehealth at this particular point in time that it makes it hard to deliver it. And I do understand the concerns about fraud in the telehealth space. But at the same time, I used the bird feeder analogy. I can design a bird feeder to keep all the squirrels out, but I can guarantee you it's going to keep all the birds out as well.

What we have to do is have incentives to continue to push this digital home-based care or community-based care forward, of course deal with the people in the front, but let's not do this with overarching rules and regulation that makes it difficult to do that.

I'll give you a quick example.

I have some of my providers that are concerned about reaching out to their patients on an every other day basis for a two- or five-minute check-in just to make sure they're doing well because that's what takes them, keeps them out of the hospital.

Yet, if they were just acute care providers in a small little urgent care someplace and did that, they wouldn't have that continuity of care, and they would be most at risk from bouncing up onto that regulatory dashboard that says, boy, this patient seems to be, quote, overusing digital care or overusing home care.

I could go on. I will turn it over to the rest of my colleagues for their comments as well.

CO-CHAIR SINOPOLI: Those were great, great comments.

Let's go to Jenny next.

MS. REED: Sure. I think I'll choose to go a little bit deeper on the regulatory issue that I mentioned earlier around patient choice.

I do believe in patient choice, and autonomy, self-efficacy. However, I do think that we, in any new model, need to consider the opportunity to help patients have an informed ability to choose.

I think there are some regulations out there, the Stars program I guess is a place

to start, but using, giving, equipping providers with more of an ability to let patients know things, like this group can see our records, or has adopted our same standards of care that your primary care provider has adopted, et cetera, can help patients choose the next level of care provider that would be best suited for them.

I think sometimes the regulatory environment is a little bit -- is seen as being a barrier, or has been for us a barrier to guiding patients in the way that we know they're going to get their best outcome because we want it to be a choice free and clear.

So, not necessarily proposing the right answer, but I do think we need to work together to find a middle ground so that we don't, to the point about telehealth, enable providers to maybe have nefarious intent. I think the great majority really want to do a good job.

The other thing that I think we used that really helped us was the bonus program and the advance payment. The APM bonus was really an incentive to get involved and be able to

reinvest in new ways of providing care. So, when we took risk in MSSP, that was a big deciding factor. It was also a clear math calculation that could be done with our finance people to show what dollars we would use to fund the additional investment required to stand up care management, to stand up a digital transitions of care management program.

Sometimes we over complicate those calculations. Readmissions penalty, as an example, is a really hard connection to make between provider and outcome and what that eventually does to my business model.

And so, when it's too complicated to understand, a lot of times what we as providers do is just kind of go over here and do the best we can. But it's not clear, can I spend one dollar to fix that problem, or can I spend one million dollars to fix that problem?

So, I think the more simple and clear we could make the calculations, the better.

I agree with the comments about the three midnight rule and the bundled payment initiative. One thing that concerns me,

though, about episode-based payments is that they center around hospitalization. In other words, a patient has to be admitted in order to be eligible for a bundle. There's not an incentive to discharge that patient from the ER.

So, models that have a connectedness across a community of care providers would be more of interest to me in the way that it connects outpatient and ambulatory to the hospital and to the post-acute care providers. And I think lends itself to more innovation.

By the same token, I don't love models that put the primary care provider on their own and don't integrate with hospital care. Because you're going to have patients that get sick enough that need hospital care. So, the models that incentivize working together as a provider community, and including all levels of care, are the ones that I have seen be most effective because you're not solving one problem at the expense of another provider in a different location, if that makes sense.

So, I think to summarize my

comments, clear calculation, regulatory leeway in terms of informed choice or informed consent for choice of provider, and models that include all levels of care or all care sites -- primary care, specialist, hospital, post-acute -- rather than models that further segment care providers into an acute bucket or a PCP bucket and cause us to be further disintegrated at the expense of each other, are my three top recommendations.

CO-CHAIR SINOPOLI: Perfect. Thank you.

Next, I'll ask Charles to go.

DR. CRECELIUS: Yes, a couple points building onto that.

Currently, my long-term care nursing home patients with acute medical problems have to go to the hospital in order to get the level of service they often need to get adequate reimbursement. There is no way to put that long-term patient in a skilled bed.

During the PHE[36] that was suspended, and we don't have all the information back yet

on how successful that was and whether there was advantage taken of it.

However, with the right safeguards in place, allowing long-term care patients to go directly to SNF and bypass the hospital would be immensely helpful. The nursing homes can provide the typical IV fluids, IV antibiotics. I can basically get any diagnostic test there but a CT scan -- they're not portable enough yet. But I could handle a large majority of ill long-term care patients if I could have the capacity to ask the home to do that.

Right now we ask the home to pay for the IV fluids, the nursing time, everything out of their pocket. And that takes a lot of their per diem.

In the demonstration project we had, we could do this. The CMMI project from a few years ago. It was very successful trying to encourage the nursing homes to build up their testing capacity, things as simple as a bladder scanner if somebody has urinary retention. That piece of equipment costs a bit of money. And if we don't supply homes with the right

equipment to test for the right things, we waste more money.

On a different note, I want to go back to the communication piece I mentioned earlier. We have communication in the style we think the next person wants. We often don't ask them. In our system we went to the nursing homes, to the home care, and say, what do you need is a discharge summary that would make this helpful for you?

And we got therefore a good discharge summary, we've automated systems like Epic. The hospital systems are robust enough. I don't have to ask hospital medicine to lift a finger to put this information: the diet they're getting in the hospital; the actual wound, the pictures, the size, what's being applied to it; do they have any lines, strained airways; when was their last bowel movement; all that in one location. You can easily pull it from the hospital's records.

So, we've gone from sending over 200 pages to sending about 15 pages of information that's the core information they need.

Now, obviously in the system the

hospitals have to do the discharge summary by the time the patient leaves for a financial incentive, the hospital gets a one percent bonus for hitting a threshold of discharge summaries by time of discharge. And we track all the physicians so they get immediate feedback on where they stand. Every month they can see where they -- how they're doing.

We're a 12-hospital system. In six of our community hospitals, we're getting 100 percent of the discharge summaries done by time of discharge. So, when that person leaves and goes to home care or the nursing home, they've got the information.

And while we constructed this for the nursing homes, we found out our PCPs actually like this information. It saves them a lot of time. Our patients going back to the office normally don't have pressure ulcers, for example. So, they've got some problems, and they've got the information if they have a pressure ulcer here.

The diet may not be fully understood. Unfortunately for hospital medicine, their pressure sometimes puts resume

previous diet. It doesn't mean anything to a nursing home. And sometimes doesn't mean anything to their, their home. They go back home, and it just reinforces the fact they eat too much sugar and salt. I could resume the same diet.

So, getting granular with the discharge summaries, discrete, specific, incentivizing it by the hospitals and vetting that system to payment would be helpful in the fee-for-service world, much less managed care.

CO-CHAIR SINOPOLI: Perfect. Thank you. Bob.

DR. WACHTER: Yeah. Let me start with your premise, Dr. Sinopoli, that we all have our acts together. It reminds me of the late Israeli Prime Minister Golda Meir who once said, "Don't be humble. You're not that great."

I think we're not, I think that we're not that great. We're all working on it and all, I think, getting better, but there is a lot of work to do.

As I hear this conversation, one of the things that strikes me that has not come up

yet is the, at least in my region, in the Bay Area, a massive shortage of primary care doctors. And so any system that's premised on the primary care doctor being the orchestra conductor for patients as they move through transitions, at least in our world, is destined to fail.

Primary care I think is -- I'm, you know, old enough to have seen many, many primary care crises, and lots of calls for changes in the way we compensate and support primary care doctors. I think the need has never been greater, in part because of they're now suffering under the weight of the electronic inbox that patients now have patient portals, digital patient portals, and do what they're perfectly, what would be perfectly rational for them to do which is send a bunch of messages to their doctors.

And so, I do think we have to address the absence or the lack of primary care infrastructure under any system that is premised on the primary care doctor being the quarterback for patients as they move across transitions.

Not much to add to what I heard. I do think the issue of regulatory sort of relief in the telemedicine space is really important. I think everybody, of course, understands the issues of fraud, and that we've got to be thoughtful about it and careful about it.

On the other hand, what we learned during the pandemic was how valuable telehealth can be and how effective it can be. And one of the things we're seeing in California is the resurrection of state-by-state licensure requirements which, for us, as a tertiary quaternary center, we've got lots of patients who come to UCSF from Nevada or Arizona or other states, and it's now become extraordinarily difficult to continue to provide telehealth services to them.

And I just think it doesn't make a whole lot of sense. Think about the medicine that should be practiced across state lines is about the same as it is in any given state. And we've created, we've resurrected a barrier to telemedicine that I think we should be trying very hard to take down again.

But, otherwise I agree with the

comments I've heard. And I don't think I've got all that much to add.

CO-CHAIR SINOPOLI: Thank you. We have some questions from our PTAC members.

So, Chinni, do you want to go next?

DR. PULLURU: Thank you to the panel. This has been a great discussion.

One of the things -- this is directed toward Dr. Wachter and anybody else who would like to opine -- one of the things we saw during the pandemic to your point is that there was greater provider adoption of telehealth. I think patient adoption was always something that was potential to be there, but the provider adoption came during COVID.

A lot of that was driven by not just the necessity of the pandemic but the fact that there was parity in reimbursement. Right?

So, as we think about Hospital at Home, Dr. Wachter, I've seen, I've seen different studies on whether outcomes are better versus not. I've seen international platforms that have tried it.

I'd love to get your opinion on A)

Do you think that's the future to sort of creating more margin for hospitals and sort of doing the right thing for the patient without heads and beds? and B) If you were to do that, would you approach it with having parity in the beginning versus arbitrage in payment?

DR. WACHTER: Yeah, thank you. That's a really good question.

I guess I would start by saying that creating an environment for Hospital at Home is tricky and will take an investment on someone's part.

I mean, to me the core issue, one of the core issues at least, was the emergence of companies -- and I don't have any financial interest in any of them, I'm just as an observer -- that could do the supply chain piece of Hospital at Home.

Until you had an environment where a doctor in an emergency room would find it just as easy to send -- to say this patient can go to Hospital at Home as it is to say this patient can go upstairs to the 10th floor where there's a bed waiting, then Hospital at Home is always going to lose.

So, the question is, can you create a financial and regulatory environment where whoever is going to run Hospital at Home, let's say it's a health care system that has hospitals, has enough of a market and regulatory signal that they are willing to invest in it, because it's a complex set of changes -- there are some cultural changes, there are obviously work flow and workforce changes -- and that the companies entering that space largely to do the logistics.

You know, to be able to, with a single phone call, deliver oxygen, and IVs, and a respiratory therapist, and all that kind of stuff, the companies have enough of a signal that they can make it in the market. And I think right now the signal is just not strong enough for widespread adoption.

Does there have to be parity? I think that's an empirically testable question. It has to be lucrative enough that the hospital believes that it's worth its own investment, and the pain and the trouble of doing it. If it's a break-even investment, they probably won't do it.

The exception to that might be a hospital like mine that's 110 percent full and is sending away thousands of potential new patients a year, including transfer patients, that need tertiary and quaternary care that we're relatively uniquely situated to provide. For us, even if we broke even on Hospital at Home, or maybe had a tiny margin, we'd still find it valuable because it opens up beds for other patients.

But, does it need to be paid at parity, or does it need to be paid at enough to provide a reasonable margin for hospitals? I think that's an empiric question. Maybe it needs to be parity for a while, while everybody sort of makes the initial investments. But, ultimately it should be cheaper to, you know, not have the fixed infrastructure of hospital beds and, therefore, the idea that you have to pay at parity forever, that doesn't sound right.

But if there's not a reasonable margin in the short term, I don't think you're going to hit the activation energy that's necessary to deliver. I don't think

telemedicine is the right analogy because the infrastructure that was necessary to stand up a telemedicine program was pretty trivial.

Whereas, the infrastructure, and the fixed costs, and the political challenges, and the operational and workforce challenges of standing up a Hospital at Home program is really pretty significant. And you're just not going to do it unless you are pretty confident that this is here to stay and that we're going to make a reasonable margin on it, at least in the short term. And so, you know, whether that's parity or a reasonable margin that's not quite parity, I really don't know. I think that has to be tested.

DR. HERMAN: I agree with Dr. Wachter.

And I would also look at it from the short-term side as a utility function. I mean, the United States didn't move everyone from burning kerosene lamps to electrifying the homes by saying, we'll tell you what, if you can't sell electricity to be able to deliver electricity as cheaply to the home from day one as you can to fill up a kerosene lamp, we would

still be using kerosene lamps.

What we did, as Dr. Wachter said, is provide funds to build that infrastructure to be able to do that.

But I also support Dr. Wachter's thing about we're never going to have the number of primary care physicians that the current model will need. And I will even take it further. We will never have the number of people that the current model says we need to do this.

We grew health care in the 1980s and 1990s when America had the largest high school graduating classes and the largest college graduating classes. So, I have people in my office all the time saying, if you can just get me more people. But those people don't exist. So, we're going to have to take a step back and redesign our care that's less dependent on people, to do things that don't require people, and be able to work it out that way.

To hope that someday we're going to have a bunch of primary care providers, or more nurses, or more people in the nursing home, those people just don't exist.

DR. WACHTER: And I would add just as a very pragmatic issue, as we do more digital transformation, the labor shortages create an environment where the politics are easier. We're not talking about AI or digital automation and, therefore, having to lay off a whole bunch of people. We're talking about doing things that we can't find enough people to do them.

If there were enough people, you would deal with much more complex labor issues and union issues and all that. But in many cases that's not the issue. The issue is we can't find enough people to do these things.

CO-CHAIR SINOPOLI: Any other comments from the panel?

MS. REED: I'll just offer an anecdotal agreement about Hospital at Home and shortage of people.

We tried Hospital at Home unsuccessfully two years prior to the pandemic, one year prior to the pandemic, six months prior to the pandemic. And it's a little bit of striking while the iron was hot because we were lacking capacity, as Dr. Wachter said, and

employing agency nurses at a rate that we hadn't seen ever.

The idea of using technology in treating people in the home was much less, as you said, political, challenging, it sort of a great environment to introduce something that otherwise might have been controversial. I think there's some other learnings we could get from that: ways to implement innovation in this challenging time. There's some innovations that we could pick up and dust off and probably be more successful than we were before.

I agree with all the comments.

DR. CRECELIUS: Yeah, I'd agree, too.

We've had great difficulties with staffing. It also goes across nursing home and home care. In any model you design you're going to have to figure that out also, because there's a great role, potentially, for home care, and Hospital at Home, and keeping people at home in community-based service.

We're sort of at a stalemate in our system how we could advance with the staffing shortage.

DR. HERMAN: If I could make a quick

comment on home care services in rural areas, they're much easier to do in an urban area because if you're taking care of Mrs. Jones and then you go to take care of Mr. Smith, it can be a half a mile away.

If you're taking care of those same two people in a rural area, it can be 40 miles away.

So, needing to have a certain number of visits, particularly Hospital at Home, how many visits do you need during the course of a day, from a rural health standpoint, it makes it almost impossible to scale because the distances are just so long.

If you can do it digitally, I think you'd be much more successful rural.

CO-CHAIR SINOPOLI: Good. Thank you all.

Jim, you have a question?

DR. WALTON: Sure. Thank you.

Given that there is a labor challenge, at licensed as well as professional levels a number of you have already mentioned, we understand that more effort by a limited labor supply using new digital tools is somehow

the combination that's necessary to do a better job at this so that the money -- the quality goes up and the costs go down.

Could you comment on what you think incentives, financial incentives or other, would be helpful for that limited labor at all levels, licensed versus professional, might need in order to do better work per unit of labor to accomplish this improvement, and the introduction of new tools, right?

So, does all the money need to go into digital re-engineering, or does some of it need to be spent focused on incentivizing the labor?

And the two labors I would describe would be that which is employed, that you have direct control over by employment, and that which is really independent still. Maybe there -- and do we really have to vertically integrate the entire system, legally, financially, or can they in some places, do you have to keep it independent, some hybrid?

CO-CHAIR SINOPOLI: Do you want to direct that to one of them, Jim, or just the whole panel?

DR. WALTON: Anybody that thought they'd like to take it. I hope it's helpful.

DR. CRECELIUS: That's a really tough one. We are trying to get everybody to practice to their highest level or capabilities. We've got NAs[37] doing nursing homes, for example. We send an NA in to do telemedicine to gather information, so when our physicians walk in they can be as efficient as possible, get in and get out.

There's more LPNs[38] than there are RNs[39] now in a lot of markets. LPNs can't assess for me but they can do a pretty good job of observation when trained appropriately, especially in a nursing home, and perform near the level of an RN.

I think we're going to have to look for lower-skilled people to do more work, frankly, in order to solve the economic problems this is going to face.

I'd be interested to hear what others say.

DR. HERMAN: I think one of the

37 Nursing assistants
38 Licensed practical nurses
39 Registered nurses

challenges we have for innovating and changing our care model, it depends on where you start the design.

I think one of the faults that we have, we start the design with what we're doing now, and how do we do that with fewer people, rather than starting, what does the patient need to improve their health and to sustain their health? We need to start in that second spot and design it new, rather than start where we are.

I do think from the challenge, is it employment or is it a hybrid model, I think it determines the area that you have the scale.

One of things that we, one of the reasons we're in the ambulance business is that we have the scale to be able to do that. No small community has the scale to be able to do that.

So, I think that will depend particularly upon the area and the skills of the people that you have. But we're going to have to start in a different place, rather than where we are right now and how we're going to deal with fewer people, rather than saying what

is the type of health care that we need to get the health status that we want?

DR. WACHTER: Let me just double down on kind of what I said before about high tech.

I think in general it's not a great idea for the government to choose winners and losers in terms of technology, or make targeted investments in technology. That's just -- technology moves too fast. It's not nimble enough.

I more trust the provider organizations to say that the combination of people and technology is going to work really well here, and this is the company I'm going to bet on in order to get us to a place where we're delivering more value.

I think the exception to that is the kind of foundational infrastructure technology. And somebody, it was like what David was saying about electrifying the system or building the highway system. If we had not invested in high tech and meaningful use, I suspect we'd be at 30 to 50 percent electronic health record implementation in hospitals, and probably at about the same percent in doctors' offices.

So, a targeted investment on creating that infrastructure, it certainly didn't solve everything, and it created some new problems, but it created a foundational -- it created a set of conditions on which we could have a system that's entirely wired and digital where all of the elements of the system are moving data seamlessly through the system.

And as we come up with better tools and analytics, I mean nobody could have envisioned GPT-4 when we did high tech in 2009. But our ability to take advantage of new AI tools will be markedly enhanced by the fact that we have these electronic health records and all of the data are in one place, except for the post-acute and home care settings.

And so, I think you can make a very reasonable argument that the same kind of investment that we made to digitize the hospitals and doctors' offices could and should be extended to post-acute care. And that would actually be a fairly, I think a wise investment.

I don't know what the math would be, but I'm guessing with a $5 or $10 billion

investment, you could probably digitize the entire system and create the foundational conditions for a much, much, much better continuity of care and much more seamless transitions than what we'll ever get. Because I don't think without that kind of core investment, you know, your local skilled nursing facility will ever build, you know, buy an electronic health record.

Maybe if they're part of a big system like the four of us are in, maybe we eventually will buy SNFs and buy nursing -- buy long-term care facilities, and put in our instance of Epic or Cerner. But I think counting on that is a pretty inefficient way to do it. I do think this would be an area where federal investment would be super helpful. Obviously, it's a lot of money.

But I don't think you get to where you want to get to from the standpoint of continuity of care and seamless transitions with two-thirds of the system wired, and one-third of the system using paper.

MS. REED: Yeah, I would agree with that, and I think incentivizing the minimum or

the capability without necessarily funding a particular brand of those capabilities is what I hear us kind of landing on.

And then what ends up happening in America is we end up picking a winner by who executes the best over time, and that's we started with a million different electronic health records. We've got Epic and Cerner, and I think Athena probably in the independent space.

I was going to a little bit different place with how I was contemplating answering the question maybe just because I work in the same market as Dr. Walton, and when he said employed and independent, I think more about providers and how we incentivize provider behavior, but same idea.

What are the minimum capabilities or programming that we think need to happen for Medicare members, and how do we incentivize the behavior we want to see repeated?

I think, again, it has to be very clear. If I do this, then I get this for it rather than some really complicated --

You know, BPCI had potential, but

when you're still reconciling the program three years later and sending money back or receiving money from the federal government, that program, those types of programs are difficult to understand and to sustain.

So, where we can connect incentives with the behavior we want to see, I think we will be more successful. We've done that with quality metrics. Utilization is a little bit different, but most of the post-acute care in America was created when we moved to DRG payments for hospitals.

So, we understand the cause and effect relationships of payment models and how those create sort of some different ways of providing care.

I think spending time not starting where we are, but understanding what patients need and how we got to where we are, maybe there's some good lessons about how we could build the next iteration of if our DRG payment hospital's at risk for payment, how do you start to make the entirety of the delivery system responsible?

I wanted to comment on your shortage

of primary care just briefly. In our hospitals, 15 to 30 percent of the Medicare patients in our hospitals are attributed to one of our value-based programs, one of our primary care providers.

What that means is the other 70 to 85 percent of the Medicare patients in any of our beds, right, now today, are attributed to no one or are attributed to primary care in the community who are not connected to our clinically integrated networks. They could be connected to the hospital across town. Our patients could be in those hospitals.

And that's where I feel like the current programs focused only on primary care are not, or hospital episodes are not integrated enough to really incentivize the change that we're trying to see.

There is no incentive for a primary care provider who is taking risk on a population to necessarily connect to other providers in the community and make transitions of care better other than what it means for them, but what's the incentive for our hospital to work with those providers and figure out a

better transition of care?

There isn't one. There's only one where the hospital has some skin in the game. I don't know how to say it more eloquently than that. When we start dividing the providers the way that we have in these different programs, the connectedness, the willingness or the necessity of connectedness starts to deteriorate.

So, I think incentives or programs where there's an incentive for the hospital to do their part the very best they can, for the primary care provider, if there is one, to do the very best they can, for medical subspecialties who can have attribution today to get credit for, you know, a cardiologist taking care of a heart failure patient and serving as the primary care, I think there are some opportunities to further think through incentives that align those folks who are working well together or incentivize them to work together rather than compartmentalize the different pieces of health care.

I could go on forever, so I'll stop, but I'll say incentivizing the behavior we want

to see repeated and incentivizing those minimum capabilities, Dr. Wachter, I agree with you, getting everyone's information visible so it can be used as discrete data that we can use to inform an improvement in the way we deliver health care, I think, is a great starting point.

CO-CHAIR SINOPOLI: Any other comments? If not, we'll move on to Lauran.

CO-CHAIR HARDIN: I have a two-part question for you building on the last question. You've all talked about longitudinal management across sectors, across systems, and really building capacity for a shift to anticipatory symptom and disease management.

And you've talked about financially incentivizing that behavior or change, but I'm curious if there are practices or education that have also created that kind of change that you've learned outside of traditional care management kinds of things?

What was the lock and key sort of change to shift people to a very different way of looking at client management across sectors and systems?

DR. HERMAN: I know this is about payment, but I'll tell you a quick story about our organization. We used to have about 10 percent of our providers' compensation at risk for quality measures, coordination measures, and it was the most divisive thing we had in our system, and it just made everyone unhappy.

I couldn't see where it was driving the results that we wanted, and so we said okay, we're going to sunset that, but what we're going to do is we're going to have standard work, and we're going to build the infrastructure underneath that to make the right thing to do the easy thing to do, and we found that to be much more successful than the incentive model.

We certainly -- I don't believe that payment models really work to drive change. I believe that payment models have to be aligned with change, but it's been my experience that we have to make sure that --

There are a lot of great people that want to do great stuff. We've got to get the barriers out of the way and make that standard work the easiest thing to do rather than

incenting people to do that.

I would also say that we have talked about the post-acute, but I don't think we've talked enough about what you do before the person hits the emergency room, and what are the, you know, health-related social factors?

We've found that partnership with our public health nursing -- interestingly, law enforcement and public safety are some of our, particularly from the behavioral health standpoint and the homeless standpoint, are some of our biggest allies on that.

So, the health of a community doesn't just sit within the health care system no matter how well-integrated. There's many social factors that sit around that I think provide a lot to drive a lot more of the health outcomes of our patients and a lot more of the costs of their care.

CO-CHAIR HARDIN: I'm going to ask one follow-on question to that which is part two and then give everybody a chance to add in. So, I completely agree with you. I spend a lot of time in that space.

One of the other things that comes

up as you start looking at cross-sector integration of social determinants or health-related social needs and really integrating across settings is HIPAA[40], so people's terrible fear that we cannot share information to coordinate care and coordinate delivery. So, I'm curious how you've addressed that in delivery in such a broad network.

DR. HERMAN: So, one thing that we did is we, in a previous job that I had, we actually developed the trusted third-party intermediary that held all of that information.

So, the hospital could put in it, the health care providers could put in it, public health could put in it, and then we formed that group to be able to share that information, of course with the permission of the people that were involved.

I also have to add that when I sat with a group on the NQF where we talked about how do you integrate care, we actually made many of these measures and many of these payments to the hospitals because we felt that

40 Health Insurance Portability and Accountability Act

the hospitals had the most powerful seat to drive that coordination.

I still believe that that's true, but it's still not sufficient enough of a power or enough of a driver to have that coordination, so we need to start thinking more broadly than just the hospitals or acute care facilities driving the coordination within a community.

CO-CHAIR HARDIN: Any of our other presenters want to comment on that two-tiered question?

MS. REED: I'm just -- we use patient-centered medical home certification as the way to first create awareness of what wasn't happening. I think, you know, one of my predecessors would always start that conversation by saying providers think they're taking, are taking good care of their diabetics, the ones that are in front of them that are coming to see them. What we forget about is what's happening to the people that we can't see and what's going on kind of behind the scenes.

So, using the electronic health --

it's a great case for the electronic health record by the way, creating registries, creating visibility of who all is my patient and what things should be happening to them.

So, that was where we started to raise awareness of are you doing all of the things that you set out to do for all of the patients who consider you their provider? And that was a great way to get buy-in.

I think what we knew is that we needed staff, so coupling that with funding mechanisms so that we could augment what the provider was able to do on their own versus what a care team can do, and how we can add right now -- at that time, it was people.

We have automated a lot of those processes now, thank goodness, and decreased the costs of delivering those services, but that's an example where I would say the funding that was available and the electronic health record worked together to be able to, not incentivize the providers like you get a reward for doing what you set out to do, but just to give them the funding they need for the resources to do it well.

So, I want to be careful not to get the word incentivize sounding like a bonus payment in someone's pocket. It's really just dollars that you can reinvest in equipping our providers and our health care system with the resources and tools it needs to do that well.

CO-CHAIR HARDIN: Thank you.

DR. CRECELIUS: Yes, Dr. Crecelius, I'd add to it real quick. Incentives, you do have to be careful with, but we've found certain incentives do work for the right groups of people.

What does work as well is just comparative analysis as Jenny was pointing out. If you just say Dr. B, you're at this level of diabetic eye screening and everybody else is here, the next step is not to berate them, but to sit down, and ask why? Why are you falling behind? What's your office flow? What part of standard work are you not getting?

Standard work was brought up before by David, I believe, and that's very important to help migrate away slowly from larger financial incentives, perhaps a few small ones.

Doctors, I think, and nurses still

have morals and ethics, and if you can play to that, play to tradition of what a good doctor or a good nurse is supposed to be, you're going to get better overall results.

We've debated too about our offices. Too many times, our individual doctors get some sort of incentive or feedback, and we're finding we really want to give it to the medical assistants too. They should know what the office is doing in terms of their best-in-class scores.

We actually found recently some very good medical assistants, and those medical assistants are going to be the trainers for the other medical assistants. They've gotten standard work down.

So, it's not always a top down approach. It's often a bottom up approach and grabbing everybody you can, the office ambulatory setting, and getting them on board with feedback, performance improvement.

CO-CHAIR HARDIN: Thank you so much.

CO-CHAIR SINOPOLI: Yes, thank you. Walter?

DR. LIN: Great discussion so far.

I wanted to circle back to something both Dr. Wachter and Dr. Crecelius talked about, the three-midnight rule. This is a rule that I think about quite often because of working in nursing homes. You know, just for those who may not, if I have a patient in a nursing home, an elderly woman who develops pneumonia and needs some oxygen, if that patient has a Medicare Advantage plan, they can actually get the IV antibiotics, the oxygen, maybe some IV fluids in their room often if they're in a dually certified bed, and the nursing home can bill for a post-acute skilled stay if the Medicare Advantage plan provides the authorization number.

But if that same patient has traditional Medicare, I have to send that patient to the hospital where, you know, they might be delirious. They might fall and break a hip, and then come back with all sorts of care transition problems, medication errors, and so this is like, it's a real problem, and so I appreciate both Bob and Chuck bringing it up.

I guess if I were to take Medicare's

view though, the reason why Medicare allows these waivers for Medicare Advantage plans and ACOs taking double-sided risk is because they are ultimately responsible for paying for the post-acute stay, so there's less of a risk of abuse of these waivers than in patients with a traditional Medicare plan.

So, my question would be, especially for Bob and Chuck, but anyone else who wants to answer, what kind of, as you've thought about this, what kind of guardrails would you suggest Medicare put in place to help prevent abuse of this rule by fee-for-service providers who may not, who may want to take advantage of it?

DR. WACHTER: Yeah, I don't know. I mean, it strikes me that the era when all of these rules were put in place was an era where health care was an analog system where the data were stored on pieces of paper, and you look at the connection and the fact that all of the data that the hospital has are digital and we have now advanced analytic tools, you would think that we would be able to figure this out.

It just doesn't strike me as the hardest problem in the world to decide whether

patients should appropriately be in a hospital or should appropriately, could be cared for in place in their nursing facility.

And, you know, it just feels like whoever said before, that there's no way to have an abuse-free system. You have to sort of look at what is the net impact of the current rules?

And as, you know, Walter, you were just describing that scenario, that sounds like a happier scenario for the patient to stay in place and get the care that they need where they are without transitioning. It sounds like it's going to be massively less expensive.

And if the cost there was that every now and then, you have an unethical provider and you can't catch them through existing systems, I still think net, you're probably ahead not sticking with the rules that really sort of incentivize, not fraudulent, but massively dysfunctional counterproductive behavior.

And so, I'd be kind of looking -- I think the question of can you catch the unusual instances of fraud, I think in an environment

now where the systems are digital is another advantage of if we can figure out a way of digitizing the post-acute setting as well so that we can look at this across the continuum and have the same digital record that we can analyze for the patients in the right setting getting the right care in the lowest-cost setting.

It feels like that would be an easier thing to do if the entire system was digitized, but it just strikes me that the incentives that are embedded in the current system get people to do the wrong thing, and often note that they have to do the wrong thing. It's the only way that they're going to be compensated.

That's just -- that creates moral hazard. It creates, I think, ethical issues for everyone, and it just -- we're not talking about perfect. We're talking a very bad status quo that we should get better.

DR. CRECELIUS: I appreciate that, Bob. It's not that hard to put the guardrails in place. If you have to have criteria to be admitted to the hospital, use similar criteria

for a nursing home paid skilled admission, you know, fever above, blood pressure below, vital signs, signs and symptoms that you have to meet. The physician has to come in and certify that. The home can't do it. They're not a medical professional to determine that.

And typically, these models would involve an extra payment to both the physician to make sure they get there in time and the nursing home, a little extra per diem for their work, time, and effort. It is a money saver by far.

DR. HERMAN: Well, and it's much better for the patient. And I think when we talk about moral hazard, we also have to weigh --

There's a moral hazard to having a two-tiered system where one person stays in their bed and gets the care that they need, and another one gets picked up, and gets disoriented, and gets put in an ambulance and moves forward on that.

You know, I'm going to be really careful about saying this because I said it one time, and if you can picture the scene from the

old Frankenstein movie where people are storming the castle, but, you know, we have -- health care, what I would say, is very data rich, information poor, and insight starved.

We have so much data on everything. We get very little information out of it, and we don't use the data that we have to gather the insights, some of which people have shared here today.

How do we start taking this incredible amount of data and getting better insights from it, and then designing the care around that rather than saying how do we buff up what we think we can all agree is a somewhat dysfunctional health care system around the edges and hope we get a better result from it?

DR. CRECELIUS: One of the regulatory barriers I'd like to bring up in this sort of analysis, telemedicine in nursing homes is limited to every two weeks, period.

It doesn't matter how sick the patient is. We're the only site of service. I could have somebody sick that I've seen. I can't help them if they're sick if I did a telemedicine visit.

If I'm across town and they're calling me about somebody really sick, I should see, I can't do it or I do it for free in order to keep the patient in place where they should be. So, that every two-week rule needs to go away if we're going to do this successfully.

CO-CHAIR SINOPOLI: Thank you. Larry?

DR. KOSINSKI: Very thought provoking discussion. We've spent a lot of time talking about post-acute transitions. I'm going to raise a pre-acute transition, and this is what's arising in primary care in multiple specialties.

I work in the GI space, and I don't want to mention specific companies, but there are many B to C digital health companies that are developing totally telehealth-based products focused on patients who have low morbidity conditions, and in the GI space, it would be irritable bowel syndrome , but maybe also mild inflammatory bowel disease.

And then when these patients intensify and need to be seen by a physician, they need to transition to a health care

provider that can actually examine them and perform procedures, possibly hospitalize them.

And so, this is a new transition that I don't think we've really discussed as yet, but it's one that's only going to grow as the digital health revolution continues down this path, and I'm just interested in what the panel's opinion is of this and how these disintermediated health care entities provide total longitudinal care for patients. How do we deal with this?

DR. WACHTER: I think you've asked the trillion dollar question, and in many ways, you could see that this would be the source of great innovation because these companies can come in and take on a single or a relatively constrained group of conditions and innovate in a way that the legacy organizations are just too complex, and interconnected, and tied bound to do.

And in some ways, you have the Southwest Airlines story. You have, you know, taking a piece of the market, innovating in that piece, and then ultimately growing out to build a more comprehensive set of services.

Because I'm guessing your inflammatory or your irritable bowel company would like to do all of GI, and if you're a gastroenterologist, they'd love to either hire you or replace you.

On the other hand, you can develop something that is, you know, just totally fragmented from the patient standpoint and markedly inefficient. You've built in tons of additional transitions.

It's a core issue in medicine, even in pre-digital. You know, when do we call something a specialty? You know, when is it valuable for the patient to see a diabetes person rather than their primary care doctor?

And I could easily imagine that, you know, a hypertension solution would work well and probably be more efficient and cheaper than having to go for your primary care doctor everywhere.

So, the cure for this is probably payment models that push for integration, and whether integration is a single system or integration is a cobbled together system of individual entities that are brought together

through digital glue, I think it's going to be determined by the market basically.

I think you're going to see a lot of this. You'll see a lot of startup activity in this space. I worry about it from sitting in a big academic medical center where are we going to be only left with, you know, the most complex of the complex, and is that going to pay our bills or not?

And also, as a training environment. If I'm trying to train a family medicine doctor or an internal medicine doctor and all of the basic stuff is done in some other space, and by the time they get to us, they only get there when they need a transplant, I can't train them anymore for general medical practice.

So, I think it raises a ton of questions. I think it's inevitable that this is going to happen, and I think it's got to be monitored very carefully by HHS and others.

I don't think there's going to be a way of putting a lid on it and saying we can't do this or see this. I think the question is then, what is the model?

What is the payment model that makes

sure the patients don't fall in the cracks as they're getting care from multiple providers? But they do today. I mean, they see you for GI, and they see me for general medicine, and they see somebody else for OB, and we've got to figure out how to integrate.

It's just going to create new pressures to do it, but also in an environment where the digital tools for integration are going to be better than we've ever had in the past.

MS. REED: Yeah, I spend a lot of time with employers talking about what they're looking for for their self-insured plans as part of our value-based care work.

You know, one arm we've been talking about is Medicare. I think in the Medicare Advantage space is probably where you're seeing the most of the B to C type innovations and a willingness. They're willing to take risks for performance. Medicare Advantage is capitating a group of providers, and they're looking for help in performing in those risk-based arrangements. That's where I worry about disintegrating care too much and that's

why I've been talking so much about including all of the members of the health care team, because my biased opinion is I don't want hospitals to be left out, left to only the most complicated, and no funding to take care of the most complicated.

I think panels like this one need to be more forward thinking, and I appreciate the fact that you all get together to talk about these things because if we don't get ahead of it, we will be left to that.

And when I have -- you know, if I have stage four cancer, I'd like to have that treated in the most effective way. I don't want it to be the least invested in area of health care.

So, but your point is this is a sign that we really need to be going further faster. When we sit with employers, they're frustrated. They're frustrated because we're not good at talking to each other, and they are leading.

They're funding the majority of health care in the country, and so they are leading where health care is going to go. Self-insured employers and commercial insurance

subsidize all government programs and the way that health care is delivered, so, and they are.

They want, you know, like Toyota builds cars, Southwest Airlines flies airplanes. They want people, pilots to be sitting in the cockpit flying the airplane, not at home with their, you know, GI condition. So, that's what leads them to look for GI solutions that can help them run their business.

So, I would say we're doing exactly what we should be doing. We just need to go further faster in groups like this to figure out how we do a better job of providing integrated health care, and using and embracing these digital solutions, because you're right.

When you transition that IBS[41] to you in person or to an emergency room, we don't know what's been prescribed. We don't know what actions have been taken. That's not the right thing for the patient.

I just think we have to offer a

41 Irritable bowel syndrome

better solution and embrace the technology where we can, but in an integrated way, and maybe that's part of the incentive of digitizing post-acute is also how do we bring in this interoperability of if you're going to put out a digital solution, who does it have to talk to?

That's where regulation, I think, could help us. How does it have to communicate so that we understand what treatment's been offered, and we can offer the next step in an effective and safe way for patients?

DR. HERMAN: I think there's asymmetries in gathering funding as well. So, we've seen some organizations that have, you know, said here's what we're going to do, here's how we're going to take care of patients, and here's what we've shown, and they've been able to gather literally billions of dollars of funding to continue that organization.

And we look at our results and where our results are better. You know, we can't take our health care system public. So, I think that there are funding asymmetries, but I

say shame on us if we're not moving in that direction as well. We just have bigger barriers in getting the funding than perhaps a smaller startup does.

CO-CHAIR SINOPOLI: Thank you for this conversation. Unfortunately, we've run out of time, but I want to thank everybody, this group, and including all of the other groups that we've met with this morning. This has been a great day and given us a lot to think about, and we really appreciate your perspectives on all of this.

And at this time, we're going to take a short break, and we're going to come back in about 10 minutes, and the group is going to talk about the things we've heard today and kind of summarize what we think we've heard from all of the panels. I really, again, appreciate your time and input. Thank you.

DR. HERMAN: Thank you for the opportunity.

CO-CHAIR SINOPOLI: You're welcome.

(Whereupon, the above-entitled matter went off the record at 4:23 p.m. and resumed at 4:33 p.m.)

*** Committee Discussion**

CO-CHAIR HARDIN: Welcome back. As you may know, PTAC will issue a report to the Secretary of HHS that will describe our key findings from this public meeting on improving care delivery and integrating specialty care in population-based models.

We now have time for the Committee to reflect on what we have learned from our sessions today. We will hear from more experts tomorrow, but want to take the time to gather our thoughts before adjourning for the day.

Committee members, I'm going to ask you to find the potential topics for deliberation document in the left front pocket of your binder. It's at the very back. To indicate that you have a comment, please flip your name tent up or raise your hand in Webex.

This is really important to capture the themes of what we've learned today from all of these very rich discussions. So, I'll give you a moment, and who would like to start? Lee?

DR. MILLS: Thank you. I was taking notes as people were talking, and a couple of

comments and I think a series of quotes that sum up my takeaway points.

So, one is we heard a lot about challenges of transitions for medically complex patients and involving specialists in care and the complexity of transitions. I maybe wonder about the TCM codes.

Right now, it's a construct that there's two levels of service only dealing with essentially the timing of the service and the medical decision-making, that perhaps we need to think about a new construct that takes the complexity or the number of team members involved instead of just the medical decision-making per se, and that we start changing our thinking that the unit of measurement is not the provider, but essentially the team, which was mentioned multiple times.

So, I think there may be an opportunity for Medicare to add a, you know, third highest complexity level code and then have a three-level gradation of number of team members involved, like one to two, three to four, greater than five or six, et cetera.

So, the second comment was I was

struck by the number of speakers who again reflected themes from prior meetings about the absolute centrality and need of full interoperability of data, again pointing to that idea of a health data utility and the need for significant investment, and then regulation requiring that movement.

And the framework is in the country, but it's very disintermediated and a lot of barriers on a state by state, region by region basis, so that came out to me strongly.

And then perhaps I'll save my quotes that summarize some other points to the end of our comment period.

CO-CHAIR HARDIN: Thank you, Lee, great comments. Angelo?

CO-CHAIR SINOPOLI: Yes, so at a high level, I kept hearing certain themes over and over, and one of the themes was teams, and our payment model seems to be very focused on physician reimbursement for an activity that nobody else can bill for and/or that it's not paid based on a team structure.

And so, I think that's something that we need to consider as PTAC is can and

should others be able to bill for some of these services that aren't physicians and/or should we be paying based on a team construct as opposed to an individual physician construct?

The other things that I heard, again going back to data and data as a utility, creating standards for ambulatory situations as opposed to just inpatient data integration. I liked the meaningful use example that Walter used, and should we be doing or incentivizing that in nursing homes and other places?

And then a lot around communication and just how difficult it is to communicate across these silos of care. Right now, most of it happens to be manual, or emails, or something. Is there a better way?

Can we incentivize communication, both in the care model so that people are aware? And maybe that will trigger some investment into various communication technologies, and so those are some of the common themes that I kept hearing throughout the day today.

CO-CHAIR HARDIN: Thank you, Angelo, very helpful. Larry?

DR. KOSINSKI: I have three comments, the first of which is this word transition needs to be applied to our process as well. So, you know, I know we've set this goal out for 2030, but how do we get there?

And so, I think there's some blocking and tackling that has to be done in the fee-for-service environment to help us get to the value-based care environment.

And the issue of the TCM codes, I mean, that's something that's already in existence. They don't have to create a new code.

You know, it could help improve patient outcomes and help build a value-based model when we can actually see how many TCM codes are being used by specialists and how much money has to be appropriated to this process. So, I think we need to walk through the transition phase to value-based care in this transition of care model.

The second thing is I think we need to stop using the word discharge, okay? I mean, no more discharge summaries. This is a transition summary. A discharge summary

implies that we're done with what we had to do and we're discharged. The patient is discharged from our care.

No, not my problem, right, and any of us who have lived this in practice knows that you're busy making rounds and you get a call from a nurse. Mrs. Jones just got discharged. Well, did the hospitalist discharge? Yes, Doctor. Okay, fine with me, and you're done. You're Pontius Pilate. You've washed your hands.

And so, I think the word transition probably needs to be everywhere, you know, transition summaries. You know, and I like the point that you should start thinking about the transition from the time that patient gets admitted.

And the third thing that, you know, I think I brought up at the end, which I think is a real issue here, and I love the way it was answered, we have pre-acute as well as post-acute transitions.

And digital technologies are creating new provider entities. We have to figure out how to integrate them into the

standard care so that we don't disintermediate providers and disintermediate hospital systems which we need when the patients are really ill, and yet we don't want to thwart technology.

We want that to grow, but the worst thing we want, the one thing we want to avoid the most is fragmented care for the patient. You don't want a patient, you know, standing there with nobody to go to because they've been getting their care from a B to C digital provider and no transition was established.

So, those are the three things that I come away with from a wonderful meeting today. The PCDT team did a fantastic job. Great presentation today, Walter. Great selection of SMEs. The gears in my head were going all day.

CO-CHAIR HARDIN: Thank you, Larry. Jen?

DR. WILER: I couldn't agree more that there was fabulous discussion today. I too am going to make three comments.

We heard that when TCM codes are billed, it improves patient care outcomes and decreases costs, but what I was struck by was

what is the role of payment policy in incenting acute inpatient care facilities to be more engaged in having a successful transition to TCM work? So, really this idea of a push versus a pull.

And there was some discussion early on around discharge planning, maybe not using that word anymore per Dr. Kosinski, but around MDRs[42], and in the inpatient space, there's this work being done, but currently, when we hear the statistic of 20 percent of Medicare payments going to unplanned readmissions, it's very clear that the readmission penalty is not working.

It's not a big enough stick. So, what are some other incentives or penalties that could be put in place to really engage acute inpatient care facilities to do a better job of transitioning care?

And then to call out, I think there's two different levels of work that we heard about today. Discharging to home for certain patients could be harder than

42 Multidisciplinary rounds

discharging to a facility, and maybe thinking a little bit through what that work looks like. That's comment one.

Comment two around the transition of care management codes, I think I was also struck by thinking about our last meeting around integration of specialists in total cost of care models, and TCM codes currently don't incent co-ownership of patients.

And at our last meeting, we talked about the scaling and fluidity of certain care conditions that require specialists to have a higher level of engagement at certain times in a care episode, and then scale back and transition to primary care.

And in some cases in the acute care setting, it would be appropriate to do a handoff to a specialist, but then transition it back to primary care, and these TCM codes don't allow for that in addition to the interprofessional and what I'm calling out as the interdisciplinary part that we know is important, and a payment model could incent that.

And then I'll call out this

statistic that you all know, but to echo it again, that 76 percent of primary care physicians don't even know their patient was admitted, so obviously that needs to be taken into consideration.

My last comment is around palliative care and the fact that we know that there's high-value patient outcomes related to involvement and integration of that care team, interprofessional and interdisciplinary.

And I thought the comments around making palliative care services for the seriously ill explicit versus implicit was something that was a really good recommendation, but unfortunately, that service is around cost mitigation, not revenue generation.

And our current payment models and certainly the fee schedule don't acknowledge that really important work, and I think there's really an opportunity for us to think about how to endorse that.

And the levers I heard today could be payment related. Another lever that was recommended was regulatory, and, you know, an

example in the VAD space, which at an academic medical center, you know, we have a VAD program.

I'm not sure regulatory is the right lever, but I liked the idea of thinking about, you know, different levers to incent good care model design.

I was surprised there wasn't a recommendation around a medical home-like model that integrates palliative care because that seems that that might be valuable.

CO-CHAIR HARDIN: Thank you so much, Jen. Jim?

DR. WALTON: Thank you. I, like everybody else, I had an experience where just I couldn't write fast enough and was getting cramps and stuff in my hand.

The things that I would add, one of the things that Larry brought up that I thought was really very important was the notion that it's pre- and post-acute transition, right? That's really the work.

And the policy that supports that is this idea of in one sense, you're reducing waste, and in another sense, you're preventing

waste, right? You're covering the waterfront from a policy standpoint, and the policy is reducing waste, right? And it's before and after.

And the second thing that I observed was I had this thing where it was said the market reality is something that is very, very powerful. I'm talking about the delivery system market now, where --

And it's specifically when we get into talking about physicians, the physician side of the delivery system that's going to make transitions effective, and we know that it's not only physicians, but we know that physicians have a role in it.

And we know that it's a 75/25 split right now or a 70/30 split where you have an employed, which is more of a command and control centralized functioning, but that the innovation within that employment structure is going to come from a lot of different places, a lot of academic places and a lot more informed, and can really accelerate innovation if the marketplace, the way it's designed or the way it's incented allows for it.

Similarly, in the 25 percent, there's going to be this magic that's being found out there in that group of people that we have to harness as well, so we have to have our eye on both of those groups if we truly believe that both groups can add to the future innovations that we can't see for today, like how we use, as you were saying, the B to C stuff, how the digital, how everybody finds a unique use case, if you will, or how they found magic in using new digital technologies.

So, the design of the future reimbursement system for me was saying well, man, that's got to be a little bit flexible to be able to cover both of those, and so there's incentives needed.

And doctors, as we know, if we just focus on what doctors are saying, like when I was managing a big physician group, they said look, you know, sometimes time relief for me is more important than the economic reward.

In fact, sometimes you can't pay me enough to take on another activity, so, but if you could take some burden out of the system for me, I can lean into doing this.

So, that might solve some of our workforce difficulties that were raised, particularly within the primary care space and from the physician side, by having time-based, like time relief incentives built in to reimburse.

And, of course, maintaining consumer choice is a powerful driver for innovation because consumers will then walk, if you will. They'll use their feet to decide I'm going to go here at Baylor versus some other place because Baylor's doing a better job. The experience is better.

So, that kind of tells me that our performance metrics have to be very consumer-centric, and I think that that was a big takeaway for me today. Thank you.

CO-CHAIR HARDIN: Thanks, Jim. Next, we're going to go to Josh. And I just want to give a frame. We've got about 10 more minutes. We're going to go Josh, Lindsay, and then finish with Lee.

DR. LIAO: Great, well, I agree, really full day. Lots of comments that I agree with have been said. I think the thing that is

kind of rattling around in my mind is this idea of yes, but, and so I really resonate with the idea of infrastructure.

I like Bob's example of high tech. Yes, it's good, net/net, but also it created problems, including ones that he mentioned, including primary care burnout and the increases in work.

You know, the idea that I think David Herman mentioned about having lots of data, but not much insight, right, is sped by high tech, so, yes.

And so, I think the takeaway for me is in the future, we probably need more infrastructure, but it also will create new problems for us. We should just steel ourselves to that.

The other is kind of with respect to transitions, and I think there's been a lot of really thoughtful reframing around what we talk about there, but very practically around kind of codes like TCM versus more global incentives, I feel like again that's a yes, but to me.

And what I mean is global

incentives, of course, are important. We've spent multiple meetings talk about that, how it creates a holistic view. It avoids myopia, which is really good, but also for those really incorrigible things like a very vulnerable, complex transition period, maybe a readmission, you know, penalty is not enough, you know, and maybe ACOs aren't enough.

We heard from Diane Meier, ACOs have been around for a long time. They've been, what did she say, slow to pick up on palliative care. I make the case that many of those population-based models have been slow to pick up lots of things actually, surgical care, this and that.

And so, I think for those really critical parts, having multiple things is probably not a bad thing, you know, and so having TCM on top of global incentives is probably okay. So, yes, more population-based models, but also, I think, specific codes really can't hurt.

CO-CHAIR HARDIN: Thank you, Josh. And Lindsay?

DR. BOTSFORD: Thanks, Lauran. I

think a lot of smart things have been summarized already, but I think some foundational things that continue to resonate from last meeting to now are just some foundational things about the accessibility of data and how important, especially at transitions, the preexisting relationship with a PCP and the identification with a PCP is critical to ensuring that someone's ready to pick up that ball quickly in the time needed to act on anything.

So, I mean, it strengthens everything just around the importance of primary care workforce and payments to make sure those people are there when we're ready to do the transition of a discharge.

Absent a PCP, having an entity that's willing to take on that responsibility of finding someone quickly could substitute, but the likelihood that a hospital is going to be able to give a list of PCPs in the community and get someone in for an effective transition is next to zero.

So, I think really hearing one of the, this last conversation about standard work

and making it easy to do the right thing struck me. You know, there's things we know that are important, getting data to PCPs, having patients identify with PCPs.

And instead of coming up with new fancier things, how can we work on using the data, and the things we know, and actually executing on them? How can that make a difference in some of the outcomes in what we're talking about?

And I think, you know, some of the things may be more actionable. In terms of making it easy to do the right thing, could be things like how do we increase incentives to patients? How can we decrease coinsurance, decrease the barriers to using these services that we've now seen studies that show there's efficacy in reducing costs and improving outcomes?

And how can we get enough payment to primary care so they can, or palliative care, whoever we designate, or a specialist who's willing to take on that continuity longitudinal relationship, but using a multi-disciplinary team with the skill set that's going to impact

outcomes?

So, not that this is simple to solve, but I just am less convinced that it requires truly new things and then doubling down on execution of things that we have more and more data on networks.

So, I think my final comment would be along those lines. Having a PCP relationship, especially in the Medicare population, could be an area to lean on even more, and how could we encourage the identification of a PCP outside of the MA space or other payers that happen to have an interest? So, good discussion though. Thank you all.

CO-CHAIR HARDIN: Thank you, Lindsay. Walter, Jay, and Jen, I wanted to give you a chance.

DR. WILER: I really don't have anything to say that is not redundant to what everyone else said, so.

DR. FELDSTEIN: I think we've covered everything pretty well.

CO-CHAIR HARDIN: Okay, Walter?

DR. LIN: Sure, I'll just make a few

quick comments here more reflecting on my fellow Committee members' comments, which has spurred more thinking in addition to the panelists that we had today.

So, I think first, we've heard the importance of the interdisciplinary team again and again. That was a theme for me. That was also evident from the environmental scan as well.

I'm not sure we really heard from our experts how to pay for it. I think that was your question initially, Lauran, but maybe Lee has a good idea here that we can explore with our experts tomorrow.

Secondly, you know, I think one of the things that the ASPE NORC study showed is that there is more pickup of TCM code usage in ACOs, and we also heard from SMEs today they felt that was also the case, and in fact, I think one of our experts said that doing good transitions is really hard to do in a fee-for-service environment.

And I wonder if there's a way that maybe CMS or CMMI can help figure this out a bit by tying outcomes to the billing of a code.

Right now, I feel like the usage of a TCM code is really like a category one activity, so you think about the HCPLAN[43] categorization of care.

The current usage of TCM codes is just category one, a straight fee-for-service. It doesn't really matter if I do a good job or bad job. There's no outcome side to it.

Is there a way that we can somehow tie outcomes to the billing of that code to make sure that actually there are some value-based payments tied to usage of that code and hopefully improve the outcomes associated with that code?

And the last thing I would just highlight is something that I think Karen said at the very first session today about the need for payers to communicate more with providers in terms of performance data.

You know, it kind of made me think. I'm sure larger practices have more access to payer data, but smaller practices like mine, it's hard to get performance data from payers, and I wonder why.

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You know, like why shouldn't the Medicare Advantage plans my practice contracts with send me my performance data and that of all the other providers in our group on, you know, readmission rates, transition code billing, ED visits? I think that is something I'd like to ask our payer experts tomorrow.

*** Closing Remarks**

CO-CHAIR HARDIN: Thank you, Walter. I'm going to call out two themes and then turn it to Lee to close us out with some quotes.

So, definitely the strong theme of longitudinal, cross-sector integration for really integrated delivery, that the focus on health equity and health-related social needs is really driving integration of social service, community-based organizations across sectors, and that's also driving some interest in hubs or coordinated approaches to actually meet these gaps in service, not only in workforce, but in preventing the syndrome of referring to nowhere, screening and then not having anywhere to refer, so a lot of really rich content today.

We want to thank everyone for their

active dialogue, active engagement, and I'm going to turn it over to Lee to close us out.

DR. MILLS: Thank you, Ms. Co-Chair. I just have some quotes from some of the speakers that really resonated a lot of the points we've heard today. Simple brain, I look for simple points that I can remember.

It starts with Dr. Diane Meier who said Mother Theresa is not a scalable model, speaking to the need to have a deliberate build. The system drives the outcomes you desire. You can't just count on people doing it out of the goodness of their heart.

Secondly, when the requirement is applied, the resources will be supplied, speaking to a pathway for thoughtful and careful regulatory adjustment.

Dr. Chuck Crecelius said the best transition is no transition, I think speaking to both the workforce, primary care workforce, and good data.

Next, moving to Dr. David Herman, he was speaking to the need to just simply commit to a delivery model even though it's not all clear how it's going to work, and he commented

that here in Minnesota, we just get in the canoe. We don't spend much time balancing.

Secondly, referring to the, you know, fanciful belief that at some glorious time in the future, there will be adequate primary care, or frankly, physician or nurse workforce supply, which isn't going to happen, is just those people don't exist.

And then lastly, he finds that we are all data rich, info poor, and insight starved, which I resonated with.

Ms. Jenny Reed from Baylor Scott & White mentioned I like models that incentivize working together, absolutely, and telling in that so many things built on a fee-for-service mechanism, CPT-driven, are individual provider focused, and then finally, she reiterated multiple times simple calculations, which is important to me as well.

And then ending with Dr. Bob Wachter who spoke to I've seen a lot of primary care crises over the years, and it's never been more urgent. I thought that meant a lot.

And then finally, if you don't start at payment parity for Hospital at Home, you

won't get the activation energy to shift, a little chemistry model there.

CO-CHAIR HARDIN: Thank you so much for that excellent summary, Lee. We want to thank everyone today for your active participation, a really deep thanks to our expert presenters who took time to do really rigorous presentations and inform this discussion today. I want to thank our ASPE, NORC, and PTAC colleagues, and also those listening in.

*** Adjourn**

We'll be back tomorrow morning at 9:00 a.m., and we'll feature two listening sessions, as well as time for public comment. We hope you will join us then. Thank you. This meeting is adjourned for the day.

(Whereupon, the above-entitled matter went off the record at 5:02 p.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Public Meeting

Before: PTAC

Date: 06-12-23

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate complete record of the proceedings.

Neal R Gross

Court Reporter