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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FRIDAY, MARCH 3, 2023

PTAC MEMBERS PRESENT
LAURAN HARDIN, MSN, FAAN, Co-Chair
ANGELO SINOPOLI, MD, Co-Chair
LINDSAY K. BOTSFORD, MD, MBA
LAWRENCE R. KOSINSKI, MD, MBA*
JOSHUA M. LIAO, MD, MSc
WALTER LIN, MD, MBA
JAMES WALTON, DO, MBA
JENNIFER L. WILER, MD, MBA

PTAC MEMBERS IN PARTIAL ATTENDANCE
SOUJANYA R. PULLURU, MD*

PTAC MEMBERS NOT PRESENT
JAY S. FELDSTEIN, DO
TERRY L. MILLS JR., MD, MMM

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

*Present via Webex

A-G-E-N-D-A

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

9:01 a.m.

* CO-CHAIR HARDIN: Good morning and welcome to day two of this public meeting of the Physician-Focused Payment Model Technical Advisory Committee, known as PTAC.

My name is Lauran Hardin, and I am one of the co-chairs of PTAC along with Angelo Sinopoli.

* **Welcome and Co-Chair Overview - Discussion on Improving Care Delivery and Integrating Specialty Care in Population-Based Models Day 2**

Yesterday we began our day with opening remarks from the CMS[1] Deputy Administrator and CMMI[2] Director Liz Fowler, and she offered some context on her -- how her work fits into the Centers' vision. We also had several guest presenters share their ideas on how integrating specialty care in population-based models can help us to move toward a patient-centered health care system.

1 Centers for Medicare & Medicaid Services
2 Center for Medicare and Medicaid Innovation

Today we have a great lineup of experts for today's listening session and our physician roundtable discussion. We've worked very 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.

Later this afternoon we have a public comment period. As a reminder, public comments will be limited to three minutes each. If you have not registered to give an oral public comment but would like to, please email ptacregistration@norc.org. Again, that's ptacregistratoin@norc.org.

Finally, the Committee will conclude the day by shaping our comments for the report to the Secretary of HHS[3] that we will issue on this topic.

*** PTAC Member Introductions**

Because we might have some new people online who weren't able to join yesterday, I'd like the Committee members to please introduce themselves. Share your name, your organization, and if you would like, you

3 Health and Human Services

can share a brief word about experience you may have with population-based payment or total cost of care models. I will cue each of you.

I'll start. I'm Lauran Hardin, Vice President and Senior Advisor for National Healthcare & Housing Advisors. I've spent the last 20 years leading and innovating in value-based payment models for complex and underserved populations.

Angelo?

CO-CHAIR SINOPOLI: Thank you, Lauran. Angelo Sinopoli. I'm a pulmonary critical care physician by training, presently the Chief Network Officer for UpStream, which is a value-based company that supports primary care physicians. Prior to that was the Chief Clinical Officer for Prisma Health where I developed our clinically-integrated network over a number of years to 5,000 physicians, and also was the founder of the Care Coordination Institute, which was an enablement company to support clinically-integrated networks. Thank you.

DR. WILER: Good morning. I'm Jennifer Wiler. I'm the Chief Quality Officer at UCHealth for our metro community. We're one

of the largest health care systems in the Rocky Mountain area. I'm co-founder of UCHealth's Care Innovation Center and a tenured professor of emergency medicine at the University of Colorado School of Medicine. And I was a co-author of an Alternative Payment Model considered by this Committee.

DR. LIAO: Good morning. My name is Josh Liao. I'm an internist and faculty member at the University of Washington where I also serve as the Enterprise Medical Director for Payment Strategy. I also lead a group that works on evaluation and research related to payment incentives and payment models.

DR. LIN: Good morning. Walter Lin. I'm an internist in St. Louis, founder of Generation Clinical Partners. We are a group of medical providers that care for the seriously ill and frail elderly in senior living organizations.

DR. BOTSFORD: Good morning. I'm Lindsay Botsford. I'm a family physician by training and a Market Medical Director with One Medical in Houston. I work at Iora Primary Care where we take total cost of care for older adults on Medicare.

DR. WALTON: Good morning. My name is Jim Walton. I'm a retired general internist and just recently retired from -- as a CEO of a large IPA[4] in Dallas, Texas. Presently working as a consultant advisory role for Medicaid and ACO REACH[5] companies trying to achieve total cost of care reductions.

CO-CHAIR HARDIN: And we have two members online.

Chinni, please go ahead.

DR. PULLURU: Hi there. Chinni Pulluru. I'm a family physician by trade. I serve to lead clinical operations for the Walmart Health Business. I'm the Chief Clinical Executive of the Omnichannel Care Delivery System. Prior to that I spent about 15 years leading one of the largest medical groups in the country, particularly during value-based care transformation across the U.S. continuum, as well as things that are care delivery within that group. Thank you.

CO-CHAIR HARDIN: Thank you, Chinni.

Larry, please go ahead.

DR. KOSINSKI: Good morning,

4 Independent practice association
5 Accountable Care Organization Realizing Equity, Access, and Community Health

everybody. I'm Dr. Larry Kosinski. I'm a gastroenterologist by training, and I've practiced clinical gastroenterology for 35 years. Currently I am the founder and Chief Medical Officer of SonarMD, a value-based care program for patients with digestive diseases which began as the first PTAC-recommended physician-focused payment model back in 2017. Look forward to today. Thank you.

CO-CHAIR HARDIN: Thank you, Larry.

And two of our members couldn't join today: Lee Mills and Jay Feldstein. Both are physician leaders in value-based payment and innovation.

*** Listening Session 2: Developing Financial Incentives**

CO-CHAIR HARDIN: So we're excited to dive in today. I want to welcome the experts for our first listening session. We have invited five outside experts to present on developing financial incentives in population-based models. You can find their full biographies posted on the ASPE PTAC website along with their slides.

After all five have presented, our Committee members will have plenty of time to

ask questions, so start thinking about what you would like to ask.

Presenting first we have Dr. Kevin Bozic who is a professor and Chair of the Department of Surgery and Perioperative Care at Dell Medical School at the University of Texas in Austin.

Welcome and please begin, Kevin.

DR. BOZIC: Well, thank you and thank you very much for including me. I've always been an admirer of the work of PTAC and have incorporated many of those principles into our practice.

I bring the perspective of a practicing orthopedic surgeon, a chair of a large academic department, and the incoming president of the American Academy of Orthopedic Surgeons, although I'm not speaking on behalf of the AAOS today, and have spent most of my career designing, implementing, and evaluating structural changes to the payment and delivery system that incentivize and reward value, and wanted to share a few of the things that we've learned in our experience.

First of all, I think sometimes we forget in payment model transformation that the

goal of the health system is to produce health. And health care can be part, but it's certainly not all of the solution. And that the changes to the payment system are intended to change behavior of the clinical teams that are responsible for improving the health of patients, but we've also learned along the way that it can be a powerful driver of bringing purpose and fulfillment to the health care team that is mitigating the costly impact of turnover and burnout. And we have some evidence for that.

I think all of us know that the fee-for-service system incentivizes volume-driven care and really feels like a death spiral to clinicians who feel like they have to run faster on the gerbil wheel, and I would argue that capitation makes us feel like we are rationing care. And the sweet spot for us is episode-based payment models for the management of conditions. And that's what I wanted to share with you this morning.

I think we believe that innovation in care occurs not at the population level, but at the condition level by teams of clinicians that come together and innovate around the care

of chronic conditions such as diabetes, cancer, cardiovascular disease, and in our case, musculoskeletal conditions like arthritis and back pain.

It can also be used to incentivize the clinical team to organize around the needs of the patient with particular conditions rather than by physician specialty. An example in my field is many patients with musculoskeletal complaints are referred to orthopedic surgeons, which never made sense to me as an orthopedic surgeon who's been practicing for 20 years why someone with shoulder pain or knee pain would be referred to an orthopedic surgeon. I know that if I wake up with a headache, hopefully I'm not referred to a neurosurgeon as my first stop.

And we also know that patients with chronic musculoskeletal disease very commonly suffer from comorbid anxiety, depression, and other mental health issues, yet rarely if ever are people who treat musculoskeletal disease integrated in any way with people that know anything about the treatment of those conditions.

Similarly, about 60 to 70 percent of

patients with musculoskeletal disease also have weight management issues, either overweight or obesity, and yet rarely if ever do the people who treat musculoskeletal disease integrate in any way with anyone who knows anything about the treatment of obesity.

So we believe that the payment model can be used to incentivize the creation of, in our case, a musculoskeletal medical home that includes advanced practice providers with specialty training in musculoskeletal disease, physical therapists, chiropractors, dieticians, and behavioral health trained social workers who can deliver cognitive behavioral therapy, and a few surgeons and other specialists that are needed for the management of musculoskeletal disease, but not very many.

We have in our field extensive experience with bundled payments. We started doing bundled payment around hip and knee replacement in the mid-2000s. And after over a decade of experience with that, Amol Navathe's group published about several years ago that over a decade of bundled payments for hip and knee replacement, we had a -- we saw a 1.6 percent reduction in spending with, quote, no

detrimental impact on patient outcomes, which for someone who spent a decade of my life working on that, that was quite depressing. I thought we could do better.

And what we've realized in the process is when we bundle at the procedure level, we make a -- fit procedures very, very efficient. So done in the lowest acuity setting that's safe, shorter lengths of stay, minimize avoidable complications and readmissions. And we completely ignore whether or not that treatment is the most appropriate treatment for that patient. And since much of health care is preference-sensitive where there's no right answer, incentivizing efficient health care services and procedures and ignoring whether the procedure is the most effective and appropriate treatment in the first place does not create value for patients.

So we've moved upstream to condition-based payment models rather than procedure-based, and this involves a single annual payment for the management of a chronic condition, including chronic joint pain and back pain. It includes all the professional services delivered over that defined period of

time, and we have accountability for outcomes which makes it -- us different from capitation in that we are responsible for measuring and improving and delivering on improvement in patient-reported outcomes. In that case, it means measuring pain, functional status, and quality of life.

It's always been surprising to me that we perform over 1.1 million hip and knee replacements a year in the United States, and less than 5 percent of the time do we measure the only thing that matters to our patients, which is pain, functional status, and quality of life. And yet no one thinks that's odd. No one in the payment world and no one in the clinical world thinks it's strange that we don't measure the only thing, the only reason we do that procedure in the first place. So we need to measure outcomes from the patient's perspective in order to understand whether we're delivering value.

And after five years what we've seen is about a 30 -- we've been -- implemented this model five years ago. We've seen about a 30 percent reduction in the per capita spending from initial diagnosis of a chronic

musculoskeletal ailment, including arthritis and back pain. About a 30 percent reduction in that annual spend and substantial -- about 90 percent of patients achieve a substantial clinical benefit in terms of their self-reported pain, functional status, quality of life. And that's patients that are treated both operatively and non-operatively.

So to summarize, I think episode payments at the condition level not only result in better health outcomes at a lower cost, but by aligning our incentives with those of our patients, they bring joy back into practice and mitigate the devastating effects of physician burnout. Our evidence for that is our practice started five years ago, and in five years we've lost exactly one member of our health care team through the Great Resignation, through COVID, through all of the turnover. And why? Because people come to work every day, and they get to do what they enjoy doing, and their incentives are aligned with the patients that we are privileged to treat.

So thank you for the opportunity to be here this morning. I look forward to hearing from the other presenters and to

getting into more detail in the discussion.

CO-CHAIR HARDIN: Thank you so much, Kevin. Very interesting.

Next we'll hear from -- a presentation from Dr. Ami Bhatt, who is Chief Innovation Officer, American College of Cardiology.

Please go ahead, Ami.

DR. BHATT: Great. Thanks so much for having me.

So just by way of prior life, I've been the Chief Innovation Officer at the American College of Cardiology for a year now. Prior to that I was practicing adult congenital heart disease, a subspecialty of cardiology, at Mass General and was the Director of Outpatient Cardiology from 2016 on.

So do I just say next slide, or do I have forwarding ability?

Perfect. Thank you. Goal today, they've asked me to talk about best practices for developing specialist-focused incentives and performance metrics, and then how do we encourage engagement with primary care providers, which is something we talk about a lot at the ACC.

Just a few facts though about practice today as we start for cardiology. Total value allocation, still pretty modest in specialty care, especially in cardiology globally. So just important to recognize.

And the second is many practices are relying on the fact that as we build these models, it's going to lay the incentive and metric infrastructure for value payments. There's a lot of alignment of when we do this, we should all do it similarly, so I think there's a lot of importance in the discussions we have and the work that the PTAC does for our field.

Next slide? So developing specialist-focused incentives. What are some key things that we're finding from our membership?

So the first is creating team-based value incentives in cardiology. And I would say -- I'm calling this specialist in general because I think this applies to some of the other specialties that are very similar to us, and it would be great to think about it as all of us together and not just each specialty deserves their own mechanism.

Team-based care has really become a basis of how we deliver care, and so we really need team-based value incentives when we don't have that. We have discussions amongst who the different team members are and who's getting credit for which RVU[6] for what, and it's really counterproductive to the kind of care that we're able to provide.

The second is we are a subspecialty that actually has subdisciplines, and those subdisciplines are oftentimes interventional and non-interventional. Other specialties have this as well. One of our challenges is that there is compensation inequality for a variety of reasons that developed over many years across those subdisciplines. So perhaps a more challenging goal is how does one compensate for the entirety of the course of a patient's care?

If you look at the average cardiovascular care patient, they don't just touch one area. They have heart failure and coronary disease. They need a catheter, and they need a pacemaker, as well as guideline-directed medical therapy. So how does one compensate equally across subdisciplines to

6 Relative value unit

encourage the entirety of care? And that's changing some models, but I think that deserves some thought.

The third is allocating value -- no, sorry. Go back. Allocating value to clinically-meaningful non-production metrics. Right now most of our metrics in cardiology are all production metrics. And so that really is a contradictory incentive for what we're doing and really want to trade those contradictory incentives for purposeful achievement. So what are the non-production metrics even in those who are not yet value-based that people agree upon and would start to use as a cornerstone for the future change?

And then lastly, I think there are specialists that know a lot and are interested in value-based compensation but are perhaps not included, as a lot of the value change happens in the primary care structures that are within their organizations. And so I think even as primary care is starting to go value-based, which we're seeing more of, it would be great if the cardiovascular team could be included in even planning those thoughts if it doesn't yet include the subspecialists only because you

then have a hand in what the floor looks like and what we were building upon.

Next? Next slide, please? Thank you.

And you can click three times for me right here. Perfect. Thank you.

One of the ways we talk to our cardiovascular membership, ACC's about 57,000 members, is to really talk about population-based total cost of care as optimizing patient care. So some of the pressures on our decreasing cardiovascular workforce and our burnt-out workforce is chronic management and really partnership with primary care, is patient-centric, but it also reduces low-value specialist care, which is oftentimes a lot of what's burning out our specialists. And so I think that is a great way for us to think about that partnership.

I think the second is rising risk when illness progresses and can be identified. That doesn't have to be managed at the specialty level. Oftentimes we have really great guidelines and closed-loop mechanisms for GDMT[7] that can be used at a primary care or

7 Guideline-directed medical therapy

specialty practice level. And so I think sharing that rising risk management burden would be helpful.

And then lastly when patients eventually get to requiring intervention what we are talking to our specialists about is the fact that the care is oriented to the right testing, the right specialist, the right location because we have this partnership with primary care, with community engagement. So this has been what we've been talking to our membership about.

Next? Separate thought. I am the Chief Innovation Officer. Clinical practice, especially since COVID, in cardiology even a little bit before, is continuous and is no longer episodic. And so we're going to need payment models to follow this trend. You can get many cardiologists on board with this concept for outpatient care, which is we use a lot of asynchronous communication: patient-reported outcome measures, electronic consultations, patient gateway through the MyChart, et cetera. So that's really important to our mechanism of care. It's also team-based. The asynchronous communication goes to

a variety of different clinical providers.

Blended care. In-person and virtual synchronous visits, whether phone or video. There are many patients who are demanding the ability to do this. And they are happy with it. So even though we continue to watch the continuing waivers and look at when phone will be covered until, which is a separate issue, it's really important that phone will likely continue. Patients enjoy it. Teams see it's necessary. So we have to figure out how we're going to really account for blended care.

Clinical remote monitoring with medical-grade FDA[8]-approved devices has been around for a long time in cardiology, but the field is growing. We do a lot of it. Right now it is reimbursed by specific codes for 30 minutes of blood pressure monitoring, et cetera. And this eating away at every single little thing and then having to pad them all into what your RVU generation is, is something that's wearing away at our clinicians. So again, another reason that people are ready to think about continuous payment rather than episodic.

8 Food and Drug Administration

And then lastly, digital tracking and wearables, health care social data. We'll talk in a minute about how we can maybe use some of that.

And then lastly, data analytics. Really thinking about collaborative intelligence and the utility of AI[9] in helping us take large amounts of data, understanding what we've put in the models, understanding what comes out. There needs to be some room for us to start looking at how to use that and compensate for it. We won't use it unless it's accounted for. And I'll get back to that in a minute as well.

Next slide? So health equity. Really central to the ACC. I wanted to make sure we addressed it. Value-based models with adequate infrastructure can really help us. So incentivizing total cost of care by supporting upstream equity in screening and disease identification and meeting social service needs.

If you look at the primary care practices, we are jealous. We perhaps have a care coordinator when we discharge a patient

9 Artificial intelligence

from the hospital in cardiology, but shy of that, we have very little knowledgeable support in how to help with the social determinants that our patients face, and that is challenging. So if there is a way that that can be incorporated in future models of care, especially if we're partnering with primary care, that would be really important.

Imbedding social determinants of health and social vulnerability index into payment models. We are used to doing this for risk-adjusted models in terms of procedures, so we're really just looking at doing it on the other side of kind of outpatient care and looking at social determinants of health. It's something that we've gotten used to, so I think we could start to learn how to apply it and mirror it in other places.

And then lastly, team-based specialty care. Whether it's upfront compensation, whether it's subsidies or incentives, sharing it across a practice is important. You'll notice that many cardiovascular practices have the three people who receive the majority of the Medicaid patients, right? The one who's in Boston, for

example Chelsea. And those are the two doctors who get all of our patients of a certain race, ethnicity, socioeconomic status.

And rather than having those people have their compensation dependent on that, if a practice were to then look at compensation holistically, and social determinants of health, if social vulnerability were incorporated into the entire practice, everybody gets credit when that practice does well. I think that's a concept to really make sure that health equity grows as we move to a total cost of care model.

Next slide? So last two slides. Options. If you say hey, doc, what can we actually do? So one that we have written and talked about quite a bit is the comprehensive condition-based value model. Episode of care from treatment to stable. So atrial fibrillation, right? Bundled care for MIs[10]. We're probably going to continue to need that for some of these models based on the way we're already set up.

However, there's also a continuous care value-based model. If we're collaborating

10 Myocardial infarction

with primary care, if we have community outreach, we address health equity, the two slides we just talked about, what does that kind of a value-based model look like? I think we need to perhaps address our specialty with the challenge we're facing, which is chronic disease management, and continuous care is a major part of the burden of what we do. And yet separate from that we have significant high-risk episodic care that needs to be controlled. And maybe we need to think about two different value-based subspecialty models that exist in parallel.

Last slide, please? So I think for us, successful value models are going to address the following challenges: For accelerating complexity, we need better partnership and upstream care, whether that's with primary care, whether that's community-based, how we're doing it, so that that complex care can actually make it in the door in time to the subspecialist tertiary institutions or caregivers.

There is exponential information overload, and somehow the value-based models

need to include RPM[11] and analytics rather than each RPM being its own separate RVU-generating code. And so how do we actually create a model that builds for that? And we can talk more about it in our discussion.

Rapid technological disruption is happening. There needs to be room for innovation. People aren't going to use the new technologies or the AI that's going to make them better at providing care because the foundation is given to them. And then clinicians use their own clinical acumen over that foundation of here's everything I found in the EHR[12], rather than I turned my back to my patients, spent a lot of time in the EHR, and still didn't get the maximal information that it can provide. But somehow, we have to account for that. If you're willing to innovate, willing to iterate, that's part of the value-based model of your care.

And then lastly, we do need health equity support. So we need stronger models that incorporate people who are really specialists in thinking about social determinants of health. We can start teaching,

11 Remote patient monitoring
12 Electronic health record

and we have started teaching our cardiologists about this at a younger age and even in med school, but it's different to be a specialist and actually have to deal with social determinants.

I think there's maybe one last slide that says thank you. Perfect. Thank you so much for having me.

CO-CHAIR HARDIN: Very thought-provoking, Ami. Thank you so much.

Next, we have Dr. Judy Zerzan-Thul, who is Chief Medical Officer at Washington State Health Care Authority.

Go ahead, Judy.

DR. ZERZAN-THUL: Oops, these ones aren't my slides. It's just the next -- there we go.

Good morning, everyone, and I'm excited to join you today.

So next? I'm going to talk from a much higher level, more about systems and integrating behavioral health care. And so to give you a little bit of a background of that, I work for the Washington State Health Care Authority. We are the state's largest health care purchaser. We provide coverage for

Medicaid folks, public employees, teachers, and retirees.

And next slide? And besides being the single state Medicaid agency, we are also the single state authority for behavioral health. And this has evolved over time. There used to be separate divisions for alcohol and substance abuse and mental health. Those two joined. And then in 2018 that division moved over into HCA[13]. And that has really allowed us to better integrate behavioral health care into the whole health care continuum and think about how community behavioral health supports fit in and think about how payment fits together.

And so the next slide, I'll show you who we served in fiscal year 2022. And it's important to know these are all Medicaid folks or people without insurance or low-income. So our behavioral health services are really focused on the non-commercial population. And most of these folks got mental health services treatment. That's the sort of lighter blue color little people. The green people got substance use disorder treatment services. And prevention is a part of what we do, but you can

13 [Washington State] Health Care Authority

see it's a small part now. We'd like to grow that. But there's a lot of need and a lot of workforce issues.

Next? Our journey at HCA to whole-person care has been a long time in coming. Before integration happened, before the Behavioral Health Division came over to HCA, there wasn't any one payer or any one system or provider accountable for whole-person care. There were two different state agencies that had kind of mixed responsibilities for different parts of care and access to care standards, treatment standards, all were similar, but a little bit different.

And so after integration, we now have whole-person care management that's provided through a single accountable managed care organization. We at HCA are responsible for that care. We've worked so that we have the whole continuum of physical and behavioral health care, including crisis services, really focused on what does the person need? What kinds of supports for behavioral health, physical health, and social needs can we support them with?

And I also wanted to point out this

has been a slow journey in many ways. So it started with different counties. It started with different chunks of populations. Children and families and then pregnant women we worked on first. But now we've really got to everyone. And so the next slide I think is a nice picture of what things looked like before integration and after integration.

So before integration, on the left-hand side, there was a confusing mix of delivery systems and payment systems run by two different state agencies. Some services were provided by regional mental health plans. Some services were administered by counties. These were mostly substance use disorder treatment. And then the state agency had inpatient. And things were not well connected, and people didn't get as good care as I think they're getting today.

So after integration, on the other side, we have MCOs[14] really leading the care. They work with behavioral health ASOs[15], they work with counties, they work with -- we have these accountable communities of health that are focused on social determinants and health

14 Managed Care Organizations
15 Administrative service organizations

needs, but it makes things much easier when medications, outpatient treatment, inpatient treatment can all be coordinated.

Next slide? But to get there it has been -- we've had to move carefully so -- both to not disrupt services and to figure out what the right payments are. We found as we made this journey that many behavioral health agencies did not know how to bill well and didn't bill for the full complexity of their services, which the managed care organizations that are very used to sort of crunching numbers and giving people payments without that claims data really struggled to make sure that they got the right payment amount.

We started our integrated managed care journey in 2016 when we put out bids and in 2018 the first two regional areas -- we did it in regions of the state that we rolled this out. So the first two started in 2018. And we found almost immediate benefits within the first year or two in terms of increased housing for these folks, particularly the ones with more severe mental illness, and also immediate returns in terms of a decreased re-incarceration. This population often is in and

out of jails and prison, and providing integrated health care really has helped people be more functional and stay in the community, which is great.

We had our final three areas of the state integrate over 2020, which of course was completely disrupted by COVID. And so it has taken us a few years to have systems stabilization, to figure out what the right reimbursement level is, to figure out what the right service level is, and get to integrated statewide coverage, which is where we are today.

Next slide? I'd like to pivot briefly to talk about our focus on value-based purchasing and some of the ways we're doing that with regards to primary care and behavioral health integration.

So next slide? We have been on a VBP[16] journey since 2016. We use the LAN[17] framework for VBP, and we measure categories 2B and above. And you could see when we started, we had a relatively modest goal, and that has increased over time. We continually strive to figure out how do we get better outcomes, lower

16 Value-based purchasing
17 Learning Action Network

costs, better experience of care for both our patients and the provider, and really reward that high-value care.

As we've done this, one of the things we've learned is that most people are sort of stalled. While we have impressive VBP penetration, most of that is stuck in the 2B level. So people get rewarded for quality, but we're really trying to push how do we get to population-level payments. That turns out is much harder for providers to want to sign up for and want to do, and so having the right communication and the right understanding to clinicians so that they want to do this I think has been another lesson for us.

Next slide? So one thing we've been working on with integration for a few years now is primary care transformation. And this has been an aligned multi-stakeholder approach. We've had extensive engagement and working on these accountabilities you see here for three groups. The clinicians that include accountabilities for whole-person care and behavioral health screening and treatment of mild disorders.

We also have payer accountabilities

to have aligned quality standards and move towards funding of a capitated model so that most services for primary care will be paid on a per-member/per-month basis.

And then we also have a group of employers at the table for the commercial insured lives in Washington that are really looking at what kinds of better integrated primary care do they want for their employees, and how can they support both the health plans and the providers and moving towards that?

HCA. Here we have a role, but we are for sure not the only one. One piece that we're doing to help advance this is measure primary care spend. Other states are doing this. And integrated behavioral health is part of what we want to spend, or what we want to measure in that spend. We have a goal of 12 percent of total health system spending being for primary care services, and we hope to have the first measurement of that out by the end of this year.

Next slide? So to get to integrated care, you have to measure integration and figure out where are practices? And so we have developed a statewide standardized assessment

tool that measures the degree of integration. And the beautiful thing about this is that we have a tool for primary care, but we also have a tool for behavioral health practices. And it's really that bidirectional kind of measurement that I think is important in this space of how do you have that communication, and how do you provide services?

We just finished our first cohort in doing this integrated care assessment, and I was surprised that practices were not as far along in some cases as I thought they were. And it gives us a really good idea of what sorts of supports practices need to move into full high-functioning integrated care.

Next slide? So there is for sure overlap across a number of our initiatives, and these are all kind of pieces of a puzzle that fit together in terms of how do you measure integrated primary care in practices? How do you pay for that? How do you have care coordination hubs that fit across this, and are both integrated with behavioral health and primary care and the community? And we are starting to work on setting up certified community behavioral health clinics, which I

think will also be an important piece of the puzzle.

And I think my sort of messages as we go along this journey are integration can for sure be done and be done well. But the payment part can be tricky and thinking about how to make sure -- many behavioral health practices are very small and are independent, and you don't want to make them go out of business or have financial difficulties as this shift happens. We spent more time on that than we were expecting.

And then figuring out ways to make payment work. Because many of these things overlap. Whether that's overlapping, whether that's nested models is important. And one thing that we are still trying to figure out is how to have -- best have that payment sort of weave in and out of different models, not be overlapping but be enough so that good care can be possible. Thank you. And I think I have one more thank you slide, too.

CO-CHAIR HARDIN: Thank you so much, Judy. It was really interesting.

Next, we have Dr. -- or Ms. Christina Borden, Director of Quality Solutions

Group at National Committee for Quality Assurance, and Dr. Brian Outland, who is Director for Regulatory Affairs with the American College of Physicians. I'll note that NCQA and ACP worked together to submit a proposal to PTAC in 2020.

Please go ahead, Christina and Brian.

DR. OUTLAND: Well, good morning, and we certainly appreciate you allowing us to be here and inviting us to be a part of this important session on improving care and delivering integrating specialty care in population-based models.

Next slide? In ACP, we have a number of primary care physicians that participate in advanced practice models and -- advanced primary care practice models, and they have gained a lot of experience with being in these models. And so in collaboration with NCQA and looking at the experience of primary care, we worked on -- embarked on a model that would pilot a program for coordination between specialty care and primary care.

One of the important things is the aim with this was to improve that coordination

between these two types of specialties, primary care and specialty groups. ACP is the largest specialty society with over 160 members, and it includes a number of subspecialty societies. So learning from the experience of primary care who are in these practice models, linking them with specialty practices that go through a vigorous clinical transformation and also coordination criteria -- those specialty practices will be able to learn from the experiences of primary care who have already been embarking on these types of models.

And so part of the experience we found with primary care was how could we best help? There was a -- information sharing was one of the areas where we found a breakdown. And it wasn't just in one specific area. It was all across the continuum of care, before the referral was made, during, and even after the referral.

So we embarked on this model, supplied it to PTAC, and it met all of the 10 criteria of the Secretary, and therefore the PTAC was able to submit it to the Secretary for testing.

Next slide? So a critical element of the model is the collaborative care

agreement. In this agreement, it will actually outline the expectations and the roles of the clinicians that are involved in it. It would help to clarify when the specialty clinician is acting as the principal care, and when primary care and specialty care are co-managing a patient. It will also help with the communication and sharing of data. It closes the loop on that data so that the primary care and the specialty care know what's going on in each area at all times, and it helps to prioritize this information to the clinicians.

It also ensures clarity at hand-off. When should a patient be handed back to primary care, or when should it continue? And so templates within this care agreement will be established so that that is clearly laid out, and the specialty care and primary care has that coordination and good communication in each of these. Each practice then would establish its own internal things that will help them to be able to prove that this works well and continues to be good coordination of their peers.

So clinical features in a collaborative care agreement is certainly

important. And here it will utilize these agreements with the primary care and specialty care, and it will help to clarify when the specialty care is acting as the primary clinician. It will also provide communication data and protocols that clearly establish what these agreements are, the mechanisms for being able to do that, and prioritize based on urgency.

Each practice should establish its own internal things.

And could we go to the next slide? So within this care there is a spectrum of primary and specialty care. And so it ranges from the simple consultation all the way back to the management of coordination of care back to the primary care from specialty care.

So within that, what happens? There could be co-management, that is shared care. So in certain instances the specialty clinician for their long-term management of the patient will perhaps serve as the patient's primary during those times. There are also times when this co-management will be managed by both the specialty care and primary care at the same time for some long-term chronic conditions that

the patient may have.

There also may be a consuming illness where just one specialty could then perhaps be serving as the primary care or their condition is worsening, and so they will take over the care of that patient, but it still keeps the primary care physician in the loop as to what's happening so that they can continue also caring for the patient's needs. And then the transfer back from one specialty care to the primary care.

Next slide. So each type of shared care has its unique types of things that have to be done, but there are some things that should be in all of these types of care when the care is shared by patient's principals. Who is principally responsible for the care? Is it the primary care, or is it the specialty care? Who is principally responsible? So the care agreement will help to close that loop to be sure who's responsible for the principal care of the patient.

Shared expectations. This is when a consuming illness may require that the principal care and co-management is co-managed by both the primary care and principal care.

There are also critical elements that need to be done from the primary care. What is involved in the primary care sending information to the specialty care so that they will receive everything that they need to be sure that they have the right patient, and the patient is seen at the right specialty care for their services?

And then there's also helpful elements, as we mentioned, templates and those types of things that can help close the loop on the coordination of information back to each of the clinical teams, not just the primary care sending information to the specialty care, but also specialty care getting that information back to the primary care.

Next slide, please? So one thing that needs to be done is encouragement of the specialty practice's engagement in this. So how can we do it? Well, any model that is created has to be understandable and predictable to the specialty care, but also to primary care. And then it has to have a foundation that is able to be worked on that has a similar framework that each can understand. And also it must be scalable to

different types of practices so that they can all use this type of a model.

Communication, as we have mentioned, is key in this. And so the specialty care should be involved in the pre-screening of all referrals with the accompanying documentation. That is where the primary care will be sure that he sends all the needed information because then it will help being sure that the patients are seen, and then also help lower the cost of unnecessary types of visits and unnecessary time for the patients being able to be seen within the specialty practice.

Also care coordination agreements are important as we already mentioned. And the reimbursement structure is also important, but while that's important, even more so is the -- reducing the unnecessary and duplicative work. So when the primary care sends the information over to the specialty care, the specialty care can then triage those referrals.

And maybe it doesn't need to be a full-on visit with that patient. Perhaps these things could be happening -- taken care of just through a consultation or other means, or perhaps it's just not the right specialty that

received that patient. And so the duplicative work does not need to take place. The patient can be sent to the appropriate place -- specialty to take care of those things.

Also in total cost of care it would be a way to encourage specialty practices to be involved from the patient level. It would get the patient involved because they could do things like waivers, transportation, and those types of things so that when the primary care refers them to that specialty practice, they will be able to go there and be involved in their care as well.

And then these specialty care and primary care will certainly work together because of total cost of care. The specialty cares will know that the primary cares who are already involved in these types of training and practices are doing their best and will help them to be able to do their best, to succeed in total cost of care type models.

Next slide, please? So how to operationalize. Here are some of the critical elements that the primary care physician would be involved in: Making sure that he has all of this data and that this data is then

transmitted to the specialty practice for the referral. When the specialty practice receives this information, then the specialty practice would then be able to go through and triage and know is this a patient for my practice? Does this patient -- can I handle this problem or this illness just with a consultation with the primary care? Or can I send this patient to a different specialty that will actually be able to take care of that? As the doctor mentioned earlier, that you don't have to go to an orthopedic surgeon when you could perhaps have had it done elsewhere. And so it will get to the right person at the right time and then lessen even the wait times for those patients being seen in their practices.

Next slide, please? Next slide is -- yes, thank you.

So here it helps us to appreciate that the specialty care is also involved. And what happens, some clear indications. What the specialty care is doing, what the patient is instructed to do, and what the referring physician needs to do and when. And so all of these things will come back from the specialty care to primary care to help close the loop so

that primary care stays involved with the patient's care, as well as the specialty care being involved and both working together for the benefit of the patient.

Now I'll turn it over to my colleague Christina Borden.

MS. BORDEN: Thanks, Brian.

So the next couple of slides really speak to the execution and many other things that Brian also addressed.

The intent of the standards that are outlined for how to set up those collaborative care agreements is really to ensure that when patients are referred to any specialty that the clinicians have the information they need to appropriately answer the clinical question, know the patient and how to treat the patient, and establish those roles and responsibilities between clinicians.

As part of this coordination, there are expectations with the referring clinician and verifies that they have received the information needed to appropriately diagnose and treat the patient. By verifying that the clinician has received the pertinent clinical information before the patient is seen, the

practice can really reduce the need for duplicate work such as collecting demographic information and lab or imaging test results. So payment models should really incentivize care coordination compacts and collaborative agreements up front so that duplicative costs are avoided and dis-incentivizes duplicative testing.

Next slide, please? So this is guidance on how to really establish those relationships, and routine and effective communication with primary care and other referring clinicians is the cornerstone of the medical neighborhood. Collaborative care arrangements focus on any specialty practices engaging with primary care and other referring clinicians, but the practice frequently receives referrals from -- to set expectations around how and what information is communicated and exchanged. These relationships should be formed from all types of referrals.

Could we go to the next slide? This is an example that shows some sampling ways on how that collaborative care agreement can be formed between the primary care and specialty practices. So this covers the collaboration on

patient care and the transition of care as an example.

If you'd go to the next slide? Once a clinician or practice receives a referral request from another provider, then there is a need to confirm that the clinician or practice has the details about seeing the patient. This begins the tracking process workflow for the specialty practice. And this is being done in exactly the same way on the primary care side. This is where it was established, kind of the processes for this how this happens, but in order for clinicians not to feel out on an island, everybody needs to be doing this, and it really helps to support the care coordination aspect.

If you go to the next slide? The expected information on a referred patient is detailed as part of the referral agreement and the care compact. The intent is that both the specialist and referring clinician understand their responsibilities and how to plan for communicating to the patient. The communication responsibilities could be captured in the assessment plan in, for

example, the patient's EMR.[18]

So really does the patient have access to the assessment plan and section so that it's not just being communicated between clinicians but making sure the clinicians understand how and when they're communicating to their patients?

The follow-up information when not received might also be a part of the process. So think about it as those red error messages for what is missing in the required information not provided that probably needs to go back to the primary care clinician or the other referring clinician.

As we know, it's not a perfect world of seamless data sharing. The patient's demographics should include communication needs, primary language, relevant cultural, ethnic information, date of birth, sex, contact and health information. Clinical information should include the patient's problem list, current medication, allergies, relevant medical history, mental health, substance abuse issues, and behaviors affecting health, for example.

18 Electronic medical record

And so these were just how those collaborative care arrangements can be set up between clinicians. And then Brian's going to go into some case studies showing the benefits.

So, Brian?

DR. OUTLAND: Here it helps us to appreciate the benefits of using the collaborative care agreements within this type of a model. An ACP member-led endocrinology practice from Colorado -- as a result of using the collaborative care agreement's information, their clinical questions increased from zero to 75 percent. And what did this do? This helped them to then reduce or increase their supporting documentation from the primary care from 30 to 60 percent within six months.

And then because of that, it reduced the insufficient information that was supplied in referral appointments. That declined from 70 percent to less than 5 percent. And then it was able to help them to save from doing duplicative testing, as well as associated costs, and was able to save even the patients on having to do cost sharing on unnecessary visits.

So by receiving more complete

information and utilizing this helps us see that appropriate referrals went from 20 percent to nearly zero because they were using this collaborative type of agreements and closing the loop on the referral process.

Next slide, please? Here's another case study from a rheumatology practice that showed that they found that at least four in 10 patients did not actually require a rheumatology visit. It could have simply been handled without -- or with just a consultation without actually having to see the patient with their primary care physician, again helping to see that the appropriate referrals improved the practice access and the efficiency and profitability and were maintained because proper patients could be seen and scheduled sooner. And the backup and wait times for a patient were much less reducing health care costs and addressing the personnel shortages and improving access because they were using these principles.

Next slide, please? So payment is certainly critical in this. So the medical neighborhood helps us to appreciate that patient collaboration and agreement with the

referral is appropriate, referring to the appropriate specialty practices. Specialty practices can then prescreen with the accompanying documentation having all that they need. The visit then triggers an active phase of attribution. And the specialty practice role may vary, but they could also co-manage the patient.

Next slide, please? And there are two tracks that were set up for this and for the payment, which is similar to what many of the primary care physicians were in in their specialty practice -- specialty-type advanced practice models. And it will be nice for them to be able to link along with the specialty care practices. So there are many benefits to a model such as this and linking primary care and specialty care together and helping them care for their patients.

Thank you for allowing us to be a part of this session today.

CO-CHAIR HARDIN: Thank you so much, Christina and Brian. Very interesting as well.

So now I'd like to turn it to the Committee members. This is our opportunity to ask questions. These have been very rich

presentations and many different directions we could go. If you'd like to ask a question, please turn your name table tent up. And also for our members online, please just raise your hand.

So I will open it up to the Committee. Who would like to start?

Jim, please go ahead.

DR. WALTON: Yes, sure. Thank you.

Dr. Bozic, thank you for your presentation. One of the things I was struck by and just wanted to be curious -- I'm from Dallas, Texas, and was really impressed with your design -- is how could -- how do you see scaling what you're doing at UT Health Austin in the Musculoskeletal Institute to be a sub-risk contract entity, specialty entity with PCP[19]-based ACOs in the Austin area or in the state of Texas? Can that model be scaled, and how might you think about that, or have you been thinking about it?

DR. BOZIC: Yeah, thank you for the question, and it's absolutely an aspiration of ours. We have a national payer and purchaser coalition that we've been working with now for

19 Primary care provider

about the last four years. Mark McClellan from the Margolis Institute and I lead that effort.

And we've been working through a lot of the blocking and tackling in terms of defining the condition-based bundles. So the trigger codes for the start of the bundle, the inclusion and exclusion, the risk adjustment.

And so we are actively seeking partners to do pilots with, and at the same time we've had a number of discussions with purchasers. So large employers. ACOs are a perfect partner for this.

It's essentially subcontracting out your risk for specialty care with a locked-in guaranteed discount on your historical spend on, in this case musculoskeletal care, which accounts for anywhere from 18-23 percent of the total spend of many ACOs.

We can lock in a lower because we know now, we have enough experience with our model that we know at the population level that we're going to reduce spending, primarily through a reduction in utilization of surgery. And without compromising on patient outcomes.

So the short answer is yes, we're very interested in scaling, and we're looking

for partners, and we'd love to speak with you offline and even involve you in that coalition.

CO-CHAIR HARDIN: And Walter.

DR. LIN: Yeah, just a follow-up, Dr. Bozic, to that response. Really interesting work.

I guess my question is, you know, most of our patients have just more than one condition. And it's great to think about a condition-based payment model. But what happens when patients have, you know, five to six different specialists they see, an orthopedic surgeon, a cardiologist, an endocrinologist, a pulmonologist, a nephrologist?

Are we suggesting that each condition has a medical home so to speak, with payments paid to that medical home, both from a condition perspective, as well as an acute event or major episode perspective? That's part one of the question.

And part two is how do you do this condition-based payment model, incent appropriate preference-sensitive care? So for example, the orthopedic surgeon still gets paid more for doing a total knee, I presume. Is

that a discount, is that how you control utilization incentives that way?

How do you control volume of procedures in that -- in that payment scheme?

DR. BOZIC: So let me start with the second question first, because that's pretty straightforward. Actually, the orthopedic surgeon does not get paid more for doing a procedure. We get -- and it's team-based care and team-based payment.

I know one of the speakers mentioned this early on. We can't even track utilization by individual clinician. I don't know how many work RVUs or anything else I'm producing because it's all team-based care.

And so we get an upfront payment, prospective payment for the management of that condition for the year. And there's no incentive, there's no additional professional fee payment, whether we do any kind of -- any kind of treatment, whether it's physical therapy, injections, cognitive behavior therapy, or surgery.

But we are held accountable to the patient-reported outcome. So if surgery's indicated, we do it.

Our utilization of surgery is about 30 percent lower than the population average, not because we're more conservation surgeons, it's because we have more treatments to offer. Most practices that treat musculoskeletal disease can offer surgery or sorry.

And we can offer them lifestyle modification, help them with weight loss, help them with cognitive behavioral therapy to retrain how they think about pain. And lots of other treatments that aren't just surgery.

Your first question around how do you think about, you know, multiple patients don't show up with one condition, they show up with multiple conditions, I think it's a great point.

I would think about it no differently than how if you're a primary care physician, you're referring a patient for the treatment of a musculoskeletal condition, you're referring them somewhere else for the treatment of cardiovascular disease, et cetera.

It's no -- it doesn't change that at all, it's just that you're now -- you're now being -- referring them to a place that treats the condition more holistically and recognizes

that there are multiple different factors that influence the outcome of treatment for that condition.

And so you've got a multidisciplinary team as opposed to an individual specialist. But it doesn't take away from the fact that yes, that patient needs similar treatment for their cardiovascular disease. It could either be done by a single individual specialist or a team like this.

And I will say that, you know, from a patient perspective, I think the comments that we get are really, you know, pretty rewarding to hear how patients feel about this. You know, if someone comes to us, we screen for anxiety and depression.

If we identify someone with a, you know, severe anxiety or depression, we don't treat that condition. We get that plugged in with the appropriate mental health.

But we have to understand how the treatments that we may offer for their arthritis, back pain, or other things are influenced by that condition. If we completely ignore that, we're not going to be delivering value for patients.

So we're not taking over the management of all of their comorbidities, we're just acknowledging that those comorbidities influence the outcome of whatever treatment we're going to offer that chronic disease. So hopefully that answers at least some of your question.

CO-CHAIR HARDIN: And Walter, just checking, did you also want to hear from Brian and Christina? You mentioned the medical neighborhood and just want to clarify that your question was answered, so. Brian, Christina, would you like to add in?

DR. OUTLAND: This is Brian. I will add that that is based on that question. One of the things that medical neighborhood model certainly tries to do is link the primary care physician, perhaps as a medical home, for the patient, so that there's one person who knows everything about the patient and things that are going on to the specialty care.

And then be able to work with those specialty cares so that somewhere along the way, this physician or that physician or group, everybody can say, I'll send my information here. They have it, they have a medical home,

they know where the information is coming and going. And the loop is closed on the patient with their referral information.

And also, the specialty practices through their agreement will know who -- which specialty is caring for which type of condition the person may have. Because all those things are listed within the specialty care agreement that they will have with the primary care.

So they can contact and be able to coordinate with the appropriate specialties that are handling those conditions.

MS. BORDEN: And I'll just add, this is Christina, I mean, I think it's for these collaborative care agreements, it's really important for clinicians to be able to communicate with each other around the different pieces that we describe.

But really ultimately benefits both the clinician and patient. And from the medical home neighborhood model, like Brian mentioned, you know, the primary care provider is really that -- that sole source of like information about knowing everything about the patient.

And then they can share that with

the specialist so that when the patient actually goes to the referral and is being seen by the specialist, it's not starting at step one. And they can see that there is coordination and collaboration between their clinicians, which gives patients like peace of mind as well.

So it benefits both the clinicians and the patients, so we should payment models to do that.

CO-CHAIR HARDIN: Thank you. Angelo.

CO-CHAIR SINOPOLI: Yes, thank you, Lauran. So my question is I think mostly for Dr. Bhatt. So you've mentioned team-based incentives, which I like a lot, and equally across the specialties. And then mentioned valuing non-reimbursed care and processes also.

So I really have kind of two questions. Can you describe a little bit what that might look like across multiple specialists being involved in non-value, non-paid services? And then the second part of the question is in that team-based approach, do you use navigators, care management teams that actually cross specialty service lines, or how

do you do that?

DR. BHATT: Yeah, great question. So first let me just say Kevin, I'm in awe, because wouldn't it be great if I didn't know the direct downstream revenue of every single member of every cardiovascular practice. But that measurement, it's like an addiction in our field right now still.

So to your excellent questions, I think starting with thinking about what a team-based -- within cardiology, just for a moment, I'm going to separate it from primary care. For example, a majority of our heart failure patients will be seen by both the heart failure and the electrophysiology service, right.

They will have some sort of pacemaker involvement or atrial fibrillation ablation procedure. And what we're currently doing is heart failure can have metrics which are generally based on readmission. And then -- or touchpoints.

And then EP[20] will have maybe an AFib metric, which is kind of value-based from beginning to end of AFib. That doesn't really account for the heart failure metric.

20 Electrophysiology

So could we, at a very simple first step basis, combine whatever we think the appropriate AFib management metrics and the heart failure metrics for that patient across the division such that if that group of patients meets them, the entire division benefits from that, right, or the entire clinical practice. So I'm used to saying, I'm thinking of Mass General. But the entire clinical practice benefits from that.

I think that's like the very first step in cardiology of getting towards what will eventually be valued-based care, but I think it's doable in our -- in our conception. So I hope that helps a little bit just in the logistics of thinking about it.

I think in a larger way, if you look at, you know, either hospital readmissions, or even if you look at individual patient experience, probably, you know, we've had numbers that vary, but at least 25 percent of heart failure patients are followed by primary care and not by a cardiologist at all.

And so I think when we go back to the, you know, medical neighborhood model, I think that's going to be essential for us to be

able to really deliver the kind of care that those patients need.

What slightly concerns me is we have a workforce issue in cardiology that is significant, as we did in primary care. And so we need to figure out how the team interacts with primary care. And some of this for us is actually very cultural. I didn't bring it up in the presentation, but I'll say it's very cultural.

So if you're a primary care practice, and you're relying on the cardiovascular team, we really need to teach a lot about the members of the team and being okay with whichever members are there and how we're communicating. Or even using remote monitoring closed loops.

And the cardiovascular practice trusting that if the closed loop tells the community practice something in the medical neighborhood, we've already vetted it. We have to trust it. We can't see that patient to make sure the remote monitoring worked because that really works against the entire concept of how we measure together.

So I guess two separate answers.

One is we have metrics that are very subspecialty-focused, and we need to start at the minimum grouping them and then having everyone be responsible.

Number two, the medical home would be essential, but we need to be okay with remote monitoring and okay with team-based care as the go-to for those medical neighborhoods. And there's still some culture change that needs to happen there from what we see.

Does that kind of answer those questions?

CO-CHAIR SINOPOLI: Yes, thank you. And if you could comment, and you may not be there yet, but how are you using navigators across specialty lines? Are they more siloed, or are they working across specialties?

DR. BHATT: Those of our cardiologists in the ACC who practice in multispecialty groups are the ones that the rest of us are looking to and saying, gee, we wish what you had.

The majority of practices do not have cross-specialty navigators at this time, unless they're in an employee-based contract. Unless they're already value-based. Unless

they're part of like a Pioneer ACO or something else that's 25 percent of the 100 percent of what's happening, and the other 75 is RVU.

So we're only seeing navigators where really value-based care or comprehensive employee-based care or multispecialty practices exist, which is still a minimal percentage, as I start in my first slide, of the majority of the practice of cardiovascular disease right now in our country.

CO-CHAIR SINOPOLI: Thank you.

DR. BHATT: But we would love it.

CO-CHAIR HARDIN: And Larry and Lindsay, who was first? Larry, please go ahead.

DR. KOSINSKI: Okay, well, great presentations. I think my question could go to just about any of you, but probably to Dr. Bhatt or Dr. Bozic.

I'm intrigued by your team-based care. I love the concept, I can see how it could be -- how it could work. But your -- cardiology is a specialty that's become heavily employed. And the number of independent cardiology practices out there, it's been dwindling over -- over the last few years.

How do you -- how do you implement team-based care in that community practice setting where doctors aren't, as Dr. Bozic said, you know, oblivious to their RVUs? They are totally tied to their RVUs.

How do we implement this in, I guess if we use the -- the real world rather than in the control situation?

DR. BOZIC: Maybe I can take a stab at it first. So I think if I understand your question, it's simpler to implement in the employed model, is that what you were referring to?

Yes, I will say, so in our case, unlike cardiology, the majority of orthopedic surgeons are in independent practice, are not employed. Although that's changing pretty rapidly. New graduates are joining employee practices.

But I work, we work closely with the Orthopedic Forum, which represents all of the large orthopedic practices in the country. It's about 60 percent of all orthopedic surgeons. And they look at this as an ancillary service.

So just like they would own an

ambulatory surgery center or an MRI or physical therapy practice, owning a musculoskeletal medical home allows them to take all comers, take risk, and out the other side of that comes patients who are appropriate for surgery.

It's actually extremely rewarding from a specialist perspective because you're not being the frontline musculoskeletal care provider dealing with patients with chronic pain, depression, obesity, opioid addiction. You have others on the team that are doing that, and then if and when they're appropriate to consult with a surgeon, we bring the surgeon in.

So from an orthopedic surgeon's standpoint, it's a dream. And it allows you to get involved in risk upstream and take -- rather than setting a whole bunch of criteria that say only send them to me if they've done this, this, this, and this, and they've already been talked to about surgery, and they're ready to schedule surgery, which is what a lot of orthopedic practices do now. We can say give us all comers. And that is more attractive to an ACO or another risk-bearing organization.

DR. BHATT: That was a really

positive outlook, so I will us more tempered version. The RVU model as it exists in community practice does not support team-based care the way we're thinking about. Because, you know, you earn what you earn.

However, if models increase volume of what comes through, increase patient interactions without having to increase the physician-patient interactions, driving towards administrative burden burnout documentation, some places have been successful in doing it.

When you talk about who is involved in team-based care, there are team-based members who require a larger salary, and then there are team-based members who don't. And so varying who that team is, is something that we're seeing practices start to really think about.

Using somebody who has a very high license to do work that would be better done by a social worker, thinking about the role of LPNs[21], really thinking about the role of pharmacists and partnering with pharmacists or recent pharmacy graduates, I think we're starting to experiment with varying who that

21 Licensed practical nurses

team is and what the exact need is in the practice.

In order to, however, increase volume and decrease burden for the physicians in the practice when they are straight RVU. All right, so but you're still driving from RVU unfortunately until you change that model.

There was a second commentary that I had. Yes, the other side that has created a lot of discussion is when you have primary care practices who have subspecialty needs, is there a role for using other team members that are not clinicians?

And that has engendered considerable discussion from all ends about whether or not that's a model that's going to work, so maybe just leave that at that.

And then I think lastly, remembering that our specialty, perhaps GI[22], maybe pulmonary and a few others, we don't have the benefit of a little bit of what Kevin's talking about with the team, which is we have interventionalists, and then we have chronic disease complicated care managers.

We have two totally separate -- the

22 Gastrointestinal

heart failure transplant doc really is worth as much as an interventional cardiologist, but it is harder to understand what that looks like in those two models.

So if you can be in the lab all day, like you can be a surgeon all day, sorry to make -- have -- but then yes, somebody else should be in office. At MGH[23], we ended up having to give stipends to interventionalists to go to clinic, right.

Because if you have to choose where you want to be, you train to do a certain thing, you want to do that thing. Some of the questions are maybe low-value care for the 35 years you spend in training, you understood it.

And so again, I think that gets back to what you want to do with your time. And the interventional versus the non-interventional groups almost are treated a little bit differently, to answer your question. It's complicated.

CO-CHAIR HARDIN: Thank you so much. I'm going to go to Lindsay. Because just to note, we have about 20 more minutes in this. There is so much rich dialogue here, but I want

23 Massachusetts General Hospital

to ask everyone if you can ask your questions succinctly and think about your answers in that context.

Go ahead, Lindsay.

DR. BOTSFORD: Thank you so much. You know, one theme I heard really layered in all of your presentations is this theme of making sure that the specialist that is highly trained to do something they've spent years training to do gets the appropriate referral.

So whether that be through the lifestyle changes that happen before the surgery or the social issues addressed, or just the appropriateness of the referral through use of e-consult.

I think my question, and Dr. Bozic, your work is amazing, I love it. I think it's a -- condition-specific treatment is a wonderful solution to kind of layering onto our current fee-for-service world.

My question comes to, you know, is there the workforce to scale a team around every specialist and does the -- does the payment for a condition flow there, versus flowing to primary care so that they can do more in primary care and get patients when

they've exhausted the cognitive behavioral therapy, the diet, and exercise?

So that same end result of the surgeon being utilized when it's time for surgery or when surgery is appropriate, maybe we don't know the answer.

But I guess for Dr. Bozic in particular, I'm curious what do you see as the advantages of embedding that team together with the surgeon, as opposed to providing more robust payment and primary care so that it would do some of those first second-line things before surgery is available?

DR. BOZIC: I think it's a great point, and I think you can do either. I would only consider having condition-specific medical homes for something that a primary care practice has a -- is the large of their spend, right. So musculoskeletal, cardiovascular, the usual ones that come to mind.

Could a primary care physician manage, you know, chronic musculoskeletal disease, which they do? It's the most common to present to a primary care physician.

I would argue that, you know, to put them in the position to say, okay, I've got to

stay up-to-date on the current treatment for musculoskeletal disease, non-operative, inoperative, and know what's the trigger point at which point I should make a referral, puts a lot of pressure on them, and it's not their expertise.

We have people -- we have advanced practice providers that spend their entire career treating musculoskeletal disease. They're integrated in a team with all of those other different treatment options so they don't have to be referred out for physical therapy, referred out for CBT[24], referred out for weight loss.

And so I think historically the reason why those referrals are, you know, historically the primary care physician would say, you know, I'm going to hold onto this patient as long as I possibly can, because as soon as I send them to a surgeon, they're likely to have surgery, which is usually the case.

And so this model, we can guarantee a lower rate of surgery, and we can provide all of the wrap-around services for that condition

24 Cognitive behavioral therapy

and still keep the primary care doctor in the loop.

So it's just off-loading their risk for managing certain conditions which make up a big part of their spend. But including them in the process. It's not -- it's not cutting them out. That's my view.

DR. BHATT: I'm sorry, I know Dr. Pulluru has her hand up. Just, I wanted to take that and send it down to Brian and Christina for a second. Sorry, down -- because you're down on my screen.

I worry sometimes if Kevin's going to, you know, or if our practice, Kevin's practice, others are sending this volume first to primary care, and we have a PCP shortage, we have a nursing shortage. Is there capacity?

This question comes to me a lot, and I'm just going to ask, is there capacity for primary care to be able to do that level of management of whatever we're calling, you know, lower-acuity care in collaboration with us or not? I think that's one of the things people worry about in our field, the specialists. Sometimes why we don't let go.

DR. OUTLAND: Brian. And at ACP,

you know, the American College of Physicians, where much primary care takes place, we do agree that there is a shortage in primary care. But the model that we've worked on and our physicians do feel like they could handle that work.

As a matter of fact, it would make it even -- it would relieve some of their burden. Because sometimes they hold onto their patients because they don't want to refer them, as the doctor mentioned, that they may get surgery and they don't -- not sure.

Or they're just receiving patients and they're holding onto. They don't know who to refer them to in the field because other specialties have shortages.

And so this way, by creating that agreement, they're able to review and say I'll send you here, and maybe it's a complication as to how best to manage that. They don't have to do it all themselves.

Or maybe then it goes to someone else, and they say okay, I'll take this person, and I'm able to manage it. And so that takes it off of their plate.

So I do feel like they can handle

this work. It's just being sure that the coordination and collaboration is there. Because they're not feeling like they're in many instances kept in the loop of their patients when they do refer them out.

MS. BORDEN: Yeah, I don't have anything additional, really additional to add, other than where the clinicians that have come through our patient-centered medical home and specialty practice programs, that's part of the patient's medical neighborhood.

You know, just as Brian said, having -- having those understandings between clinicians of when it is good to have a consultation versus a direct referral, and building those relationships over time just make it more and more seamless.

And so that it just becomes natural when you know when you should be doing a consultation or actually making a referral. And I think definitely for specific types of conditions, it's easier for primary care to automatically just kind of handle it like when it comes to like diabetes care, for example. But there are going to be instances where you -- you need to navigate the patient to that

actual referral.

And having a -- having an understanding of who actually will be a part of that collaboration and coordination is another aspect. You know, you're -- you just want to refer out to anybody. But having that really hinge up with somebody, with another clinician to be able to coordinate for the patient is very important.

But I think we've seen that clinicians have that capacity to be doing both, to be both part of the consultation but also making the referral that encompasses everything that the clinician needs to know.

DR. ZERZAN-THUL: And I'd like to just jump in here, having worked with primary care practices pretty deeply on our model the last few years and being a primary care provider myself. I think the reimbursement for primary care isn't there to have the social worker, to have an extra nurse care manager, to have a peer navigator, all within that practice.

How we currently reimburse primary care in our fee-for-service system just doesn't -- doesn't allow for that. There's not --

there's not extra. And so there really need to be Alternative Payment Models so that you can have that full team of people.

And I think there are some good programs that are working on, including in Washington state, how do you grow that workforce, how do you grow that level, lower-level workforce to provide that kind of care. And I think -- I think that's definitely possible.

CO-CHAIR HARDIN: And I'm going to just quickly check. Jen, Josh, Chinni, Walter, are any of your questions for Judy? Josh, okay, I'm going to go to Josh next then.

DR. LIAO: Great. Judy, it's good to see you. I think I've really enjoyed everyone's comments about how, you know, integration happens at the clinical point of care between clinicians and their teams.

But one thing that keeps coming back is, to me, is the sense of knowing who you're referring to, knowing the capability of the team, the clinic. Knowing that Kevin has a musculoskeletal institute rather than a different type of orthopedic practice.

So Judy, your comments about this

integrated care assessment and how Washington has tried to step back and try to understand the capabilities of clinicians and their groups, I think is really striking to me. I was wondering if you could comment on that briefly.

And you mentioned it, you're thinking about payment models as well. That's what our Committee's thinking about. So if we believe that assessing capacity, right, is important as a very first step, how can that interact with models?

Either how can that assessment kind of help groups and policymakers think about where to target those models, based on capability to integrate? Or vice versa, what can payment models teach us about how we need to assess integration?

DR. ZERZAN-THUL: Josh, thanks, it's good to see you too and a great -- a great question.

So I think one thing especially thinking about this first cohort of primary care and behavioral health providers that we -- we did the integrated care assessment on, it was surprising, although maybe it shouldn't

have been, that most providers were on the very early tier of like they give people a PHQ[25]-9, they screen for anxiety.

But then like the next steps after that, there were very few. And so I think that sort of speaks to my last comment of like there's not -- there's not this extra money, and there's not this extra workforce to figure out how do you have a handoff to someone of like, oh, this person has depression, it's more complicated than what I can do. How do I -- how do I do that?

You may know, but I know others of the Committee don't know, part of our primary care work is figuring out some of this assessment. And we've been talking for a little while about a certification model or a readiness model to sort of say not everyone is advanced primary care. Like, there's a whole range.

And we've started in our model to sort of lay out a first level, a second level, and then a third level, which is advanced primary care fully integrated to all the bells and whistles, that sort of thing.

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25 Patient Health Questionnaire

And so, and we imagine that there would be different payments for that. Because I think the practices that are very early in this journey and are not very integrated, they are completely dependent on fee-for-service.

And so they need additional funding to help them. And they need some education and understanding of how the risk works, how they would manage a more global payment or a capitated payment.

Some of the ones on the advanced end are ready for that, and then some of the ones in the middle are like, oh, maybe what's this going to look like? I love my RVUs, that's what I know. We really need to think about how do we sort of move them out of that?

And we've been thinking about it as sort of a continuum that, you have to have these steps along the journey. And you have to, before you get to like what kind of payment do each of these get, you have to understand where they are and what kinds of care they're providing today, and then how you -- how you get them there.

And you go, there's been a lot of conversation, do you just jump in and force

everyone into the pool, you ease them along. We've sort of thought about, and we haven't implemented this yet, but a kind of three-year runway so that like you have to get there, but we'll give you a little time to get, recognizing practice change is hard.

CO-CHAIR HARDIN: Angelo, is there anything you wanted to add layered on?

CO-CHAIR SINOPOLI: No, thank you, she answered my question.

CO-CHAIR HARDIN: Jen, please go ahead.

DR. WILER: So thank you so much to each of our presenters. What I'm thinking about is, you know, our two days have been spent thinking about how to integrate specialty care into total cost-of-care population models. And this session in particular was focused on developing financial incentives to do that.

So Dr. Bozic, what I want to acknowledge is I think you've done exactly what we've asked, and that's put forward a model that is not only successful, but shows how specialty care can ultimately be integrated in a model, nested or not, as we've talked about over the last day or so in a total cost-of-care

model.

What I think is interesting about the model that you've proposed are a couple of things. One is, as we all know, with mobility, that there are positive secondary outcomes that occur that you just described around reduction of pain, influence on mental health conditions like depression, and ultimately weight loss, which has impacts in other areas, like cardiovascular care, for instance.

But what I am struck by in your model is the fact that the primary outcome measure is one that's a patient-reported outcome. Pain, functional status, quality outcomes. I think that's really unique, really special, and important to all the other process measures that we just talked about.

That said, what I'm mulling over is how is -- how is that scalable to other areas or specialties? Larry, for instance, has presented to us before about a gastrointestinal model that the patient-reported outcome for a Crohn's patient is, you know, less days of diarrhea. That also makes sense a patient doesn't want to -- doesn't want to have that symptom.

But when I think about cardiovascular care, less days of AFib may or may not be meaningful. So anyway, I'm curious about, again, there's some really important principles that I think that we can all align on.

There's a model that, you know, shows what financial incentives can do, and that's exactly the space we want to be in, great care incented by the right model. But I'm curious your thoughts around scalability to other disease conditions.

DR. BOZIC: Yeah, thanks. I think that patient-reported outcomes, as you point out, are -- can be specific to the condition. That said, the work from the PROMIS[26] Group and others have shown that probably a lot of these are measuring the same thing. And so we might not have to have disease-specific patient-reported outcomes.

I think that if -- understanding why the patient is presenting for care in the first place, and then are we actually addressing what's important to them is really what I think about when I think about the importance of

26 Patient-Reported Outcomes Measurement Information System

patient-reported outcomes.

They're not mutually exclusive from other clinical outcomes. You may have hemoglobin A1C and other things that you want to track as well.

But particularly for musculoskeletal disease, if the only reason the patient's coming to see us is because they're having pain and limitation in function that's impacting their quality of life, and we're not measuring it, I don't understand how we could ever expect to deliver value to patients.

The biggest challenge we have is patient-reported outcomes don't fit neatly on a claims form. And so that's a big challenge for us with payers. And we've done things like work with payers. We did this in California to require the measurement of a patient-reported outcome before approving a surgery.

So it's basically a prior -- it's a waiver of prior authorization. Instead of saying did you do this, this, and this, did you even measure the thing that the patient cared about in the first place? Ninety-five percent of practices don't.

And so it seems like a simple thing,

but it's a barrier. And I think we -- there's a lot we can do synergistically with payers and purchasers to incentivize patient-reported outcome measurement can be more integrated into routine clinical practice.

In fact, the American Academy of Orthopedic Surgeons has a large initiative right now we're working on to try to do that with electronic health records and payers and others.

CO-CHAIR HARDIN: Chinni, you had your hand raised previously. Did you have a question still?

DR. PULLURU: Yeah, I'll try to make it quick. So a lot of the conversation around specialty integration and particularly procedural, you know, one of the things that I was curious how you guys address. And Dr. Bozic and Ami, I believe, Dr. Bhatt, I believe I'm sort of directing this to you.

How do you negotiate site neutrality type of things? Like for example, you know, in order to get a lower cost of care, you have to have certain -- that the place of service matters, right. And so surgeries that are outpatient versus hospital.

And you have multiple stakeholders that need to either, you know, it's a revenue thing for hospitals to have surgeries in the hospital or CAHs[27] or whatnot, versus outpatient. How are you negotiating that as you're putting these plans into place?

DR. BOZIC: Ami, why don't you takethat? I've been talking a lot.

DR. BHATT: Yeah, I think one of the most important things, at least for cardiovascular, is actually our time to procedure is strongly related to the likelihood that the patient does well and outcome. And so that has helped us drive a little bit in terms of being okay using a variety of locations.

Now, we do not -- so there's two big things that we are discussing in our field right now. I'll start with number two, I'll go back to number one. The use of ASCs[28] for invasive procedures like interventional cardiology is still lagging. We haven't really, you know, started to come to terms with that the way a lot of the other procedural subspecialties have.

27 Critical access hospitals
28 Ambulatory surgical centers

And we talk about, you know, the why, and there's a variety of things. But financial actually ends up being at the top of everybody's list every time we bring it up, so you are right.

However, having said that, there are within systems or practices, opportunities for us to save on dollars by being at outlying institutions within a system. So as I -- as somebody mentioned earlier, we don't have as many individual practitioners, right. Everybody's employed now.

But even employed hospital systems have less expensive hospitals and less expensive community centers that are part of our network. And so in those networks, you really realize that we're pushing a lot of air out into the community where people live.

Because we can get it done faster. It's just as good because it's the same people who are working out there as there are working anywhere else. And the patient satisfaction is generally greater when you're not coming into the larger institution, but rather in the community-affiliated hospital.

So in those models where we have,

you know, everybody is invested in the same concept and the same thing, it's working fine, ASCs have not really taken off for us just yet, partly for the reason you said.

I wanted to go back for one minute, oh no, I forgot it. All right, when I remember it I'll come back. There was another thought based on what Kevin had said.

Kevin, I'll turn it over to you.

DR. BOZIC: Well, I know we're at the end of time. I'll just say I think site, and this is me speaking, not the AAOS, I think site neutrality is incredibly important for delivering value.

Right now, I work in a health system that we literally measure and hold hospital operators accountable to how many joint replacement procedures they can keep in the inpatient setting, not HOPD[29], not ASC.

Because the margins are astronomically higher in the inpatient setting. Once you flip to the HOPD, they drop. And then once you go to the ASC, you're at least losing 50 percent of the revenue because you don't own 100 percent of it, and the margins are even

29 Hospital-based outpatient department

lower.

And so there's strong incentives the way the payment system's set up right now to keep procedures in the hospital and not in the lower-acuity setting that's more convenient for patients and more appropriate.

We learned during COVID that we can do a lot of procedures safely in the -- in the ambulatory setting. But to do that, we have to partner with health systems to say what can you backfill with high-complexity, high-acuity care that should stay in the hospital, rather than keeping low-acuity care in the hospital, which is not good for patients, and is certainly more expensive.

CO-CHAIR HARDIN: Thank you so much.

DR. BHATT: I remembered the second thing. But I just want to add back to Kevin. We are forcing, right, we are forcing low-acuity care into the community hospitals where we have systems. And so I think it is happening. But I'm not sure what'll happen with ASCs, and I don't know that we'll get to site neutrality with ASCs because it's such a different model.

I just wanted to mention the PROMs.

When we talk about taking what Kevin's doing and moving it to other subspecialties in scale, there is a large effort in cardiology to take patient-reported outcome measures, which we've had for a long time and are very good, and really push those to be one of the ways that we judge value, even within fee-for-service, our view-based models.

So I think that will come first in cardiology before a lot of other things that are value-based, because our patients are pushing for it, and so are we. We're also pushing for it internationally, FYI, to really get the same, especially in heart failure, the same metrics be the patient-reported outcome measures kind of globally that we look at.

So I do think you'll see that in cardiology soon.

CO-CHAIR HARDIN: So I want to thank each of you, Judy, Christina, Brian, Ami, and Kevin, for this very rich dialogue. We probably could have spent an hour with each of you independently, but your perspectives are very valuable.

At this time we're going to take a break and return at 10:50. We have a really

engaging panel roundtable physician discussion, so we hope you'll join us then.

We'll see you back at 10:50, thank you.

(Whereupon, the above-entitled matter went off the record at 10:42 a.m. and resumed at 10:52 a.m.)

*** Roundtable Physician Panel Discussion: Enhancing Specialty Integration**

CO-CHAIR SINOPOLI: Good morning. And welcome back.

When we were planning this PTAC session, we wanted to prioritize hearing from physicians that are actually practicing on the front lines. And that's why this group was actually selected. We really want to understand your real-life experiences with population health models and care coordination.

I've asked our panelists to go ahead and turn the video on, if you're not already on. It looks like you're already on.

And what I'm going to do is I'm going to briefly introduce each panelist. Then I want you to introduce yourself. And if you have slides, I know that a few of you have

slides to present. And if not, if you have a short discussion that you want to have, go ahead and do that.

The full biographies of our panelists are on the ASPE PTAC website, along with other materials for today's meeting.

And after you all introduce yourself and share with the group whatever you have to share, we have some structured questions that we'll walk through. But then after a few questions, I'm going to open it up to the PTAC Committee for questions to you and for a discussion.

So we'll start out with Dr. John Birkmeyer, who is President of Medical Group at Sound Physicians. Welcome, John. Do you want to make any statements or share anything?

DR. BIRKMEYER: Sure. Good morning, everybody.

So my name is John Birkmeyer. I'm a general surgeon, a health services researcher by background. I grew up with the Dartmouth Atlas. And I'm President of Sound Physicians.

Sound Physicians is a large-scale medical group specializing in inpatient care,

so EM[30], hospital medicine, critical care, and anesthesia. We employ a little over 5,000 docs and APPs[31]. And we have practices in approximately 350 hospitals across the country.

You know, my part of the ecosystem tends to get painted with a broad brush. But we're generally viewed as one of the good guys. So we're physician founded and led. We like have never been in the surprise billing business.

And, you know, uniquely, we're one of the early adopters of the interface between hospital-based care and value-based payment models. We were an early entry, an early entrants.

And up until last year, we were probably the largest single episode initiator for the Medicare bundled payment initiative. We have a very large long-term care ACO. And we have, and all of our national contracts with private payers are value-based.

You know, just given the theme of this session, you know, I'll close by, you know, leaving you with a couple of thoughts or at least a couple of recommendations about how

30 Emergency medicine
31 Advanced practice providers

to think about the role of specialists in Alternative Payment Models. This is something that I and we have thought a lot about.

And recommendation number one is, you know, to rethink how we categorize physician specialties. You know, as I've seen and, you know, some of the agenda for this panel and otherwise the dichotomization is primary care versus specialist.

And I would tweak that a little bit to say that it's generalists versus specialists. Generalists consist, obviously, of groups like primary care providers. But they include a lot of folks working outside of ambulatory settings, such as EM docs and hospitalists.

A generalist, of course, is somebody that treats patients across a full array of conditions and organ systems. But relative to this discussion, they are just like PCPs in that they influence not only quality but total spending by serving as gatekeepers for downstream services rather than what they themselves do.

The second and somewhat correlated

recommendation is to design APM[32] models, you know, that reflect the most important levers for each type of specialty.

So, for example, for emergency medicine docs, their biggest impact on health care spending is decisions about who gets admitted and who doesn't get admitted from the ED[33]. You know, so their most important role in the APM world is probably in payment models that at least pull them into a share of, you know, the spending attached to hospitalization rates, you know, alongside the PCPs that are upstream of them.

Hospitalists, and this is kind of largely what Sound Physicians does, influence total spending by what happens, by not whether people get in the hospital, but what happens during and afterwards. So, by far, the biggest impact of hospitalists is in decisions about where people go after discharge.

So it's the use of facility-based post-acute care. It's readmissions. It's managing what happens for patients in SNFs[34]. And it's basically managing end-of-life care

32 Alternative Payment Model
33 Emergency department
34 Skilled nursing facilities

and aligning intensive care with patients' values and their preferences.

So it's not surprising that hospitalists best align with those types of spending and, you know, probably with episode payment models rather than with population payment models.

And finally, specialists are so heterogeneous as to be impossible to leave sort of a single recommendation. But, you know, at least, you know, most of them best align with population rather than episode-based spending models, you know.

And I think at least for procedurally-oriented specialists, specialty-specific spend per capita or procedure rates per capita are, you know, probably the biggest, you know, segment of population spend that they should be considered for.

So thank you, everybody, for the time.

CO-CHAIR SINOPOLI: John, that was great. I appreciate all that input.

So next we have Dr. Nichola Davis, who is Vice President and Chief Population Health Officer at NYC Health and Hospitals.

Nichola, do you want to make some statements and introduce yourself?

DR. DAVIS: Sure, sure. Thank you. Good morning.

So really I'm excited to be here this morning. And I want to just thank you for the invitation to participate in such a timely and really important discussion.

So I'm a general internist by training and an obesity medicine physician. And I lead population health at New York City Health and Hospitals.

Just in the way of a little bit of background, New York City Health and Hospitals is the largest municipal health care system in the country. We deliver high-quality health care services to all, regardless of their ability to pay, regardless of insurance status, regardless of income or immigration status.

We serve over a million New Yorkers, and these are some of our most vulnerable New Yorkers, each year out of 70 locations with, throughout all of our five boroughs. And most of our patients are insured by Medicaid, or they may be uninsured.

So our system includes 11 hospitals,

five post-acute and long-term care facilities. We have a large network of federally qualified health centers, as well as home care services and an Accountable Care Organization, as well as a health plan.

So, across our health system, we have over about 700,000 primary care visits and a disproportionate amount of specialty visits, with about two million specialty visits each year.

Several years ago, I'd say about five years ago, we went to a single electronic medical record across our entire system. And that has been really critical in helping our specialty and our primary care providers to really coordinate the care of the patient. Just being able to see what each provider is doing has been really important.

So I'd like to just highlight a couple of things that we've been doing in terms of just how we are integrating specialists and primary care.

And one of the things that we've really worked on is building out e-consults. And for us, e-consults are asynchronous. And they're within our system. So they're within

providers within our integrated system. And it really has been helpful in several ways.

One is that for specialists, we can get the right patient to the right specialist. And so specialists can review the chart before for a patient that's been referred to them, for example. And then the specialist can determine whether or not they actually have to see the patient or whether they can just provide a consultation without the patient having to come into see them. And they could provide that consultation and recommendation to the primary care provider, which is really helpful.

And in a system like ours where we have challenges with just access, it's really helpful for e-consults to be able to triage those visits and to determine how urgent a visit might be, as well as to really think about whether or not the specialist has all of the information that they need.

So a specialist might refer back to their primary care provider and say, and recommend certain labs or testing be done prior to that visit so that that specialty consultation is really a good consultation with all of the information at that time.

That's been, there definitely have been challenges with rolling out e-consults, which I'm happy to get into a little bit later in our conversation.

But some of those challenges are really just getting providers on board, both the primary care providers, as well as specialty providers on board and comfortable with getting away from that culture of patients having to be seen by the specialist.

Another thing that we've really worked on is integrating our behavioral health into primary care. And we've done that through the collaborative care model over the years.

That has really been helpful in managing our patients with depression and anxiety. And we're now thinking about expanding that model to include adolescents with ADHD in particular.

And in that model, our psychiatrists, we have consultant psychiatrists that support our primary care providers and within this collaborative care model where there are collaborative care clinicians, who are primarily social workers and nurses, that will see the patients directly.

And then they will have case reviews with a collaborative care psychiatrist. And that psychiatrist will make recommendations either to the primary care provider or to the collaborative care clinicians.

And so that is a model that we've also had for about seven years now. And we've expand that throughout our system.

And as I mentioned, we also have an ACO, which has about 7,500 attributed lives. And that ACO is a shared savings model.

And one of the things that I'd like to highlight there is because of the patient population that we take care of, we really have to focus on how we manage the social needs of our patients. And through models like the ACO where there are shared savings, those things can be put back into, those savings can be put back into the primary care practice.

And we've been fortunate to really meet the benchmarks each year. So we have been able to participate and receive shared savings that have gone back into the practice to really inform our model of care and be able to hire other support staff where there may not be a reimbursement model for us, for example,

patient navigators and community health workers, things like that where there really isn't a clear reimbursement model for it at this time.

And those roles are really important in working together as a team to help our patients to achieve optimal care outcomes.

So I'm really happy to be here to get into some of this discussion today. And I look forward to the conversation.

CO-CHAIR SINOPOLI: Thank you, Nichola. It was very interesting. I'm looking forward to digging into that a little bit deeper.

So next we have Dr. Carol Greenlee, endocrinologist and owner of Western Slope Endocrinology. Carol.

DR. GREENLEE: Thank you. I'm happy to be here. And I also want to thank you for the hard work that this Committee is doing. It's amazing.

I am an endocrinologist in western Colorado. But probably most relevant to the PTAC and this panel is my work on the patient-centered medical neighborhood.

Within the American College of

Physicians, I served as chair for several of the medical neighborhood-related workgroups and subsequent policy papers and toolkits.

And within the CMS/CMMI Transforming Clinical Practice Initiative, I served as faculty helping implement components of the medical neighborhood. I also implemented it in my own practice.

The medical neighborhood is intended to reduce fragmented care. Fragmented care occurs when we practice in silos of care with poor communication between those silos.

The American College of Physicians recognized that for the patient-centered medical home to truly impact the harms and cost of fragmented care, there needed to be better connections to specialty care. However, there were no established guidelines, no defined standards for how to improve those connections.

So the ACP convened workgroups made up of primary care clinicians, specialty care representatives from a wide range of medical professional societies, patient and family advocates, and quality improvement and subject matter experts. And these workgroups utilize consensus, along with any available evidence,

to determine what is needed for better primary and specialty care collaboration and care coordination.

So the resultant patient-centered medical neighborhood is not itself a delivery model or a payment model. Instead, it's an approach to coordinating care, connecting care, care collaboration that can be used as a framework inside of any care delivery model or any payment model, including a population-based total cost of care model.

Since a referral is usually the first step in a primary/specialty care interface, the first work focused on what is needed for a high-value referral process. This includes the critical elements of a referral request and a referral response, critical processes such as pre-visit review, close-the-loop, and referral tracking. Next slide.

The first work also clarified the definition of a specialty care medical neighbor and the relationship of that medical neighbor to the patient and to primary care.

The patient is, in this model, it's actually the patient's medical neighborhood. So the patient is the center of care. Primary

care is the hub of care. And specialty care is an extension of care, with the role in care determined by the needs of the patient and their condition. Next slide.

Subsequent work looked at what is needed for ongoing care collaboration beyond that initial referral. This includes a playbook on specific roles in care and their associated care responsibilities and shared expectations.

This diagram shows the spectrum or the continuum in care and the division and responsibilities between primary care, in blue, specialty care, in dark blue, for a referred condition.

Primary care maintains the hub of care for the patient's ongoing needs. As the roles move to the right, the responsibility for the referred condition increases for the specialist. And with a consuming illness, the specialty care team may take on most management issues for a limited period of time.

Now, a patient may have more than one condition that needs assistance from specialty care. So, for example, a primary care clinician may use an e-consult to get

tele-derm advice on how to handle a skin lesion. They may do shared care co-management with the oncologist on cancer survivorship.

A rheumatologist may take on principal care co-management for the elements of care for lupus. And if they also have type 1 diabetes on top, an endocrinologist might do principal care co-management for the diabetes.

These roles need to be fluid so that if a condition worsens or deteriorates, specialty care can take on more of the management. Next slide.

But also if a condition improves or resolves, there needs to be a pathway back to primary care or to a lower involvement of specialty care more appropriate to the condition.

Right now a lot of patients get stuck in primary care, excuse me, in specialty care management because there isn't an established mechanism for transitioning back.

And the playbook that goes with our policy paper provides a pathway and shared expectations for a safe and patient-centered transition of care for a condition back from specialty care to primary care. Next slide.

So these principles, processes, critical elements, shared expectations provide a way within any model to actually improve care coordination, collaboration, and cohesion where we're all working together instead of in isolated silos to care for the patient.

And I look forward to further discussion. Thank you.

CO-CHAIR SINOPOLI: Thank you. Great information.

So next we have Dr. Jackson Griggs, who's Chief Executive Officer at Waco Family Medicine. Jackson.

DR. GRIGGS: Well, thanks so much for the introduction. And I'm just so honored to be a member of the panel. I'm a, I think a small fish compared with some of the magnitude of some of these systems, but nevertheless delighted to be in the conversation with you today.

So we're in Waco, Texas. We're a 15-site FQHC[35]. We've been 24 years as an FQHC. We've had a family medicine residency program for 53 years that evolved into an FQHC 24 years ago. And we have 61,600 patients, just shy of

35 Federally qualified health center

a quarter million visits. Seventy-three percent of our patients fall below federal poverty level.

And, you know, Texas has chosen to be a Medicaid non-expansion state. So it makes taking care of our population challenging from a financial standpoint. We have 32 percent uninsured. And that's going to grow as soon as the public health emergency ends, and we start unraveling the Medicaid extension that's been in place. So next slide.

It's kind of the Wild West for FQHCs in Texas in value-based arrangements. We are, actually this is, compared with, again, some of the scale of other panelists, you know, we're just very early in our process.

But we've got, you know, upside only, shared savings plans with a local ACO for a small commercial insured population, Medicaid health plan, Medicare Advantage. And we're just entering into some downside risk shared savings plan with another Medicaid MCO. And we've just joined that FQHC-only ACO for Medicare Shared Savings Plan for traditional Medicare. Next slide.

But I think I was asked to speak on

the panel because of some of the work that we've been doing for about the last decade in behavioral health integration. And this is born out of necessity because of the dearth of mental health specialists in our region and including a near absence of psychiatrists who care for under-insured or publicly insured patients.

We've become the de facto mental health safety net in our community. We have, this 10-year motto, which still rings true, which is we're reminded that the cavalry isn't coming. There is no wave of psychiatrists that's coming. And we're going to have to take care of the population.

So, out of need, we have built accordingly with non-psychiatrists, behavioral health experts, and ancillary tools in primary care. And as we've only more recently begun to lean into value-based contracts, we can see how that early integration will dovetail in an important way.

So really quickly let me introduce those delivery transformation efforts in behavioral health. So, first, we assume that behavioral health is intrinsic to primary care.

And given the high prevalence of mental health conditions and social factors that impact health in our population, we've invited clinical social workers to become a part of the core primary care team.

And like work in primary care, and unique from traditional psychotherapy settings, we expect those clinical social workers to move efficiently and sometimes juggle multiple patients at once.

Our social workers, they screen for common mental health conditions, aid in diagnosis. They collaboratively develop treatment plans and are just in constant dialogue with PCPs throughout the day. Sometimes they'll see patients before, sometimes during, and sometimes after the primary care clinician, depending on the patient needs and the flow of the clinic.

And by bringing social workers onto the primary care space, the inequities that were previously seen within referral-based mental health access really just dropped to zero.

So the second little column there, an eye towards, you know, population access in

the setting of scarcity, we emphasize, you know, returning to functioning, focused psychotherapy, psychopharmacology, and really only when needed, stepping up to more in-depth and resource intensive psychotherapy.

So we do offer a co-located counseling service for evidence-based treatments that build onto the work started in primary care.

And then the third category, with a high burden of substance use disorder in our population, we are working to mainstream substance use disorder diagnosis and management to primary care.

But complicated cases need specialized help. So we have a primary care addiction medicine expert and a clinical social worker operate a consultation clinic for challenging cases. So, if we have a woman who's pregnant who has alcohol use disorder, she would be someone who would be seen in our consultation clinic.

But the specialty clinic operates on the premise that once the patient is, a stabilized treatment plan is established and the patient is stabilized, that patient then

returns to the primary care team, so I think similar to what Dr. Greenlee was just describing.

So this premise is the same premise that's used by our human behavior and mental health clinic, which is staffed by a clinical psychologist and family physician.

The clinic takes the most challenging cases from the entire population in the center. And then rather than keeping a patient for, you know, seven to 10 sessions, the team works to get accurate diagnosis, a good treatment plan, and then returns the patient back to the primary care clinician. And obviously, if the treatment plan fails, then the primary care clinician would return the patient back to the HBMH[36] clinic.

But stewardship really is kind of the key here. If we don't have models where scarce specialists are able to see the most challenging cases and once stabilized, you know, then return back to primary care, then we're just not going to reach the population mental health.

So a stepped care approach can

36 Human behavior and mental health

contribute to health and reduce health care costs. Next slide.

And so we have, and this is just a for instance in this kind of stepped care model, our pediatric behavioral, behaviorist program stepped care model. So, for children who have suffered traumatic stress, which is really most of our children, you know, executive function, behavior regulation is much more challenging.

So externalizing behaviors, which get classified as ADHD[37] or disruptive behavior disorders, conduct ODD[38], require understanding by all who interface with the child, so that's front desk staff, nursing staff, et cetera, who all get the training in child development relationship attachment.

And then we train clinicians more intensely in a model we developed and published on how to coach parents to empathetically care for their children, which has demonstrated noteworthy improvements in outcome.

But when these preliminary interventions fail, then those children get referred to the parent/child interaction

37 Attention deficit hyperactivity disorder
38 Oppositional defiant disorder

therapy, a 10- to 12-session therapist guided program, so, but again, you know, stepping up to more intensive care and then stepping down as we can.

So just a final comment about stepped care model in primary care, it does require some base level competency in primary care. So next slide.

This meant for us once we began to identify mental health conditions a decade ago with much more higher prevalence because we were integrating behavioral health, we realized that our primary care team members were not comfortable with psychopharmacology.

So we built decision support. There was such avid uptake in that decision support that we were building that we began to share that decision support outside of our own institution, ultimately, developed an app. This is working collaboratively between our faculty and Mass General Psychiatry Academy.

And so, you know, we now have, it's called the Waco Guide to Psychopharmacology Primary Care. You know, the last report, this is outdated slightly, you know, we've got about 10,000 downloads and nearing 100,000, you know,

website users, just decision support to help primary care doctors use psychopharmacology in an evidence-based manner. And that has helped a great deal our clinicians.

So that's the last thing I have. So thank you.

CO-CHAIR SINOPOLI: Great. Thank you. That was great information.

So next we have Art Jones, who is principal of Health Management Associates.

DR. JONES: Yes, hi. I am a board certified internist and cardiologist. I worked with a community group while I was in training on the West Side of Chicago in an underserved area that led to starting a community health center on the West Side back in 1984.

There were no new access points. There were no look-alikes, so we got paid $13.65 for [code] 99213 and $5 for uninsured. Fortunately, the local hospital which had the highest percentage of uninsured and Medicaid in the state except for Cook County, didn't have a cardiologist. So they paid me $8.50 to read an EKG, which was the money that supported the health center because it only took me a minute to read an EKG and 20 minutes to see a patient

for 99213.

So we realized that wasn't sustainable. And so we started with primary care cap in 1987 and over five years gradually assumed capitated responsibility of a single FQHC for primary care, specialty care, outpatient diagnostics, behavioral health pharmacy, ER[39], both professional and facility, and took upside and eventually downside of a single FQHC for inpatient services. When Medicare went to managed care in '97, did it with the same national companies for Medicare Advantage, for Medicare, and also for commercial.

And the strategy for this was to realize that I needed to recruit not just primary care providers at the FQHC but also specialists who were willing to serve the primary care provider decision-maker for really complex patients. And in fact, most of our PCPs were comfortable doing a lot of what they were trained. But when it came to really complex patients is that they often refer those patients off in the multi-specialists who didn't communicate with each other and didn't

39 Emergency room

lead to good intern -- good outcomes. Excuse me.

So our strategy to manage total cost of care was to bring on specialists that were willing to serve those really complex patients as the primary care decision-maker. I stayed there for 27 years. I left in 2011 to help create Medical Home Network, which is 13 FQHCs and three health systems from the West Side of -- serving the Chicago community.

We have 178,000 Medicaid beneficiaries. We are totally delegated for care management. We're NCQA-certified for care management.

All the care management is done by staff. They're employed by the FQHCs. We progressed from shared savings to shared risk to global risk.

And we've generated after covering all of our cost over $100 million in the first six years and margin that went back to our medical homes. Last year, we started a direct contracting program. And this year, we are in ACO REACH supporting 51 FQHCs in seven states, about 50,000 Medicare beneficiaries in that global risk contract.

And so I think the lessons kind of learned, so you see actually I got introduced as a consultant with HMA[40]. I should've got that changed. I'm the chief medical officer for Medical Home Network, but I also serve as a consultant for HMA where I try and spread the experience that we've had at Medical Home Network.

I think kind of the lessons that we have learned over the years is that every patient needs a primary decision-maker. And sometimes that's a PCP and sometimes that should be a specialist. It really depends upon the comfort of the primary care provider with what's really serving in that role, but sometimes it's also a particular specialist.

I think that there need to be care management dollars directed to that because care management belongs at the practice level, not at some centralized health plan someplace belongs at the practice level. And it belongs side by side with the primary decision-maker for that patient. So that patient and their family are working with one individual.

And yes, sometimes they need to do

40 Health Management Associates

consultations and referrals and get advice from other specialists. But that person needs to be the primary decision-maker. And then that person, I don't we need new APNs[41].

I think we need to change the MSSP[42] and the ACO REACH program to recognize that in fact attribution needs to go to the primary care decision-maker, which means that if you're a specialist and you're willing to assume that role, not all specialists are. If you're willing to assume that role, then that's where -- and you're providing the plurality of ambulatory services, you should be the attributed provider. As long as you're willing to play that role and you're willing to be a part of the integrated delivery system as participating in that MSSP or ACO REACH.

And that is how we can pay specialists. That's how we're going to keep them engaged which is -- because that is actually the most complex work, is to really serve those complex patients with multiple comorbidities, is to serve in that function. And that's actually where the savings are.

So the money is there. We don't

41 Advanced practice nurses
42 Medicare Shared Savings Program

need to come up with a new way of paying for specialists. We need to be able to allow them to be the attributed primary care provider in those programs.

CO-CHAIR SINOPOLI: All right. Thank you for that. It's very good information too. I'm going to ask a few scripted questions just to get the conversation started, and then I'm going to ask my PTAC colleagues to chip in and ask some questions. They've been pretty engaged today.

And the focus of this meeting obviously is integrating primary care and specialty care. And so I'm going to start out with a question. What approaches have you used to encourage increased coordination between primary care and specialty providers, and what challenges have you faced? And have you gotten around those challenges? And Art, I'm going to go back to you first.

DR. JONES: Yeah, so I think I sort of answered that question as far as my preferred model, which is to put them in the same delivery system and make sure that we have the appropriate person. We also e-consultation. The challenge with e-

consultation is getting adoption, and also there's no payment methodology.

There is within an organization that is assuming global risk. So we'll use that as well. Within Medical Home Network, we also allocate total cost of care savings as we allocate it to PCPs. But we also allocate it to the health systems.

The reality in the city and medically underserved areas, those specialists are employed by the hospitals. And so we set up metrics and make sure we reserve a certain percentage of savings that are going to specifically underwrite the cost of those specialists. And so in that sense, they are also incentivized through their employers and through usually the health systems to reduce total cost of care and improve patient outcomes.

CO-CHAIR SINOPOLI: Perfect. Jackson?

DR. GRIGGS: Yeah, so I think that coordination of care sort of hinges on there being specialists to coordinate with. And so in the behavioral health world, particularly in areas like Texas where there just aren't

psychiatrists to coordinate with, we end up doing a great deal of that work internally. I definitely agree with Dr. Jones that when that can be coordinated within one system that it's much better for patients, and cost comes down.

I'd be curious to hear more from Dr. Davis, who mentioned a real success with the collaborative care model because what we found is that once we really tooled our primary care clinicians adequately that the benefit of having a psychiatrist consultant who was reviewing charts and offering advice just went to about zero. In fact, we just let our psychiatrist go because it wasn't particularly beneficial. It wasn't incrementally valuable after our primary care clinicians had adequate decision support.

Now, the key, the lynchpin of the collaborative care model being the care manager, that has been really imperative. And more time for the more severe patients, more contacts for the more severe patients. But the psychiatry value has really diminished in the collaborative care model for us.

CO-CHAIR SINOPOLI: Thank you. Carol?

DR. GREENLEE: Yeah, so what we found is that there's not -- most clinicians want to improve care coordination and communication. They really miss it. They want it.

They're eager to improve it, but they haven't had a way to do it. So what we've done to implement it is use the medical neighborhood model that I talked about starting with the referral process, putting something in place with shared expectations, processes, enforcing things like close-the-loop. But it also required practices looking at their internal processes because there can be silos within silos in a lot of practices.

And there's a lot of chaos and wasted time and effort a lot of times around the referral process, especially if the other processes aren't in place. And I'll give you an example. If there's not a close-the-loop back from specialty care, primary care spends a lot of time trying to track down the response from the referral appointment.

And then they don't have time to send a good referral request. And specialty care has chaotic referrals coming in. So when

we can put a process in place on how to do that care coordination, it really helped practices.

And this includes all types of practices, including radiology where they often don't get the clinical question, including work with emergency departments where there's a lot of referral out of patients. And hopefully, that would reduce if there are more primary cares being fully accountable. So having a structured approach which includes internal practice processes around the referral and then making sure to incorporate patient-centered processes and elements within that because currently most referral processes are schedule-centered.

It just amazed me how poorly patient-centered, even the referral out from primary care is, but especially the referral in to a lot of specialty care. So I'm not sure if I answered your question. But we found that there needs to be -- there's not a scaffolding now.

There's not an internal structure or how to do care coordination. And so when we provided that along with measures, like, how often do you close the loop? What is your wait

time? What's your delay in care?

I'll say one cardiology practice thought they had a wait time of three to four weeks. And when they actually looked at the data, it was three to four months. And at one institution, only 18 percent of the time did they send a response back to primary care. And in many of the institutions that we worked with, they didn't even have a way to send a referral back if the -- I mean, a response back if the referral came from outside of the organization, which most of the referrals did. So I will stop there.

CO-CHAIR SINOPOLI: That's a great answer. John?

DR. BIRKMEYER: Sure. Well, let me preface my answer to your question with a couple of observations. The first is just a reminder for folks that aren't quite as, like, close to this. But, like, 47 percent of Medicare Part A and Part B spending accrues to acute hospitalization stays and the 90 days that follow.

And the corollary to that is that ambulatory-based primary care physicians largely are independent of the main clinical

decisions that occurred during that window of time. So we largely -- so we tend not to think about kind of the same simple conceptual model that's one hub where there's a primary care physician at the center, and there's a whole bunch of spokes where the hospital is a cost center. And kind of I think about it as two hub-and-spoke models or ecosystems, one that's ambulatory care with a primary care physician and everything that follows his or her decisions in a hospital, and a hospital-based physician ecosystem that really drives what happens, like, around those acute care episodes.

As we've tried to drive integration between those two hub-and-spoke models or systems, kind of there's two things that we focused on. One, so I mentioned earlier, we have value-oriented but still fee-for-service contracts with United, Humana, and other payers that directly incentivize both EM docs and hospitalists where the interface between themselves and primary care physicians after the hospitalization episode [is]. And those include warm handoffs, metrics that tie patient risk status to being seen by a PCP within seven

days, in use of IT systems that help close some of the gaps and help mitigate the extent to which patients are on the other side of the moon to PCPs when they enter the hospital.

And then finally, aside from incentivization around that type of care coordination, I think there's a couple very practical things that we're incentivized and paid to do basically to help patients reenter sort of the ambulatory care space after the hospitalization episode. And one is we have universally implemented post-discharge telemedicine service that basically oversees both in-SNF care or home health certifications and oversees what happens to patients while they're still getting home health care after hospitalization discharge. In many cases, the hospitals that were managing patients for their acute care illness are much better positioned to manage what happens immediately afterwards. And it creates more seamless handoffs than what historically happens when patients just show up on day one after hospitalization to a PCP's office.

CO-CHAIR SINOPOLI: Thank you. Nichola?

DR. DAVIS: Sure, yeah. I think just to echo what others have said, I think one of the key things is communication and how the specialist can communicate back to the primary care provider and to really create systems that can facilitate that. So for us, a major transition when we went to a unified EMR. And so much of our specialists in primary care communication is within our system.

Now when we have patients that go outside of the system, it really is challenging. And you almost need someone to really do the tracking and get that information back. And sometimes that falls on the provider.

And I think we can all agree that's not a good use of a provider's time, to track down exactly what has happened to those referrals and to try to get that information back. So I think things that we can do to have interoperable electronic medical records would be really key and a step forward in being able to just facilitate that coordination. And I think if I could just answer or address Dr. Griggs' comment around the use of consulting psychiatrists in our collaborative care model.

We still continue to have value with our consulting psychiatrists. They support multiple practices. And one of the things that they're doing -- one portion of their work is providing that advice to primary care providers around psychopharmacology and all of that.

The other key aspect of their work is actually supervising our social workers. We have early career social workers as opposed to social workers that have been out in the field for a while. And that's been one way of really cutting down on that cost.

So having early career social workers, who are still relatively in training, as well as our nurses. And so our psychiatrists are really used to support those clinicians as they start to take care of our patients who have varied behavioral health conditions. And our consulting psychiatrists also at times do see those patients who have been more challenging to manage within the collaborative care model and might need more direct care. So I think I will end there.

CO-CHAIR SINOPOLI: Perfect. So the next thought is what have been the most effective payment mechanisms you all might've

used to incentivize the primary care and specialty integration, and what shared savings models or other PMPM[43] models? Or what are you using, if anything, have you found that's been necessary at all to help facilitate that integration? So I'll go back and start with John.

DR. BIRKMEYER: Sure. Appreciate that. Well, I alluded to kind of one common model by which we incentivize entire coordination in our payment models between inpatient physicians and PCPs that resume ownership after hospitalization. And that's in the form of our national contracts with our main commercial payers. But the second model that we have in place and many large markets, particularly large markets where there's very large, well organized, risk-oriented primary care groups. And I'm taking up, like, some of the large groups that often fall within the Optum family.

The model that we have in place with them is one that doesn't go through a payer but is really an incentivization arrangement that flows from the primary care groups to the

43 Per member per month

inpatient physician groups. And specifically EM and hospitalists. So in those arrangements, we get incentive payments that tie to a small number of specific spending metrics that are largely beyond the control of ambulatory PCPs. And those are readmissions, next site of care metrics for the use of host discharge SNFs and total spending on specialty consultations within 30 days of discharge.

CO-CHAIR SINOPOLI: Great, thank you. Nichola?

DR. DAVIS: Yes, so as I mentioned, we do have primary care -- we have a Medicare ACO which is really based within our primary care practice. And so our specialists are aware of it. But I wouldn't say that they're fully integrated into that model.

Some of the things that are done with shared savings does go into the practice as a whole, though. And so which would include the specialists that are a part of that general practice so they can participate in what we call, like, the team funds that will go back into the practice based on those shared savings that come from the ACO. And they can get benefits from that. So I think just having

them be aware and be partners in the care and in the outcomes of those patients that are in those models like the ACO has been important.

CO-CHAIR SINOPOLI: Perfect, thank you. Carol?

DR. GREENLEE: So I'm not part of a large system. But I can give you some examples. A local independent physicians association in Colorado using (audio interference). Now this is just working on getting primary care and specialty care to communicate better, coordinate better.

The first time they did it, they withheld some of the payments. But they worked with a local payer. And to earn back those payments, they needed to meet certain criteria, like, sending a referral with a clinical question, answering the clinical question, that type of thing just to get started.

What Denver Health did is they included metrics around care coordination when they're assessing specialty care. So they actually kept track of how often they closed the loop, how long it took to get that response back, and a few other metrics that they tie in that contribute on top of the specialist RVU

salary. So those are at least two incentives that I'm aware of to improve specifically care coordination and communication.

CO-CHAIR SINOPOLI: Thank you, Carol. Jackson?

DR. GRIGGS: You know, again, probably too early to -- in the journey to speak authoritatively on that. We're banking on the fact that because compared with those who lack mental health conditions, those who do have mental health conditions have higher incidence of hypertension and heart disease, diabetes, asthma, other chronic conditions. And folks with mental health illness are more likely to be hospitalized for medical conditions and medical spending on those mental health conditions.

It's three times higher than those without. But this population that we're investing in right now through advanced integration is as we build out more value-based arrangements. It's going to -- particularly because of the high prevalence in our population, be of benefit. But I can't speak authoritatively to how we've captured those dollars and reinvested it to further

incentivize the project.

CO-CHAIR SINOPOLI: Thank you. And then Art?

DR. JONES: Yeah, so one of the problems we face again with the Medicaid population, not to mention the uninsured population, is a lack of specialists willing to serve that population. And so things that we have that we're rolling out this year, so we're just about to roll it out, is to actually give salary support and pay a specialist for half a day a week to cover a slot half a day a week in which we're going to give them salary support. And during that half a day, they will do two things.

One is that they will respond to e-consults. And secondly, they will actually be scheduled to see, have phone consultations with primary care providers to really cut down the wait times. And the appeal to the specialists is that they get frustrated because they realized there's not enough of their colleagues willing to serve that population.

So the more that they can do to actually improve the ability of primary care providers to serve those particular and meet

those needs, and a lot of that happens because unlike usual consultations where there's one note, there's not an ongoing back and forth conversation. With e-consults, you can do that and even better with phone consultations. We're going to roll out this year, it's paying them for salary blocks to cover their cost to provide that type of service. We'll see how it works, but that's our plan for this year.

CO-CHAIR SINOPOLI: Great. Thank you for that. And we have a question from one of our PTAC members, Jim Walton. Jim?

DR. WALTON: Yeah, thank you. It's kind of for Jackson and Art. Thank you both for -- well, all of you for being here and particularly Art and Jackson I've worked with in the past.

My question kind of ties into kind of what Art just answered a little bit. And I want to kind of bring it back. One of the things that PTAC, that I've learned being on the Committee, is interested in is the idea of health equity -- the ideas of health equity and also the space of rural, semi-rural, underserved areas.

And Jackson, I think what I know

about what you've done and what you've explained today is that you solved a problem because of lack of fill-in-the-blank behavioral health support to the point where you've got a working model. And I would argue maybe what Carol was talking about and ACP has been talking about, which is this medical neighborhood. You actually have it next door or in the same building, right? It's co-located.

But I'm also aware of the financial realities of FQHCs and other rural doctors when I was practicing in Waxahachie. If I was still there and if I was trying to put together a medical neighborhood of specialists, I would be challenged economically with how to do that. Let's just say if I wanted to care coordinate complex patients that have low income and low health literacy, and they'd been marginalized on and on with complex problems, how could we actually break through that, right?

And I hear that CMMI and PTAC are very interested, like, laser focused on that question, right? And so that's why it's so important that you all are both here today to talk about that, right, in my view because we

have this historical burden on generations of issues around these populations that are experiencing today and tomorrow, they will continue to experience, inequity in both access and care delivery and outcomes. And so what could you -- what would you say, right?

What if you said, hey, if you could give the ACO that I'm contracting with, X, I will create a medical neighborhood around Y to complement what I've already built, Z, because you built it with your own money. And I think what I hear Art saying is, hey, we're going to now start. We've got an idea of where we're going to pay half day for e-consult and phone consultation with PCPs.

He's, in effect, a virtual medical neighborhood builder. But he's using funds from somewhere, right? But those funds are not necessarily easy to get access to.

And Art can speak to how he got access to those dollars in his contracting mechanism. But I'm a little bit more familiar with Jackson's world coming from Texas. And I'm so, I'm just curious, Jackson, if you would go first, and then Art, maybe you'd comment on him, is what could you advise us, to PTAC?

Like, what could we actually recommend ACOs that are on a total cost of care professional cap? What could they do to help you build out what you need for your patients to create more equity? And where would you start after BH[44] and the lessons that you've learned with BH?

DR. GRIGGS: So multi-part question, Jim. So if I don't get to answer all the pieces of it, just ask me again. But as I demonstrated with payer mix, we live on, really, a knife's edge financially.

And it's really exciting to hear about the larger groups of FQHCs that have been able to solve for this. We can tolerate some -- - in bigger systems, upside risk seems to be like no risk. It really is for us.

If we make some investments in an initiative using time and resources. And then there is no positive ROI[45], then that has real meaning to us. I mean, I think that there's more anxiety, of course, around downside.

But for us, even the upside is anxiety provoking. So the notion of either an ACO or health plan investing on the front end

44 Behavioral health
45 Return on investment

and in the initiative and bearing the risk. In other words, if, for example, we need additional care management staff or care coordination or fill-in-the-blank that's not borne by the FQHC, the investment.

Now if the contract were such that as positive ROI occurred, some of that investment gets paid back, almost in the form essentially a loan. But it gets paid back whenever either shared savings are achieved or whatever, then that seems like a viable way to win for us because we have new services for our patients. Win for the health plan or the ACO because they're getting better quality.

But if there isn't a positive ROI, then we're still not holding the investment even again in the upside only. So that would be one way of making an arrangement such that those of us who are just so constantly conscientious about every dollar because we're always a hair's breadth away from deficit would work. Now from the standpoint of equity, I think that what we have seen in mental health is -- and I think this is corroborated by the literature.

It's that different subpopulations

for very clear historical reasons have less trust in various aspects of the health care ecosystem. So while trust in primary care might be relatively high, trust in mental health services might be lower. So by virtue of saying, hey, this is a part of the basket of services that we provide in primary care.

When you come through our door, we're going to offer you behavioral health services as an aspect of primary care. Then the disparity between -- access disparity really goes to zero because the populations who tend to be more reluctant to see a psychologist are now seeing a mental health specialist in the primary care arena. Similarly, I just think there's such value in co-location.

Next door, let me introduce you to the cardiologist who's here today. So in those instances where that's feasible, that's outstanding. But if you're in Waxahachie or in Muleshoe, Texas, then potentially the primary care site being the place where you leverage the trust with primary care and invite that person to see the rheumatologist in the telehealth platform.

Just right next door, hey, let me

usher you this room. Let me introduce you to the rheumatologist or the rheumatology nurse. And she's going to -- this is somebody I trust. I think that could also similarly decrease the disparities in access.

DR. JONES: So I would -- and so first of all, we're fortunate enough the Medicaid agency put out some grant opportunities that they want to see practice transformation. So the program I'm talking about is being funded for a three-year because it takes time to build it up and demonstrate impact. It's being funded by the state.

And that is in distinction, for example, to what CMS has done with advanced payment under MSSP for safety net providers because what they're not doing is they're not asking for us to pay it back out of our insurance savings. In fact, MSSP, if you make it -- one of the changes I'd really recommend you make is that if you borrow that, say, $250,000 for your MSSP. When you pay it back, you're paying it back out of your portion of savings, which is not fair.

I mean, so if, in fact, I use that dollar to invest in care management, that

should count as a cost just like a medical cost. It'd be shared by CMS, as well as the providers. Why should all of that portion come out of my portion of savings? So that's one issue.

The second thing for federally qualified health centers and for rural health clinics is something called change in scope. And so to the extent that you decide that, hey, what I want to do is I want to move towards adding specialists to my staff. You can appeal to the state.

There's a mechanism, additional cost impacts your encounter rate. So that's the second methodology. A third methodology that we're moving towards is moving away from the fee-for-service chassis for reimbursing FQHC.

So we move to primary care cap. There's also an option that says you can move away from fee-for-service and move to an Alternative Payment Model. So at Medical Home Network, we've been at primary care cap.

There was nothing like primary care cap during the pandemic. But we were already moving in that direction. It's something as I think you probably realized we did back in 2001

at our health center.

And what that does is give us the flexibility to say, how are we going to allocate our resources? How are we going to best use a full care team and not worry whether or not it turned into a billable visit? I've worked now in nine different states under HMA with FQHCs and their primary care associations to move towards to develop a primary care cap Alternate Payment Model.

I can tell you it takes about three years. There's no reason for that. There's no reason so that we can't streamline that process that CMS can't come up and sort of say, well, if an FQHC chooses to move from a fee-for-service PPS[46] to a capitated PM[47], here is a strong model. You can certainly flex it.

Then what that allows me to do, see, the nice thing about ACO REACH is I can pay primary care cap. The bad thing about ACO REACH is that for FQHCs, Medicare is usually 10 percent of their population. I've got to put in models of care under capitation for my Medicaid and for my Medicare.

And quite frankly, they work very

46 Prospective Payment System
47 Plan Management

well for my uninsured because I lose money every time I do a face-to-face visit with an uninsured anyway. So I think another recommendation to you is to go back and say, can we streamline and make a uniform approach to primary care capitation, which basically takes historical revenue then (audio interference) to their primary care services and turns it into a prospective PMPM. And then the last thing you're seeing is that traditionally what's happened is the wrap payment, which is the difference between the PPS rate and what the MCO pays for the private doc down the street.

There's an increment. That's called -- that's why they do PPS is to reflect the fact that they are required to provide additional service beyond what a primary care practice has done. What has happened increasingly over the last few years is that states have decided they're going to put that wrap inside the premium and make the MCOs pay it, which in effect what that does is it takes that wrap in terms of shared savings and shared risk and distributes those funds across all providers, not just FQHCs.

So just think about it. If my PPS rate is twice what the Medicaid reimbursement rate is, and I have a shared savings on a percentage of premium basis and every time I do a primary care visit, my shared savings will get strained twice that of the guy down the street. It puts me at a severe disadvantage in terms of performing.

So I think there's some real concrete things that we can do particularly around a safety net to really get them moving. FQHCs are lagging behind in terms of value-based (audio interference). And there are things that can be done, very concrete things that can be done to get them and make it feasible for them to get involved and really be chasing value-based payment arrangements.

CO-CHAIR SINOPOLI: Anybody else have any other comments? If not, I'm going to open it up to the other PTAC members. And Larry has his hand up. So Larry, do you want to go?

DR. KOSINSKI: Thanks for the presentations, everybody. Nice to see you again, Carol. My question is going to go both to Dr. Jones and Dr. Greenlee.

I'm intrigued about your concept of providing a -- I would imagine a PMPM payment to a specialist when they become the principal care provider, they're assuming care. I'd love to tie this in with Dr. Greenlee. And I want to understand this transition.

So a primary care doctor calls a specialist in for a certain service depending on an illness that now -- let's call it diverticulitis. Patient goes in. They have multiple medical problems, but they go into an episode of diverticulitis which requires that gastroenterologist to take over care.

How does the payment work there? And then the transitions, and this is where Dr. Greenlee would come in. How do we transition these back and forth? How does it come back? Because we know very clearly that these things bounce back and forth between doctors for a period of time.

DR. JONES: Who would you like to respond first?

DR. KOSINSKI: Either one. I don't care.

DR. JONES: I'll respond that I think that the specialist that is willing to be

the primary decision-maker is someone who is managing chronic conditions. So it's obviously not a surgeon. I would even suggest probably not necessarily a GI person with someone with acute diverticulitis.

I think it is someone -- it's these patients that have multiple chronic conditions where they're willing to say I'm going to be the primary care decision-maker. So it's your patients with advanced CHF[48], your oncology patient, your end-stage renal patients. It might be COPD[49].

The nurse is saying, well, I realize that this person has CHF. But I also realize that he has diabetes. And so I'm going to still be the primary care decision-maker, and I may at times say I'm going to use an endocrinologist to consult with me.

But I'm going to serve that primary care role. And they have to be willing to do that. And they can't act as traffic cops. And that's what's happening too much in medicine today, is that people with multiple conditions go to the PCP, and the PCP feels overwhelmed. So they just start sending out multiple

48 Congestive heart failure
49 Chronic obstructive pulmonary disease

referrals.

And the specialists don't talk to each other because they're not paid to talk to each other. They're paid for certain services. So we need somebody who is going to be -- so if that specialist is willing to play that role for those complex patients, then I think they should be paid a PMPM for that role.

And I think they should have -- they'll get paid for fee-for-service. But their real incentive is just like any other PCP group. Those people are attributed to me to the extent that I reduce their risk-adjusted total cost of care that I'm going to get a portion of that savings.

DR. GREENLEE: I can say when we were working on all the different stages of patients and their medical home neighbor that once -- in the beginning, every specialist wanted to be in medical home mainly because they didn't -- they thought they were going to get more money that way. But when they realized what advanced primary care is, we look at primary care as a specialist in primary care. And then the other specialists are specialists in GI or even neurology.

But even within neurology, there's subspecialists. Or within endocrinology, there are people who only do adrenal, et cetera. And most of it, even a neurologist that worked in our work group did not want to take on primary care. What they want is better coordination with primary care.

But when a patient has a consuming illness which for most of the conditions that Dr. Jones just mentioned, at that time, specialty care may need to be the team lead. They may need to be the one that organizes other referrals. They may use the patient's preexisting specialty care like an endocrinologist.

They may use the primary care. But they're the main organizer around that critical illness. They take first call if the patient has pain, bleeding, fever, whatever.

But if that condition either goes to end-of-life and transitions back to primary care or gets better like with a liver transplant or something, there does need to be a transition back. And there needs to be defined expectations around what is required for that. And I think that's what you're

asking or how does that happen.

There needs to be agreement with the patient, specialty care, and primary care about transitioning back so no one is left feeling frightened or unattended. Specialty care needs to send the care plan for what's needed and other documents, like, what happened during this time so that primary care has that. The patient needs to have a copy of the care plan, what needs to be followed, what needs to be done.

And specialty care needs to be available to help primary care if they have questions after that transition back. And the patient needs to know that there's a safe route back to specialty care if they need it, if things get bad again. Larry, I don't know if I answered what you were asking.

DR. KOSINSKI: No, I think you both did a good job there. It's the serious chronic longitudinal illness that may be best managed by a specialist. And that has to be clearly documented and communicated for the care team. And then somebody who's paying the bills has to be informed of that as well so that payment is going to the appropriate provider.

CO-CHAIR SINOPOLI: I think John has his hand up too. I think you're on mute.

DR. BIRKMEYER: I just wanted to add one sort of additional observation in thinking about how to share risk between primary care physicians and specialists. And I agree with Art that if you're thinking of it through the lens of specialty -- of specialists sort of medical homes, then I think the paradigm of co-management of chronic illness by rheumatologists, endocrinologists, ambulatory, cardiologists, well, that model makes sense.

But on the other hand, before you exclude other types of specialists, let's say interventional cardiologists and cardiovascular surgeons, while recognizing that those groups never really take longitudinal management of those patients, they make a small but real number of decisions about, like, really expensive things that just have a disproportionate impact on total spending and on variation in spending. So the medical home model isn't exactly right. But there certainly are models by which those types of groups could be held accountable, upside and downside, to not just quality but to total spending where

that population of patients for that portfolio of, like, high-impact, high-cost things.

CO-CHAIR SINOPOLI: Thank you. So the question I have is, are any of you using non-physician resources, teams to help facilitate communication integration from primary care to specialty care? And are you accessing chronic care management billing to support any of that? And I guess I'll start out with Nichola.

DR. DAVIS: Sure. So yes, we use non-physician team members. We have nurse care managers, for example, that will help with care coordination. For our collaborative care model, we're using nurses often in that model, as well as clinical social workers.

And we're billing within the collaborative care model. And so we are able to do some billing for that care coordination. We use a lot of -- we're fortunate to have a lot of community health workers, and that's been funding that's come from the cities.

And they do lots of non-billable work right now. We hope that there will be some movement in terms of reimbursement of the work that community health workers do. And

they really help to -- help patients to kind of navigate the system, make sure they're keeping all of those multiple appointments that might be between the primary care, the specialist.

Help the patient to kind of communicate with providers and ask the right questions. And so really help them to be advocates of their own care and so that they can help to kind of bridge some of that gap as well, as well as really importantly helping to address our patients' social needs. And I think the other thing I would just say about this conversation is we have to really be thoughtful as to what the patient really needs and what those patient outcomes are because I think we often will live in those silos of thinking about the specialist care outcome and the primary care outcome and thinking about this in terms of cost.

But we really also have to think about all of those patient-related outcomes and what's important to the patient as they're navigating the system and going from primary care to specialist and inpatient to outpatient. It can really be traumatizing for the patient. And really giving them the support so that they

can manage all of these different providers and provider groups that they're in contact with is really important too.

DR. GRIGGS: I'm so glad you said that, Dr. Davis, because I was thinking the same thing. It's so easy just to fall back into that physician-centric way of thinking. And people become cogs in a very complex machine. We've got to be asking the patients, do you understand or what matters to you, what are your goals, as opposed to just assuming that this organ is broken, so this management needs to happen.

DR. GREENLEE: I would just like to add that, yes, the medical neighborhood I talked about is outpatient ambulatory. But it certainly needs to interface with whoever is in the hospital. But what we built into that made it more patient-centered.

So we suggest that the primary care clinician, when they're going to refer the patient, talks to the patient about it. You'd be amazed how many times right now a patient is referred. And they don't even know they've been referred.

Specialty care gets a referral, and

they're cold calling the patient. But we don't want that to happen. We want the patient's goals for the referral to be clear and give them information about where they're being referred, how to get there, what the role of the specialty care is supposed to play, or what primary care has asked them to just give advice.

And if primary care can get it to an e-consult, truly support that. But if the patient needs to be examined, say, we're just asking for advice or I want them to help manage. And then to be also very clear once you're stable, I'm going to take this condition back over.

And again, it's for the condition, not for the patient. Or this is hypopituitarism with diabetes insipidus. You'll probably have the endocrinologist manage that for a long time.

But make the patient be part of it. And that's part of that pre-visit review, too. Which patients are more urgent? Which patients really don't need to take the time to come in?

Which patient needs to really go to urology instead of nephrology? All of that is

much more patient-centered. But building that patient-centeredness into the referral process and then the ongoing care as well. Thank you all.

DR. JONES: Yeah, I would just mention that Medical Home Network takes a portion of our savings and passes it down to the medical homes to hire community health workers to do the collaborative care model, not just for depression but also for hypertension and diabetes. And we use the COMPASS model for the collaborative care model for depression, which basically proved with one of the CMMI innovation challenge grants that showed that using a trained community health worker in the collaborative care model for depression was just as effective in terms of patient satisfaction, provider satisfaction, and PHQ-9 improvement as it was using behavioral health clinicians. We do not have enough behavioral health clinicians to serve our population.

So everything has kind of moved down the slots. We end up having them be the contact. It's clinically licensed social workers and clinical psychologists at the FQHCs that cover the cases.

And we use e-consult to go to the psychiatrists when we need help in terms of medication management. And so it's really kind of saying, hey, again, that's the care team approach. How do we best utilize because there are not enough primary care providers and behavioral health providers to serve the underserved?

CO-CHAIR SINOPOLI: John, any thoughts?

DR. BIRKMEYER: No, I don't really have anything to add. Thank you.

CO-CHAIR SINOPOLI: All right. We're getting close to time. But I am going to ask one last question, and maybe we can just make this brief. But just a question around your access to data and how difficult an issue is that. And where are you getting your present data sets for particularly, in regards to things like risk stratification and specialty referral decisions, et cetera? So I'll start with John.

DR. BIRKMEYER: So again, speaking through the lens of care models that are based during and around the acute hospitalization stay. But our data come from three sources.

One is we get real-time and continuous feeds from our hospital partners with regards to who the patient is, where they come from, and what clinical diagnoses they're actively managing. We have our own IT platform that basically not only manages physician billing but basically runs through value-based care checklists, which include social determinants of health to the extent that they drive some of our key metrics.

And then finally, with a lag, we get payer claims particularly from both governmental and non-governmental payers with which we have risk-based arrangements. Those, kind of the data that we have, serve our fairly narrow purposes. But what's really missing is any connection between sort of that acute care data flow and what's occurring on the ambulatory setting, both prior to and after acute episodes.

CO-CHAIR SINOPOLI: Great, thank you. So maybe in contrast, Carol.

DR. GREENLEE: Well, when I worked with practices around the country, it was really hard to get any data on specialty care. If you wanted to see what their unnecessary ED -- preventable ED and hospital patients were,

it was really, really hard to get that. You had to try to sort through ADT[50] data to see which applied to the specialist.

So we ended up doing patient surveys to see how often the patients felt they couldn't get in to see the specialty care when their condition exacerbated, if specialty was the principal co-manager in that situation. I know for our primary care clinicians locally, one of the payers gave them just the spend for specialist. But it's not divided down for how complex the cases were.

But they knew which specialist spent more money. And that was the limitation of what they knew when they were going to select who to refer to when they were in a capitated Medicaid program to try to save money for their program. So we need more data, I'll just say. And it's really hard to get it for specialty care.

CO-CHAIR SINOPOLI: Anybody else want to comment?

DR. JONES: Yes, so Medical Home Network gets complete claims data from our payer, including pricing. We get medical

50 Admission, discharge, and transfer

claims on a weekly basis. We get daily pharmacy claims data in addition to the ADT feeds.

We also have an 84 percent collection, HRA[51] completion rate that includes social determinants of health. And we're using an AI vendor that dynamically risk stratifies our patients. We high-risk care manage 3.2 percent of our population.

And that AI vendor puts in all the data income stratification. It's specific to our 178,000 Medicaid beneficiaries. And it tells us who's going to most likely be benefitted from high-risk care management.

DR. DAVIS: And I'll just add we use a lot of our clinical data that is the bulk of what we have. And it does have both our acute inpatient episodes, as well as our outpatient episodes, and as well as our specialty visits. And we have risk-stratified our population internally looking at various variables to be able to estimate who's more likely to have a future hospitalization.

And so that's really been helpful data that we can use to then think about how we

51 Health risk assessment

proactively outreach and address that patient population. We also incorporate some of the data that might reflect their social needs, like, whether or not they're a patient who's experiencing homelessness. That can all go into how we stratify and look at our patients who are high-risk.

We also look at our scheduling data. So we have access data for all of our clinics, both our ambulatory care, as well as our specialty clinics to see how long out the wait is in terms of just availability or those practices. One of the challenges, what we don't necessarily have or takes a long time to get into our system, is external utilization.

And so that's challenging to know when patients are getting admitted outside of our system. And it might take a long time for us to get that information into our system. But we do have lots of data that we're able to use to proactively manage the patients that are receiving care within our system.

CO-CHAIR SINOPOLI: Okay. Thank you. So we've only got a minute left. I see Walter has a quick question.

DR. LIN: Yes, hopefully, this will

be very quick. I just wanted to thank all the panelists for being here. And this is a question for Dr. Birkmeyer. John, it's nice to see you again.

The current specialty payment framework that CMMI put out last fall contemplates paying specialists in part for acute care episodes and bundled payment nested within a more total cost of care total accountability model. And I know Sound has a lot of experience with bundled payments. I'm just wondering if you can comment on the interactions you've had with BPCI[52] in the setting of total cost of care models like ACOs or other kind of total risk frameworks.

DR. BIRKMEYER: Well, thank you, Walter, and good to see you again. Sound does have huge experience in managing episode-based alternate payment models. And we've run about three or four hundred thousand acute hospitalizations through those programs.

And really kind of the core measure of success, both for patients, their families, but also for managing total cost of care is primarily around managing post-acute care in

52 Bundled Payments for Care Improvement

readmissions. And I think that's, like, very much the sweet spot of hospitalists, which are basically the PCPs of the inpatient setting. I disagree with CMMI's focus last year when they were trying to solicit input on the role of other types of specialists.

I think that there is some role that other types of specialists play with regards to managing the acute hospitalization. But I think certainly epidemiologically and from a spending point of view, their biggest impact is not in how efficiently those episodes get delivered but in how many episodes there are. So there are decisions about who needs surgery, who doesn't need surgery, who needs to be hospitalized, who doesn't.

That's really kind of where the focus should be. And that's not an episode payment model. That is a population payment model.

CO-CHAIR SINOPOLI: Agree. Thank you. We've unfortunately run out of time, but this has been a great, great discussion. And again, I want to thank all of the panelists here for being able to participate in this discussion. You've given us lots of

information to chew on. And again, just appreciate your participation. Thank you.

DR. BIRKMEYER: Thank you, everybody.

DR. DAVIS: Thank you.

(Whereupon, the above-entitled matter went off the record at 12:22 p.m. and resumed at 1:17 p.m.)

*** Public Comment Period**

CO-CHAIR HARDIN: Welcome back. We have three people who have signed up to give a public comment. I will announce your name and your organization, and our moderator will unmute you so that you can speak. First, we have Tom Merrill, who is a principal at Redstone. Please go ahead, Tom.

MR. MERRILL: Good afternoon. How's my audio? Can you hear me?

CO-CHAIR HARDIN: Yes, we can hear you.

MR. MERRILL: Okay, great. So yes, this is Tom Merrill, principal at Redstone. Real briefly, we're a research and advisory firm that supports organizations in their value-based care strategy work. Very supportive of this Committee’s work.

We do our best to encourage private sector clients to take advantage of the great thinking that's been produced here. Relative to the comment we'd like to make, I apologize if you covered this yesterday. But I was on early and then got called away.

Eager to go back and review. But if you didn't cover this already, just take this as support that you're exploring the right things. But we at Redstone would love to see specialty population models developed around specifically high-cost, high-needs populations that can be defined by non-medical factors, for example, social determinants of health. We think the multi-visit patient work done up in Massachusetts and New York state and the DSRIP[53] programs could be instructive here.

Plenty has been published on that front. Relatedly, with private sector, we'd love to see this group explore the misalignment between more preventive health-oriented care models and the limited annual timelines of most insurance benefit design. We know this isn't a problem in Medicare, per se, but clearly, this prevents a huge portion of U.S. health care finance from

53 Delivery System Reform Incentive Payment

being able to justify payment for services that often don't bear fruit until years later when a member is likely with another insurance company. So we believe that this could probably involve more payment for measurable health improvements rather than simply relying on cost savings that may accrue years later. So anyway, that's our comment. And again, we love your work and appreciate the time and the opportunity to comment.

CO-CHAIR HARDIN: Thank you so much, Tom. We really appreciate your presentation. Next up is Jennifer Gasperini, the director of regulatory and quality affairs at the National Association of ACOs. Please go ahead, Jennifer.

MS. GASPERINI: Hi, good afternoon. Thank you. NAACOS appreciates PTAC's focus on this issue and the coordination with the Innovation Center's work on specialty engagement. NAACOS and ACOs share the commitment to the administration's goal of having all Medicare patients and most Medicaid patients in an accountable care relationship responsible for total cost of care and quality by 2030.

And to achieve this goal, we must focus on allowing providers to coordinate care across the continuum of care, working together to achieve optimal patient outcomes. This includes engaging specialists and total cost of care models like ACO models. After more than 10 years of payment model design innovation, we've learned that having mandatory specialty-focused bundled payment programs and primary care-focused total cost of care models can lead to overlap challenges that can create provider and patient confusion and administrative burden.

Designing specialty payment approaches within a total cost of care arrangement can create the proper incentives to encourage coordinated care across the care continuum. To support ACOs in this work, there must be more data transparency to give ACOs and specialists access to quality and cost data to inform referrals to high-value specialists and create financial arrangements and incentives that encourage this coordination. There must be flexibility to allow ACOs' plans and other entities to design approaches that are best for their population.

However, a lack of standardization will ultimately lead to more provider burden as well. So approaches should allow for options from a menu set of more standardized approaches that allow a level of flexibility, for example, defining industry standard definitions for episodes. Finally, ACOs engaging specialists in shadow or nested bundles are often faced with challenges regarding small numbers.

And sample size is critical for accurate measurement. So performance data must be based on a sufficient volume of cases, even if we have to look across payers so that spending estimates are statistically reliable. ACOs are very interested in finding ways to further engage specialists and total cost of care models.

And providing more data, both episode cost data and quality data, to ACOs will help support this work, whether it's supporting referrals to high-value specialists or subcontracting financial arrangements like gain sharing in an ACO. ACOs are not all the same. And flexibility must be provided to ensure ACOs are meeting their patient needs.

For example, a rural ACO may have

less referral options. So engaging specialists may look different for that ACO in that particular market or region. We look forward to continuing to work with the Innovation Center, CMS, and ACOs on this issue to find ways to meaningfully engage specialists in total cost of care models. And we thank PTAC for their attention to this issue.

CO-CHAIR HARDIN: Thank you so much, Jennifer. We appreciate your comments. Next up we have Amita Rastogi, independent consultant, industry expert in value-based payment. Amita, please go ahead.

DR. RASTOGI: I lost volume. Can you hear me?

CO-CHAIR HARDIN: We can hear you. Please go ahead.

DR. RASTOGI: Oh, good. Okay. I'm Dr. Amita Rastogi. I'm currently an independent consultant in value-based care. I was the chief architect of PROMETHEUS[54] Payment in the episodes of care space.

As a cardiothoracic surgeon trained at the Mayo Clinic and with a Master's in

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Health Administration degree from the Martin School of Public Policy and with a Master's in Biostatistics and Epidemiology from the University of Chicago, I bring clinical, business, and analytical skills to the table. Moving from volume to value requires a simple mind shift. For providers such as myself, we have to think, is this procedure appropriate for the patient?

Is this service really required? Is this referral truly necessary? Will it improve outcomes for my patient? By making specialists accountable for total cost of care arrangements, they become part of the value-based movement.

Building on the CMS programs such as for kidney care, the nephrologists are made accountable for the total cost of care for kidney patients. We have already seen this mind shift happening with the specialists in the real world, such as in my husband's 11 nephrology group practice, which is adopting the CKCC[55] model. Nephrologists are watching every lab test being done, every procedure that is being ordered.

55 Comprehensive Kidney Care Contracting

Similarly, we can make cardiologists, orthopedic surgeons, GI physicians, and other specialists as a quarterback for patients with complex needs in a total cost of care arrangement with primary care physicians still being part of the team. Using a nested design, every inappropriate procedure or referral they avoid would go towards their shared savings, much like Dr. Kevin Bozic highlighted earlier today. For example, cardiologists could team up with cardiac surgeons in total cost of care arrangements for a cardiology cluster.

As is happening in the nephrology world, kidney transplant surgeons are reaching out to nephrologists to be part of the kidney care team. This is happening, and I'm seeing it in real time. So the tables are turning, and the true value-based movement has begun.

Organically grown systems and accountable arrangements avoid biases and the system from being too prescriptive. It is the willingness of providers to change their mindset that will truly drive the shift to value, and it is happening. And once they take accountability for whole person care being

responsible both for clinical as well as financial outcomes, we see true value-based movements come in. Thank you.

CO-CHAIR HARDIN: Thank you so much, Dr. Rastogi. We really appreciate your comments. Amy, are there any other public commenters that have signed up? All right.

*** Committee Discussion**

Hearing none, that is the end of public comments. Now the Committee members and I are going to discuss what we've learned yesterday and today from our guest presenters, the roundtable discussion, the background materials, and the discussions. PTAC will submit a report to the Secretary of HHS that includes our findings from this public meeting, in addition to what we want to highlight from yesterday and today.

Similar to yesterday, we will start with time to reflect more generally before staff continue with the slides identifying potential comments. Members, you have a document on potential topics for deliberation tucked into your binder to help guide the conversation. To indicate that you have a comment or question, please flip your name

tent. I know we have a lot of great insights from the last two days. It's been really rich discussion. So who would like to begin? Jen?

DR. WILER: Well, yesterday, I had 10 comments. Today, I have five in no specific order. The first thing that we heard about a few times is that specialists, quote, just want better care coordination as a desired outcome.

But when I heard those comments in the context of that conversation, it made me wonder, were they really saying they wanted to stay in fee-for-service with no risk? I think our discussion over the last two days has highlighted why the incentives are not aligned in the current system to make specialists want to participate. And I hope that some of the things that we were able to highlight today have demonstrated what those incentives need to be or could be even if they're not financial.

Number two, what I heard was that we probably are using the wrong language and rubric. When we say primary care and specialists, we are disadvantaging both groups. Not all primary care services are the same, and not all specialist services are the same.

And what I heard was -- and not to

be too simplistic. But what I heard was that maybe a disease-based care model might be the right approach. I do think our PCDT[56] team framework that we recommended in the beginning as a straw person got it right and that looking at both cost and utilization factors are potentially a way to start thinking about how do I identify these disease-based care models where there's potentially avoidable cost in the system.

Now one caveat to that is that potentially avoidable cost is based on a fee-for-service chassis. So there may already be inequities within the system. But that is the simplest way for us to start thinking about it.

The next thing I heard is that PROs[57] can be a really important component. I think we all know that. But it's around how do we actually implement those -- how to identify those outcomes that are important and then include them as one of those incentives that I talked about in my first comment because those are actually a really strong driver.

And although collecting the information is not free, the opinions of our

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57 Patient-reported outcomes

patients is really important, and it's free. Number four, I heard -- what I liked in Dr. Zerzan-Thul's presentation about what Washington state has done, it really summarized what I think we heard throughout the two days, and that's practice transformation can happen. We have lots of examples of that in various sectors.

But it's expensive, and it requires up front funding, a prospective payment. And I like -- I think there's some things there that she described around doing practice assessments and identifying readiness. And then thinking about a model to help nudge groups to move to the next level.

But what I thought you said that was really important is that there's also an expectation. So it doesn't sit in pilot phase forever. It then pivots, and that's explicit from the beginning about what that expectation is.

But I think there's really something interesting there about creating practice transformation with prospective payments. But what I'll note is that I think that requires interagency collaboration to fund. And

although that may be challenging from a policy or regulatory perspective, I think if our country wants to move forward into true value-based care, we have to do that.

And then last, I'd comment that in the most recent presentation about the musculoskeletal model, what I thought was interesting was that with the right incentives with various collaborators, there is healthy competition about who should be the attributable owner of a patient. And no pun intended. I think that healthy tension and competition is a good one for Medicare beneficiaries and for patients. So I think models like that that make care teams want to be responsible for care for a patient regardless of what the subspecialty training is of those groups, those are the right kind of care models that we should be thinking about and then trying to create financial incentives for them. Thank you.

CO-CHAIR HARDIN: Excellent. Thank you so much, Jen. Who would like to go next?

CO-CHAIR SINOPOLI: I don't think there's much to add to that to be quite honest. But just wanted to emphasize that we heard --

in addition to what we heard yesterday, we continue to hear today how clinical practice is now continuous and that we shouldn't think of it in buckets or silos but rather a disease process across an entire continuum. And therefore, that dictates what our payment policies need to be, what our clinical models need to be, what our team structures need to be and clearly help in getting the system teams that are capable of working across multiple specialties, including primary care in general and specialty care. And also we heard again today how lacking -- unless you're part of a big system, how lacking crucial data is in terms of truly being able to manage patients across multiple specialties.

CO-CHAIR HARDIN: Excellent. Thank you, Angelo. Josh?

DR. LIAO: Yeah, I agree. I think many -- I agree with many of the comments that have been said. I think my overarching reaction is that assuming adequacy of workforce, which is an assumption, is not always true in some areas.

But assuming that, one of the key takeaways from me is that I think a lot of this

begins with capacity assessment. And that really sunk with me from today. I think a lot of the things we heard these last two days about what works and what doesn't work can be tied pretty directly back to that, expectations, loss of communication, what the goals are for the clinicians and the patients involved.

And so I really like that idea of making that assessment. In one session, we heard about what's advanced primary care, maybe more intermediate. But I think it can be applied more broadly.

What I liked about that example too, there were separate but complementary assessments for primary care and in that case behavioral health practices. But you can imagine analogs for other subspecialty practices as well. And I think that -- that also, I think the reason that's so important to me is that then it emphasizes the other things you heard over the last two days, which is that if you want to integrate it, it might be through acute episodes or procedures or conditions, one condition, multiple conditions.

And so it's not all or nothing. As

I mentioned yesterday, I think it very much is there are many choices there. And I don't know a better way to assess those choices unless we understand those groups or those clinicians that we want to integrate into these models and engage what is our capacity for integration. And so I think that's very important.

I also agree with Angelo. I think care is increasingly continuous. And yet under the aegis of payment models, accountable entities are pretty discrete, right?

And so that, again, underscores the point about capacity. So even if we think about this continuum of care, one large group, a collection of smaller groups, and these clinicians, and those clinicians are going to take accountability and integrate with that other group. And that discreteness to me again underscores it's really important to understand screening, referral, QI[58], ongoing care management, workforce, physician, non-physician. Those things, I think, are really integral.

And finally, I'll say when I think about how that can be applied to payment

58 Quality improvement

models, I can imagine at least two potential approaches. One would be that in that assessment, we identify when and where certain payment models and certain incentives, many of which have talked about at this meeting, would be more than likely to work and create less inappropriate abrasion on clinicians and practices. On the other hand, we can then better learn from models that are ongoing now or that have completed about why are we hearing in the field these things aren't working. And so I think that capacity assessment gives us a new lens into that.

CO-CHAIR HARDIN: Excellent. Larry?

DR. KOSINSKI: Well, I have several. But they may be -- some of them may be replicative of what we've just heard. But I came up with the number one conclusion that as we have learned before, risk should be borne at the level of the entity, and incentives need to be deployed at the level of the provider. But this implies on the basis of what we've heard that all providers need to be either employed or tightly contracted by a risk-bearing entity. Our focus should be on patients and their diseases, rather than providers and their

chosen field of practice.

Providers may be better categorized, therefore not by their specialty but by their main function within their specialty, screening acute care, chronic longitudinal care. And then we can build complex patient attribution models to be deployed based upon the patient needs and the provider function and how those two can be brought together. Finally, payment models would then need to be deployed based upon this function, bundles for acute care, payments for chronic longitudinal care regardless of the provider specialty but totally consistent with who's bearing the responsibility for the care.

CO-CHAIR HARDIN: Thank you, Larry. Jim?

DR. WALTON: Thank you. I'm just going to try to add what's not been said. After the capacity assessment, it seems that what we heard was capacity building is somewhat organic at the medical neighborhood level and that one of the strategic opportunities that sits in front of the country is to -- kind of like what Walter was alluding to yesterday afternoon was keep it simple and then a little

bit get out of the way, right?

And then I think we just heard from NAACOS that moving the funds to the accountable entity but having some requirement that the accountable entity enabled the development of capacity building within entities that really wanted to create the medical neighborhood. So there's some prescriptive opportunities. We need the medical neighborhood for the accountability that digitized and connected in telehealth and all the things that can work.

But let the money be front-ended so that capacity building is done differently in Houston than in Central Texas than Dallas or in Minnesota. And so the other thing I wanted to say is I think that when we talk about value providers, whether that's a specialist today, some primary care doctors that are in value-based work for the last four or five years, nursing homes, or skilled nursing facilities. I think it's incumbent upon us to recognize it's kind of like a time zero for them, that integration really hasn't happened in value-based work, hasn't started.

And if we go back and think about what it was like when primary care doctors

first started to think about value-based work when ACOs first came about, they were at time zero. And so I've watched quality metrics inside the ACO -- primary care ACO organizations improved significantly. Certainly not at goal yet but getting better.

And so I know that if we were measuring primary care doctors at time zero and saying they're not value, so we're not going to give them a contract, that would've been a huge mistake. Further, that just erodes the sense of professional dynamism that's inside medicine that will kind of create the competitive juices, the competitive forces I think that Josh was bringing about that will cause improvement in quality and cost control. If we just assume that we're still pretty early in the game and that lots of specialties in lots of organizations along the continuum of care haven't really engaged this yet.

So we really don't know how valuable they're going to actually be until we actually bring them into a neighborhood that's connected to primary care doctors who have attributed patients who've got to get the job done and create equity and reduce disparity. So I'm

hopeful that with CMMI's goal that we can continue to advise, to take everybody at a time zero, and build capacity. But front-load the funds so that that capacity can be developed and try to stay out of the way, not create more complexity. So we've got to sort through that.

CO-CHAIR HARDIN: Thank you, Jim. Audrey?

MS. McDOWELL: So just wanted to ask you all given that in this meeting we've been talking about having payment for people that are providing chronic disease management separate from payment for people who are doing procedures or acute episodes. Are there any concerns about the potential for underutilization stinting on care, issues around disparities for certain patients? If specialists are getting kind of this payment not based on fee-for-service and actually seeing the patients, does the Committee have concerns about that? And are there performance metrics or other opportunities to guard against that?

DR. WALTON: I'll jump in on that. I thought that one of the comments, and I think Jen brought it up, which is this idea that was

introduced today around this self-reported health status starts to address that concern, right, that the consumer ultimately or the collection of consumers within an ACO in the aggregate could actually start to express whether or not in fact there was an unintended consequence of rationing, which then leads to poor health and greater disparities. I also thought that -- and we see this in REACH, which is that there's this equity improvement plan requirement. So there's not only -- and inside that plan, there's this idea that you have to pick a goal and actually demonstrate movement of that goal.

Being accountable for moving it seems to be a way to kind of build in -- or it was already built in to some of the ideas to kind of help protect against I would call the rationing approach of reducing care delivery for the sake of cost control. So I think in both of those, having an equity plan, an execution, and strong equity reports requirements and let the market solve for that, I think is going to protect the consumer. But more valuably than that would be the consumer themselves talking about in particular

conditions whether or not they are actually relieved of their pain, their functional status is better, and they're satisfied with the care they received.

DR. LIAO: Yeah, maybe I'll just add to that too. I mean, I think -- how do I say this? I think one of the concerns I would have is that we take history and carry it forward as the rule, like, an example from history and carry it forward.

So I don't think many if any of us would argue that bundle payments by volume and experience has really been an orthopedic procedure experiment in a formal way. And yet there are many different types of -- what's another world since bundles is not a good one? But the other bundle-like things that can happen.

I think episode-based cost measures, a lot of the things that we're seeing are moving us away from that. And I would really encourage us to think outside that in a bigger frame. And partly because I worry about potential under-provision, and I'll come back to that.

And what I mean is that there's was

comment today made that epidemiologically you're not worried so much about the efficiency of the episode. You're worried about whether a person gets a procedure. And I would admit for something that's relatively preference-sensitive and high-volume and common like joint replacement, that's arguable.

There are many other episodes like acute exacerbations of medical disease where that's not actually true I would say. It's a different epidemiological process. And so I just want to make sure we shake free of history, which teaches us a lot.

But we can rethink episodes and conditions and bundles in a different way. And I think it's particularly important because of what you said, which is that I think implicit, this idea of cost efficiency is an implicit assumption that in many cases less is better. And I think given the huge inequities in this country, I think that's not always true.

And I think sometimes what's right and what's equitable needs to be more. And so I would hope that we take that wider aperture when we think about these topics. And just to take that analogy that I mentioned in joint

replacement, we know dating back unfortunately many decades that receipt of joint replacement, where they go after the surgery, the types of post-acute care, are highly disparate by income and by race. So how do we deal with that? I certainly don't have the answers, but I think the idea that we would just say let's just nest and design and risk-adjust and be more cost-efficient.

I don't want that piece to be lost. So Audrey, I really appreciate you bringing that up because I do think sometimes we probably want more of coordinated and high-quality care. And I hope our models can reflect that.

CO-CHAIR HARDIN: Larry?

DR. KOSINSKI: I just wanted to address what Audrey just asked. What I heard from McClellan, de Brantes, and Jones today was not a standard PMPM payment but a PMPM payment for the cognitive risk-based responsibility taking components of medical care but then a markedly discounted payment for those procedures that have to be performed. Audrey, I'm going to flip what you just asked us with a different type of example.

And I'll go back to the gastroenterology space again. You have gastroenterologists today that are in their ASCs doing colonoscopies on inflammatory bowel disease patients and having the cognitive work being done by APP in the office, whereas when you really think about it in a repetitive procedure like a scope, that probably could be performed by an APP. But the person who went to school, they were 32 years old to master the knowledge of how to take care of that ill patient, should be the one making the decision.

So I think taking some of the money and appropriating it for the cognitive services of specialists that have been actually undercompensated. And to pay that, you take money from the procedural services. Somewhere there may be a sweet spot there so that we encourage the cognitive services from our specialists but at the same time make sure that the procedure is still being done. But the procedures don't become the main source of revenue for the specialist.

CO-CHAIR HARDIN: And I'll just add a couple things. I think that's a really important question, Audrey. One of the things

I heard and we've heard in other sessions as well is the move towards disaggregating data by race, ethnicity, and other components and utilizing that as a quality metric. That's critical in looking at outcomes and really understanding.

And then I heard a whole theme in this session about the emergence of technology in different ways that I think bridged disparities. So the ability to do e-consults, telehealth, wearables in the home, things that address some of the barriers related to transportation, hours of availability to get to offices, access issues that make things more possible. And then an underwriting theme that I heard about success in any of these payment models is the need for longitudinal relationship and trust and also the integration of interprofessional teams, other disciplines, and trusted providers which may be a community health worker, a nurse, a social worker who's following longitudinally over time.

I think those types of models have a lot of promise for addressing the barriers of trust and access. And some of the data discussions around proactively seeking

populations who are not accessing care I think has promise for being standard and how we're looking not only at high utilization but no utilization as just as important of an indicator. And then the themes that also came out is the importance of anticipatory symptom management, anticipatory disease management, and proactively addressing social determinants of health and health-related social needs and populations.

Those things will start to drive care reaching out to clients rather than waiting for clients or patients to crash and go into crisis before care is delivered. I think all of those things are really critical for underserved populations. Any other comments?

MS. McDOWELL: So again, just in terms of process measures, for example, if a patient is attributed to a certain provider or certain care team and they have a certain condition and the care team has not had any visits with that patient, say, within a reasonable amount of time, is it possible to build those things in relating to accountability?

CO-CHAIR HARDIN: I think that's

critical. And having worked in hospice care, which kind of is a total cost of care model, you're completely driven by preventing crisis. So the team interaction when the client is based on proactively reaching out, proactively visiting, proactively engaging because the payment model is such that you want to prevent crisis and manage it responsibly. So it changes your interaction. Walter?

DR. LIN: So it's been a really productive two days. I want to thank the PCDT team again for lining up some great speakers along with the PTAC and NORC staff. I won't repeat a lot of the comments that have been already stated which I largely agree with.

A couple additional thoughts, though. I think one of the things that stuck out to me from our two days is the current risk models that the current pilots don't really do a good job of somehow taking into account preference-sensitive care. So they don't reward providers for preventing something that is going to require more care down the line, care that doesn't happen, right?

So I always got to go back to kind of chronic kidney disease and the nephrologist

who prevents Stage 3 chronic kidney disease from progressing to dialysis doesn't get reward for that, right? The many years of payment that CMS would've had to pay for the dialysis care is not seen. There's no value to that nephrologist besides maybe some fee-for-service (inaudible) payments for the visits.

And in fact, that nephrologist is hurting him or herself financially by not performing all those dialysis treatments, right? So how do we design payment systems that can somehow reward the appropriate preference sensitivity of intensity? It's an open question.

I think one of the models that we've heard kind of describe the most detail is the condition-based payment model as articulated by Drs. McClellan, Bozic, and Francois de Brantes. I guess to that some extent, right? But essentially, I think the condition-based payment model, the Musculoskeletal Institute as an example as a subcapitated payment stream to a specialist for chronic longitudinal care.

And all of the care that specialist provides comes out of that payment, right? So the way I think about it is it's not so much

condition-based payments but rather specialist-based payments because -- and again, we hear this from Dr. Bozic. I should've asked.

But let's say someone is in the Musculoskeletal Institute. You can subcap for it, and an orthopedist doesn't get paid more for not performing -- sorry, for performing elected joint replacement. But what if that same patient falls and has a fracture, right?

Does that subcap payment cover that as well? I mean, there are all these other kind of details that I wish I had more time to dive into. Maybe those payments are more acute episode-based and the bundle payments.

But I don't know that -- this is a payment innovation for sure. But I don't know that needs to happen at the national level. I think just hearing Nichola's comment just now makes me think again that we should let these payment innovations occur more at the local level.

And then ACOs, managed care organizations can contract with organizations like the Musculoskeletal Institute. But at the national level, I don't know that we need to dictate that kind of care. Maybe we can have

some pilot models to show its effectiveness. But I think if we just let the risk-bearing entity figure things out with the appropriate counterbalances and protective measures, we should just let them do that. You know what I mean?

I don't know that we can necessarily design a payment scheme that will help the frontline provider decide which are the high-value specialists in their locality. But I'm sure that primary care provider probably knows. And so just give them the appropriate risk and reward framework and let them make that decision.

So I was only kind of, like, half in jest when I was suggesting. We already kind of have the basic framework we need. We just need to kind of maybe tweak it a bit and then get out of the way and let the frontline providers figure out how best to manage that risk.

CO-CHAIR HARDIN: Thank you, Walter. Lindsay, did you want to add anything? No? Okay. So we have covered a lot of ground today. If we went around the room and went around the table and said, what one thing did we not bring up, one theme or one thought that

wasn't covered that you would want to add? And Josh, would you start?

DR. LIAO: Well, I think I only brought up one today. So maybe I'll just parrot myself and say I think the capability is really important. I didn't directly call it out, but Audrey's comments made me realize too that I think Jim mentioned time zero, I think at least for primary care since the concept of medical home came about in the late '60s.

I think that clock started at some point decades ago. So I think maybe the one thing I would highlight, I mentioned this yesterday, is I don't think it's a cool app or just a change in the way we do a form and then we can all go on our merry way. I think if we really want to integrate, it's going to require change in how we deliver care and operate organizations.

And I think everybody has a role in that. But I think particularly potentially specialties or parts of care that are closer to time zero, I think, I hope that's part of it. I hope that we don't just think about incentives and think about communication and think about technology.

We think about, how do we bring them along in culture? How do we bring them along in capability to do that? Because I don't think it's even across the health care community.

CO-CHAIR HARDIN: Thank you, Josh. Jen?

DR. WILER: I think it was said, but I'm going to amplify it. Data, data, data. We cannot move this conversation forward in a meaningful way and improve health outcomes for patients unless we have ubiquitous -- that doesn't mean a lot -- but important, actionable, transparent data to allow entities to become risk-bearing and for risk-bearing entities to deliver high-quality care.

And that kind of infrastructure is expensive. And again, I think we need to encourage building off an infrastructure that we heard at our last meeting that's starting to exist maybe through a RHIO[59] structure, maybe in partnership with our predominant EHR vendors. But that is a large hurdle, and it's very potentially expensive. And those would be dollars that are well spent to do practice

59 Regional Health Information Organization

transformation.

CO-CHAIR HARDIN: Thank you, Jen. Angelo?

CO-CHAIR SINOPOLI: So I was going to talk about data. But I'll go back and kind of reemphasize Josh's comment. So I think education and training, that's what I see missing in a lot of the practices. When I say that, the basics of how risk works and what a health plan does to understand RAF[60] coding, HCCs[61], all those things that frontline primary care practices often have little idea about but are so critical to their success. And there's really not a good resource for educating them and then able to learn quickly.

CO-CHAIR HARDIN: And Walter?

DR. LIN: So I guess I would just reemphasize my other comment about how to somehow reward specialists for preference-sensitive care that doesn't happen appropriately so.

CO-CHAIR HARDIN: And Lindsay?

DR. BOTSFORD: Yeah, I think a closing reflection would be around when we think about high-value care and how we've

60 Risk adjustment factor
61 Hierarchical Condition Categories

rewarded. It's maybe not just in payment. But I think the other piece we need to figure out is how do we measure and value the communication and collaboration that go into that high-value care.

And who and where should that care coordination happen, practice level, plan level? And I think the arguments were in favor of practice level, funded at the practice level. But that definition for what good looks like maybe is a gap to being able to evaluate.

CO-CHAIR HARDIN: Thank you, Lindsay. Jim?

DR. WALTON: My mind tends to think toward, as you already know, probably migration from the triple aim to the quadruple aim. And one of the things that we really maybe want to spend some time thinking about is -- as we kind of iterate is, is what we're suggesting going to actually improve the experience of being in the field as a profession as opposed to -- because what's not measured, an unmeasured event that's happening is what happens when physicians are burned out? What are the sequelae in the way care is delivered?

And then kind of what am I going to

do next week? Or how am I going to adopt the next model? Or what technology I will or will not say yes to? How will I code? How will I document? How will I share, not share is all driven by this kind of palpable burned out, discouraged, disappointed, somewhat almost defeated workforce.

And that includes our nurses and APNs and doctors as well. So some of what we need to think through is just making sure we have that filter at the end kind of as we push everything through. It's, like, will this make it a better experience or not, and what may we need to add to do that, so adopting the quadruple aim.

CO-CHAIR HARDIN: Larry, I'm going to let you take us home. So I'm going to say mine and then let you close because I know you're really --

DR. KOSINSKI: You go ahead and do that.

CO-CHAIR HARDIN: So I'm just going to build on what Jim said. I think one of the most striking things, data points, today was around Kevin Bozic where he said in five years, they only had one person turnover from their

team. And that's what I see nationally.

These integrated teams, integrated models, interprofessional teams, different disciplines practicing to the top of their license. And really creatively looking at design and efficiency of how do we come together to meet the needs of the client holistically and in a way that makes sense I think is critical. When we look at workforce shortages, we may have more workforce than we imagine by the creativity of how we deliver what we do. So I think that's really key and an opportunity in total cost of care models. Larry, it's up to you.

DR. KOSINSKI: I think my parting words are let's bring down the silos. It's time to break down the data silos, the provider silos, the contracting silos. We had a lot of knowledge shared with us over the last couple days.

But I go back to Dr. Jones. He said, I get daily claims. Look what you can accomplish when you got data, when the silo has broken down. And I think that's my parting thought is we've got to figure out how to break down the silos.

*** Closing Remarks**

CO-CHAIR HARDIN: Thank you, Larry. So I think are there any other comments before we close from any of the members?

Then I want to thank everyone for your very active and important participation today, our expert presenters and panelists, my PTAC colleagues, and all those listening in and actively participating. We explored many different facets of improving care delivery, strengthening primary care, and integrating specialty care within population-based models. Special thanks to my colleagues on PTAC.

This was a lot of information to take in, in these two days. And I appreciate your very active participation, thoughtfulness, and deep reflections about learnings from these two days. We will continue to gather information on our theme through our Request for Input on our topic.

We're posting it on the ASPE PTAC website and sending it out through the PTAC listserv. You can offer your input on our questions by April 7. And we're very interested in your input.

*** Adjourn**

The Committee will prepare a report to the Secretary with our findings and recommendations from this public meeting. And with that, the meeting is adjourned. Thank you.

(Whereupon, the above-entitled matter went off the record at 2:06 p.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

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Before: PTAC

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Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter