

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

**March 3, 2023  
9:01 a.m. – 2:06 p.m. EST  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201**

**Attendance**

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

Lauran Hardin, MSN, FAAN, PTAC Co-Chair (Vice President and Senior Advisor, National Healthcare & Housing Advisors, LLC)

Angelo Sinopoli, MD, PTAC Co-Chair (Chief Network Officer, UpStream)

Lindsay K. Botsford, MD, MBA (Market Medical Director, One Medical)

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

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

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

James Walton, DO, MBA (President and Chief Executive Officer, Genesis Physicians Group)

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

**PTAC Members in Partial Attendance**

Soujanya Pulluru, MD (Vice President, Clinical Operations, Walmart Health Omnichannel Care, Walmart, Inc.)\*

**PTAC Members Not in Attendance**

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

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

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

Lisa Shats, PTAC Designated Federal Officer

Audrey McDowell

Steven Sheingold, PhD

***\*Via Webex Webinar***

## List of Speakers and Handouts

### 1. Listening Session 2: Developing Financial Incentives

Kevin Bozic, MD, MBA, Professor and Chair, Department of Surgery and Perioperative Care, Dell Medical School, The University of Texas at Austin\*

Ami B. Bhatt, MD, FACC, Chief Innovation Officer, American College of Cardiology\*

Judy Zerzan-Thul, MD, MPH, Chief Medical Officer, Washington State Health Care Authority\*

Christina Borden, Director, Quality Solutions Group, National Committee for Quality Assurance, (NCQA) (*The “Medical Neighborhood” Advanced Alternative Payment Model [AAPM] [Revised Version] proposal*)\*

Brian E. Outland, PhD, Director, Regulatory Affairs, American College of Physicians (ACP) (*The “Medical Neighborhood” Advanced Alternative Payment Model [AAPM] [Revised Version] proposal*)\*

#### Handouts

- Listening Session Day 2 Slides
- Listening Session Day 2 Presenters’ Biographies
- Listening Session Day 2 Facilitation Questions

### 2. Roundtable Physician Panel Discussion: Enhancing Specialty Integration

John Birkmeyer, MD, President, Medical Group, Sound Physicians\*

Nichola Davis, MD, MS, Vice President and Chief Population Health Officer, NYC Health & Hospitals\*

Carol Greenlee, MD, MACP, Endocrinologist and Owner, Western Slope Endocrinology\*

Jackson Griggs, MD, FAAFP, Chief Executive Officer, Waco Family Medicine\*

Art Jones, MD, Principal, Health Management Associates (HMA)\*

#### Handouts

- Panel Discussion Day 2 Slides
- Panel Discussion Day 2 Presenters’ Biographies
- Panel Discussion Day 2 Discussion Guide

### 3. Public Commenters

Tom Merrill (Redstone)\*

Jennifer Gasperini (National Association of Accountable Care Organizations [NAACOS])\*

Amita Rastogi (Independent Consultant)\*

#### ***\*Via Webex Webinar***

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

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

The [ASPE PTAC website](#) also includes copies of the presentation slides, other handouts, and a video recording of the March 3 PTAC public meeting.

## Welcome and Overview: Discussion on Improving Care Delivery and Integrating Specialty Care in Population-Based Models Day 2

Lauran Hardin, PTAC Co-Chair, welcomed members of the public to day two of the March public meeting. She noted that Elizabeth (Liz) Fowler, Centers for Medicare & Medicaid Services (CMS) Deputy Director and Director of the Center for Medicare and Medicaid Innovation (CMMI; the Innovation Center), spoke at day one of the public meeting about how PTAC's work is related to some of the Innovation Center's areas of focus. Co-Chair Hardin provided an overview of the second day of the public meeting, including a listening session on financial incentives, a physician roundtable discussion, a public comment period, and a Committee discussion to shape the Committee's comments for the report to the Secretary of Health and Human Services (HHS). Co-Chair Hardin invited Committee members to introduce themselves and describe their experience with population-based total cost of care (PB-TCOC) models.

### Listening Session 2: Developing Financial Incentives

#### Subject Matter Experts (SMEs)

- Kevin Bozic, MD, MBA, Professor and Chair, Department of Surgery and Perioperative Care, Dell Medical School, The University of Texas at Austin
- Ami B. Bhatt, MD, FACC, Chief Innovation Officer, American College of Cardiology
- Judy Zerzan-Thul, MD, MPH, Chief Medical Officer, Washington State Health Care Authority

#### Previous Submitters

- Christina Borden, Director, Quality Solutions Group, National Committee for Quality Assurance (NCQA) (*The "Medical Neighborhood" Advanced Alternative Payment Model [AAPM] [Revised Version] proposal*)
- Brian E. Outland, PhD, Director, Regulatory Affairs, American College of Physicians (ACP) (*The "Medical Neighborhood" Advanced Alternative Payment Model [AAPM] [Revised Version] proposal*)

Co-Chair Hardin moderated the listening session on developing financial incentives related to population-based TCOC (PB-TCOC) models. The listening session included five SMEs. Full [biographies](#) of each SME and their [presentations](#) can be found on the ASPE PTAC website.

Kevin Bozic presented on making the transition to value in health care. The themes covered in his presentation are described below.

- The fee-for-service system incentivizes volume-driven health care and produces high levels of burnout for physicians, while capitation can make providers feel like they are rationing care. Payment model transformation can improve the health of patients while bringing a sense of purpose to health care teams. Sustainable episode-based payment models for condition management can incentivize clinical care teams to organize around the needs of patients with particular conditions, rather than by specialty.
- Procedure-based bundled payments make procedures efficient, but do not account for whether a given procedure is the most appropriate treatment for the patient. Because quality of care is sensitive to patient preferences, incentivizing efficient health care does not always create value for patients.
- The UT Health Austin Musculoskeletal Institute's condition-based models involve a single annual payment for the management of a chronic condition, including all professional services delivered during that period of time, with accountability for outcomes.

- Condition-level episode payments produce better health outcomes at a lower cost, align physician incentives with patient needs, and create a better work environment for physicians.

For additional details on Dr. Bozic’s presentation, see the [presentation slides](#) (pages 2-6), transcript, and [meeting recording](#) (5:45-13:55).

Ami Bhatt presented on developing financial incentives and performance measures in subspecialty care.

- Team-based care has become foundational to how care is delivered, and team-based value incentives are needed to prevent counterproductive conversations about who receives credit for different outcomes.
- Sub-disciplines can be both interventional and non-interventional, and there is unequal compensation across sub-disciplines. This creates challenges related to compensating teams in entirety across the course of care given that patients in treatment by cardiologists often need different kinds of care provided by different specialists.
- It is important to allocate value to clinically meaningful “non-production” metrics. Currently, the majority of metrics in cardiology are all production metrics.
- Some specialists are interested in value-based compensation but have not been engaged in the primary care value-based structures within their organizations.
- One reason the cardiovascular workforce is decreasing relates to physician burnout, which can be partially alleviated by partnership with primary care practices, which can help to reduce the number of low-value specialty referrals .
- Progression of illness can be managed at both the primary care or specialty level.
- Patients requiring specialty care should be directed to the right testing, specialist, and location.
- Payment models should reflect that clinical care is continuous, not episodic. Payment should also account for care that is increasingly asynchronous and virtual.
- PB-TCOC models with adequate infrastructure can support health equity by incentivizing screening and referrals while also meeting social needs.
  - Future models should consider how specialists can address social determinants of health (SDOH).
  - Data on SDOH needs and social vulnerability indices should be embedded into payment models.
  - In team-based subspecialty care, compensation (including up-front payments, subsidies, and incentives) should be shared across a practice, so all providers are rewarded for addressing a patient’s SDOH needs.
- Both comprehensive condition-based models focused on medical treatment and stabilization and continuous care models focused on primary care, community outreach, and health equity may be necessary to improve access to care and quality of care.
- Successful value-based models will address the challenges of accelerating complexity, exponential information load, rapid technological disruption, and disparities in access and quality.

For additional details on Dr. Bhatt’s presentation, see the [presentation slides](#) (pages 7-16), transcript, and [meeting recording](#) (13:57-26:15).

Judy Zerzan-Thul presented on the integration of behavioral and physical health in the state of Washington.

- The Washington State Health Care Authority (HCA) provides whole-person care management, including physical and behavioral health care, through a single accountable managed care organization.
- Integrating physical and behavioral health care services required careful planning to determine correct payment amounts and avoid disrupting services.
- The HCA has made progress toward transitioning providers toward value-based payments; however, it has been challenging to incentivize providers to participate in population-level payments.
- Under the HCA’s approach, clinicians are accountable for whole-person care, behavioral health screening, and treating basic behavioral health needs, while payers are accountable for aligning quality standards and moving funding toward a capitated model.
- Washington developed a standardized assessment tool to measure the degree of integration of primary care and behavioral health practices, which gives the HCA information on what supports practices need to move toward more integrated care.

For additional details on Dr. Zerzan-Thul’s presentation, see the [presentation slides](#) (pages 17-29), transcript, and [meeting recording](#) (26:19-38:18).

Christina Borden and Brian Outland presented on improving care delivery and integrating specialty care in population-based models.

- ACP and NCQA submitted a proposed Medical Neighborhood Model (MNM) to PTAC in 2020. The MNM is a pilot that seeks to improve care coordination between primary care and specialty practices. The model involves connecting primary care practices participating in advanced primary care models with certain specialty practices that specifically meet clinical transformation and care coordination criteria.
- Under the MNM model, collaborative care agreements outline the expectations and roles of the clinicians involved. The model specifies situations when the specialty clinician is the patient’s primary clinician (because they are the provider engaged most frequently with the patient), or when the primary care provider (PCP) and specialist agree to co-manage a patient’s care. The collaborative care agreement also establishes communication and data sharing protocols.
- The spectrum of collaboration between primary and specialty care providers under the MNM ranges from consultation between these clinicians to various co-management arrangements, but the PCP is always involved in the patient’s care.
- Each shared care arrangement has elements specific to a given patient’s needs, but each arrangement follows a consistent framework that clarifies principal responsibilities, shared expectations, critical elements of care (e.g., advance care directives), and use of helpful tools (e.g., electronic templates to facilitate communication).
- To encourage specialist engagement in Alternative Payment Models (APMs):
  - Models should be built on a fundamentally similar framework to be understandable and predictable for both primary care and specialty practices, while also remaining flexible so that they are relevant to different types of specialties.
  - Specialists should be involved in pre-screening all referrals with accompanying documentation, which will help reduce unnecessary visits and reduce patient wait times.
  - Reimbursement structures should reduce duplicative work and administrative burden.
  - PB-TCOC models should incorporate incentives for patients to engage with specialists (e.g., transportation, copayment waivers).

- Collaborative care agreements ensure that roles and responsibilities are established between clinicians and set expectations for how and what information is exchanged.
- The presenters reviewed two case studies where coordinated care agreements were used in endocrinology and rheumatology practices.

For additional details on Ms. Borden and Dr. Outland’s presentations, see the [presentation slides](#) (pages 30-64), transcript, and [meeting recording](#) (38:20-57:40).

Following the SME presentations, Committee members asked questions of the SMEs. For additional details on this discussion, see the transcript and [meeting recording](#) (57:45-1:41:10).

Dr. Bozic discussed scaling the UT Health Austin Musculoskeletal Institute’s condition-based episode model.

- The Institute is working on defining condition-based bundles appropriate for the model and looking to conduct pilots with partners such as large employers or Accountable Care Organizations (ACOs). This would involve subcontracting out risk for specialty care in a way that assures reductions in spending for that care relative to the historical experience.

Presenters discussed how condition-based payment models would function when patients have multiple conditions and how to control utilization incentives. The following are some highlights from this discussion.

- The UT Health Austin Musculoskeletal Institute’s condition-based models include a single up-front team-based prospective payment for the management of a chronic condition. There are no additional professional fee payments for treatments, which disincentivizes overutilization. Additionally, the team is able to offer a broader range of non-surgical treatments. The team is held accountable for patient-reported outcomes.
- When a patient with multiple conditions receives care from a specialist participating in a condition-based bundled payment model, the patient is cared for by a multidisciplinary team as opposed to an individual specialist. However, a given multidisciplinary condition-specific team may not be able to treat all of a patient’s comorbidities, which means that the patient may also need to receive treatment from another multidisciplinary team for one of their other conditions.
- The MNM involves one individual who is responsible for knowing everything about a patient’s care and coordinating among specialists.
- Collaborative care agreements facilitate communications among clinicians.

Presenters described the team-based approach across specialty services, including involving multiple in delivering non-reimbursed care. The following are some highlights from this discussion.

- Subspecialty outcome measures could be combined across specialty divisions to align care team goals.
- For example, heart failure patients can receive their care from a combination of primary care providers and specialists. Depending on who is leading the care, there would be a need to clarify the roles of the varying team members and how everyone will communicate.
- Most American College of Cardiology (ACC) practices do not have cross-specialty navigators unless they are in a value-based contract, but practices would benefit from these navigators.
- Within medical neighborhoods, remote monitoring and team-based care could be used to improve coordination of care for cardiology patients.

Presenters discussed how to implement team-based care in situations where independent specialists are focused on Relative Value Units (RVUs), which do not incentivize team-based care. The following are some highlights from this discussion.

- The Orthopedic Forum allows orthopedic surgeons to focus on their specialty while others on the care team manage a patient's other conditions.
- Care team members should be practicing at the top of their license. In cardiology and some other specialties, there are both interventionalists and chronic disease managers, and they practice differently and should be treated as such.

Presenters discussed the advantages of specialist care teams and whether the workforce and payment systems can support these care teams. The following are some highlights from this discussion.

- Condition-specific medical homes are appropriate when treating patients with specific conditions makes up a large proportion of a primary care practice's costs. The care team can provide wrap-around services for that condition while maintaining strong communication with PCPs.
- There is a concern about whether the primary care system has the capacity to support specialty care teams.
- The MNM relieves PCPs of the burden of finding reliable specialists to refer to because there are strong relationships across a variety of providers in the medical neighborhood.
- There is not sufficient reimbursement for primary care practices to employ additional staff such as social workers or care managers. APMs are needed to provide this funding and grow the workforce.

Presenters commented on how capacity assessments can inform APMs. The following are some highlights from this discussion.

- Practices should be assessed on their readiness to participate in value-based care models. Payment methodologies should be appropriate for practices' level of experience with value-based payments.
- Additional funding and education may be needed for practices who are new to APMs to gradually introduce more advanced value-based care.

Dr. Bozic discussed scaling the patient-reported outcomes measures in the UT Health Austin Musculoskeletal Institute's model to other disease conditions.

- When developing patient-reported outcomes, it is important to consider what is important to the patient.
- One challenge with patient-reported outcomes is that they are not necessarily captured in claims data.
- Patient-reported outcomes should be integrated into clinical processes, such as electronic health records (EHRs).

Presenters discussed negotiating site neutrality among multiple stakeholders. The following are some highlights from this discussion.

- There may be opportunities for savings and greater patient satisfaction by having patients receive care in community-affiliated hospitals outside of a health network.
- Within the current system, there are incentives to keep procedures in hospitals and not in lower-acuity settings that may be more appropriate and preferred by patients. Dr. Bozic suggesting working with hospitals to keep high-acuity activities in the hospital while moving low-acuity activities to other settings.

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

- John Birkmeyer, MD, President, Medical Group, Sound Physicians
- Nichola Davis, MD, MS, Vice President and Chief Population Health Officer, NYC Health & Hospitals
- Carol Greenlee, MD, MACP, Endocrinologist and Owner, Western Slope Endocrinology

- Jackson Griggs, MD, FAAFP, Chief Executive Officer, Waco Family Medicine
- Art Jones, MD, Principal, Health Management Associates (HMA)

Angelo Sinopoli, PTAC Co-Chair, moderated the panel discussion of five SMEs representing different perspectives on enhancing specialty integration in population-based models. For additional details, please see the transcript and [meeting recording](#).

The panelists introduced themselves and provided information on their backgrounds, organizations and expertise. Full [biographies](#) and [panelist introduction slides](#) are available on the ASPE PTAC website.

- John Birkmeyer shared the following insights about how to think about the role specialists play in APMs.
  - Physicians should be categorized as generalists and specialists, rather than categorizing them as PCPs and specialists. Generalists include PCPs as well as clinicians working outside of ambulatory settings, treating patients across a full array of conditions and organ systems, and serving as gatekeepers to downstream services.
  - APM design should consider where physicians can have the biggest impact on spending.
  - Specialists are heterogeneous, and the impact of some specialists may be better aligned with population-based models rather than episode-based spending models.
- Nichola Davis discussed the transition NYC Health & Hospitals underwent to establish a single her system, which has helped to coordinate patient care. She highlighted how specialists have been integrated into primary care, including building out e-consults and integrating behavioral health into primary care using the collaborative care model. Dr. Davis noted that the ACO has used its shared savings to invest in primary care practices to help it manage the social needs of the patient population, such as hiring patient navigators and community health workers.
- Carol Greenlee discussed the patient-centered medical neighborhood, which is intended to reduce fragmented care associated with poor communication. The medical neighborhood is an approach to care coordination that can be used as a framework in any care delivery or payment model, including a PB-TCOC model. In medical neighborhoods, the patient is the center of care, the PCP is the “hub” of care, and specialists are the “spokes.” PCPs care for patients’ ongoing needs, and specialists may take on co-management responsibilities as a patient’s condition changes. Dr. Greenlee emphasized the importance of having a pathway for a safe and patient-centered transition of care from specialty back to primary care. For additional detail on Dr. Greenlee’s background and organization, see the [panelist introduction slides](#) (slides 2-7).
- Jackson Griggs discussed care delivery transformation efforts in behavioral health integration due to a lack of psychiatrists in the central Texas region. His organization incorporates clinical social workers as part of the primary care team, offers co-located counseling services, and is working toward incorporating substance use disorder management in primary care. The development of a decision support application aids PCPs’ use of psychopharmacology in an evidence-based manner. He noted the importance of his organization’s step-care model in addressing the reduced supply of specialists in the region. In this model, specialists can see the most challenging cases and once these cases have been stabilized, return them to primary care, as key to addressing mental health at the population level. For additional details on Dr. Griggs’ background and organization, see the [panelist introduction slides](#) (slides 8-13).
- Art Jones described the integration of primary and specialty care physicians in the Medical Home Network (MHN). PCPs, as well as specialty care providers, can serve as the primary care decision-maker for complex patients with multiple comorbidities. He suggested that APMs should allow attribution to go to the primary care decision-maker, even if a specialty care provider assumes this



role. For additional detail on Dr. Jones' background and organization, see the [panelist introduction slides](#)(slides 14-15).

Panelists discussed approaches for encouraging increased coordination between primary and specialty care providers, the challenges they have faced, and how they addressed those challenges. The following are some highlights from this discussion.

- Primary and specialty care providers should be in the same delivery system.
- E-consults can encourage increased coordination between primary care and specialty care providers. While there is currently no payment methodology for e-consults, providers can be incentivized to reduce TCOC and improve patient outcomes within an organization assuming global risk.
- Coordinating care within a single health care system is better for patients and reduces costs. Consulting psychiatrists can advise PCPs about psychopharmacology, supervise social workers, and provide care to more challenging patients. However, with adequate decision supports, it may not always be necessary for PCPs to consult with a psychiatrist to provide psychopharmacology. The key component of the collaborative care model is the care manager.
- There should be a patient-centered, structured approach with shared expectations that includes care coordination processes, the referral process, and methods to measure these processes.
- The care delivery system is often described as a hub and spoke model with primary care at the center. It may be better conceptualized as two "hub and spoke" models: ambulatory care with the primary care physician at the center, and the hospital-based model surrounding hospitalization and discharge. These two models should be integrated.
- Post-discharge telemedicine consultations that oversee and manage care delivered in a skilled nursing facility (SNF) and with home health care help patients re-enter a period where care is focused on outpatient ambulatory care after hospitalization.
- Interoperable EHR systems reduce administrative burden and facilitate coordination between PCPs and specialists around referrals.

Panelists discussed effective payment models used to incentivize and facilitate primary care and specialty integration. The following are some highlights from this discussion.

- In large markets with well-organized, risk-oriented primary care groups, and incentive arrangements, there may be ways to directly set up agreements between primary care groups and inpatient physician groups that are tied to spending metrics which are beyond the control of PCPs.
- Specialists are not yet fully integrated into the ACO model, but specialists can benefit from shared savings if they are part of a general practice.
- In one example where payment mechanisms are used to incentivize primary and specialty coordination, an independent physician association used bonus payments to encourage better communication and coordination between specialty and primary care providers. In another example, an organization tracked care coordination metrics, such as closing referral loops, which were tied to specialists' salaries.
- Individuals who have mental health conditions often have other chronic conditions, are more likely to be hospitalized, and are more likely to have higher costs. This population will benefit from advanced primary and specialty care integration, which can be encouraged through value-based arrangements.
- There are insufficient specialists who are willing to serve the Medicaid population and the uninsured population. The MHN program will offer salary support for specialists to spend half a day

a week responding to e-consults and phone consultations with PCPs. This will encourage specialists to help meet the needs of underserved populations.

Panelists discussed how APMs can support programs aimed at addressing health equity, particularly with respect to behavioral health. The following are some highlights from this discussion.

- An ACO or health plan should take on risk and make front-end investments, rather than a federally-qualified health center (FQHC). This would be beneficial for both the FQHC, which can provide better patient care, and the ACO, which can achieve better quality and shared savings. Additionally, the financially vulnerable FQHC would be protected from potential losses.
- Different groups of patients have different levels of trust in various aspects of the health care system. For some groups, trust in primary care might be stronger than trust in mental health care. Including behavioral health services as part of primary care services can help leverage the trust in PCPs to address disparities in mental health.
- It takes time to build a program and demonstrate impact. If an organization borrows money for its Medicare Shared Savings Program (MSSP) ACO, the organization should not be required to pay the money back out of its portion of shared savings; CMS and the providers should share this cost.
- Primary care capitation allows organizations to allocate resources and invest in care teams instead of focusing on billable visits.
- Change in scope is an issue for FQHCs and rural health clinics whose focus is primary care. Organizations can appeal to the state if they wish to add specialists to their staff. There is a mechanism in place that calculates how the additional cost impacts the organization's encounter rate.
- Moving away from the fee-for-service (FFS) system toward primary care capitation provides flexibility for organizations to allocate resources and make the best use of the full care team.
- A streamlined, uniform approach to capitation would help move more practices into value-based arrangements more quickly.
- FQHCs face additional complexities in estimating revenue when moving from FFS to value-based arrangements due to the higher proportions of Medicaid, Medicare, and uninsured patients.

Panelists discussed payment mechanisms for transitions between PCPs and specialty care providers. The following are some highlights from this discussion.

- Specialists often do not want to take on the role of a PCP; instead, they want better coordination with primary care.
- When a patient is experiencing a critical illness, specialty care providers may need to lead a patient's care team by helping with referrals and serving as the main organizer of the patient's care. It is important to define expectations and responsibilities for how a patient transitions back to primary care management.
- Before excluding some types of specialists (e.g., cardiovascular surgeons) who do not typically take on longitudinal management of patients, it is important to remember that these types of specialists make decisions that can have a disproportionate impact on total spending. There are models that can hold these specialists accountable not just to quality of care but also to total spending.
- A specialist who is willing to be a primary decision-maker is typically a physician who is managing complex patients with multiple chronic conditions. If a specialist is willing to serve in the primary care role, they should be paid accordingly.

Panelists discussed the use of non-physician resources and teams to facilitate communication between primary and specialty care providers, and whether they are accessing chronic care management billing to support these efforts. The following are some highlights from this discussion.

- In the collaborative care model, non-physician team members, such as nurse care managers and clinical social workers, are used to help with care coordination. Billing occurs within the collaborative care model, and some billing is for care coordination. New York City also helps to fund community health workers who do a lot of non-billable work, such as helping patients navigate the system and helping patients address their social needs.
- It is important to consider patient needs and goals as they navigate the health care system, including transitioning between primary care and specialty care and between inpatient and outpatient care.
- The referral process must be patient-centered and clearly communicated, including why the patient is being referred, the goals for the referral, the role of the specialty care provider, and the process for transitioning care management back to the PCP once the patient is stable.
- The COMPASS model demonstrated that trained community health workers are just as effective as behavioral health clinicians in treating depression in terms of patient and provider satisfaction. Clinically licensed social workers and clinical psychologists can help with behavioral health cases, and e-consults with psychiatrists can be used when medication management support is needed.

Panelists discussed challenges related to data access. The following are some highlights from this discussion.

- Data sources needed for care models based on acute hospitalizations include real-time, continuous data from hospital partners; data from value-based care checklists (including SDOH data); and payer claims. Data connecting acute care and ambulatory care settings are lacking.
- More data on specialty care are needed, but these can be difficult to collect and analyze. Specialist-level spending data that include information on case complexity would assist PCPs in making decisions about specialty referrals in capitated models.
- The MHN receives complete claims data from the payer, and a vendor produces the risk stratification of patients and identifies which patients will most likely benefit from high-risk care management.
- It is important to have clinical data, including acute inpatient episodes, outpatient episodes, and specialty care visits. Risk stratification can identify patients that are more likely to have a future hospitalization. Data on social needs are also used to understand how to stratify patients who are high-risk. Scheduling data are used to understand wait times. One challenge relates to knowing when patients seek care outside of the system.

Panelists also discussed their experience with bundled payments nested within PB-TCOC models or other types of total risk frameworks. The following are some highlights from this discussion.

- The core measure of success for both patients and for managing TCOC is related to managing post-acute care in readmissions. Some types of specialists play a role in managing acute hospitalization; however, from a spending perspective, the largest impact of specialists is not on how efficiently those episodes are delivered, but how many episodes there are. The focus should be on clinical decision-making, such as whether a patient should be hospitalized. This focus is more supported by the incentives in a population-based payment model than by the incentives in an episode payment model.

## Public Comments

Co-Chair Hardin opened the floor for public comments. The following individuals made comments:

- Tom Merrill (Redstone)
- Jennifer Gasperini (National Association of ACOs [NAACOS])
- Amita Rastogi (Independent Consultant)

## Committee Discussion

Co-Chair Hardin invited Committee members to reflect on the past two days of presentations and discussions, noting that PTAC will be issuing a report to the Secretary of HHS to summarize the Committee's findings on delivering and integrating specialty care in population-based models. The Committee members discussed the following topics. The following are some highlights from this discussion. For additional details, please see the transcript and [meeting recording](#) (9:13-49:35).

- Specialists desire better care coordination that might be facilitated in value-based models, but current incentives may not be adequate to encourage specialist participation in these models relative to staying in an FFS system.
- The terminology of "PCPs" and "specialists" is too simplistic for the variety and complexity of work that physicians perform. Instead, a disease-based care model might be the right approach.
- A disease-based care model as identified by cost and utilization factors identified in the Preliminary Comments Development Team's (PCDT's) presentation may help to alleviate potentially avoidable health care costs. However, because such costs would be defined based on data from the FFS system, there will continue to be inequities.
- Patient-reported outcomes are important data points for evaluating the success of a model and should be tied to financial incentives.
- The presentation about Washington State showed that practice transformation can happen, although it is expensive and requires up-front funding through prospective payments. Practices should be assessed for readiness to participate in models and encouraged to take on greater risk as their practice advances. To move toward value-based care, there should be an expectation that models move out of a pilot phase to something more sustainable, which is a challenge that will require greater coordination on rules governing different approaches to payment.
- The presentation about the musculoskeletal model showed that with the right incentives among various collaborators, a model can encourage healthy competition among providers seeking to be considered responsible for the "overall" care of a patient.
- Care delivery and payment models should reflect the vision of the health care system as a continuum rather than as a collection of silos. The current system lacks crucial data to be able to manage patients across this continuum.
- Capacity assessments can assist in gauging the extent to which practices and physicians are equipped to meet expectations built into value-based models and help those who are designing models to better understand how to align incentives with the capabilities of potential participants. Capacity assessments can help to identify when payment mechanisms are more likely to work and why current mechanisms might not be working.
- Risk should be assigned at the entity level in cases where providers are employed or tightly contracted by a risk-bearing entity.
- Payment model design should consider patients and their diseases, rather than providers and their fields of practice. It may be more useful to categorize providers by their main function (e.g., screening, acute care, chronic longitudinal care) rather than their specialty. Complex patient attribution payment models can then be built and deployed based on patient needs and provider

function (i.e., bundles for acute care providers, bundles for providers involved in chronic longitudinal care) regardless of provider specialty.

- Accountable entities can use up-front funding to invest in capacity building that is tailored to their local networks.
- Accountable entities have an important role to play in enabling capacity building financially at the local level for medical neighborhoods. When measuring specialists' ability to improve quality and control costs as part of a continuum of care, it is important to consider that most specialists are not as far along as many PCPs are in the journey toward integrated, value-based care.
- Current models do not take into account preference-sensitive care and as a result do not reward providers for preventing more expensive future care because the FFS system cannot account for avoided utilization. Condition-based payment models may best incentivize chronic longitudinal care through capitated payments specific to care for specific conditions.
- Federal policy should not dictate the level of care where specific incentives rest; payment policies should occur at the local organization level. With appropriate protective measures, risk-bearing entities should decide what payment incentives are best suited for their providers.

Committee members discussed concerns about the potential for underutilization or stinting of care, leading to disparities for certain patients, and potential performance metrics or opportunities that could assist in preventing stinting of care.

- Patient-reported health status may be a way to monitor potential underutilization or care stinting, particularly when aggregated for groups of patients.
- Equity improvement plans hold entities accountable for making progress toward reducing disparities and protecting patients against care rationing.
- Cost efficiency often assumes that less utilization is better, but this assumption can lead to inequitable care and under-provision of care. Past experience with value-based models demonstrates the importance of considering quality and what is equitable.
- Payment models should ensure that specialists performing cognitive services, versus those performing procedures, are funded appropriately to encourage the provision of cognitive services and ensure that procedures do not become the primary source of specialists' revenue.
- It is crucial to analyze data disaggregated by race, ethnicity, and other patient characteristics for use in measuring quality and examining outcomes.
- It is important to provide up-front funding to support technologies such as e-consults and telehealth that can help address barriers such as access and transportation.
- Longitudinal care relationships between patients and their care teams can address barriers of trust and access that can result in a lack of utilization, which can be as important an indicator as high utilization.
- Providers can use data to identify individuals who are not seeking care and conduct proactive outreach to those individuals. Anticipating and addressing symptom and disease management needs and health-related social needs (HRSNs) may require providers to reach out to patients proactively instead of waiting for them to seek care during a health crisis.

Committee members also discussed any additional takeaways that had not already been mentioned.

- Specialist integration will require rethinking how care is delivered, how organizations operate, and how providers communicate.
- Actionable, transferable data are crucial for risk-bearing entities to deliver high-quality care and bring about practice transformation.
- Training and educating providers about how models work is critical for their success.

- High-value care may be rewarded through avenues other than payment. It will be important to define, measure, and value the communication and collaboration that facilitate high-value care, particularly at the practice or plan level.
- Models should aim to improve the experience of the health care workforce to prevent burnout, particularly from the administrative burden associated with participating in complex models.
- PB-TCOC models offer the opportunity for interdisciplinary care teams to devise creative solutions to provide holistic patient care and circumvent workforce shortages.
- Value-based care transformation will require breaking down silos across the health care system.

**Closing Remarks**

Co-Chair Hardin thanked presenters, panelists, Committee members, and the public for their contributions to the meeting. She announced that PTAC will continue to gather information on integrating specialty care into population-based models through a Request for Input (RFI) that will be posted on the [ASPE PTAC website](#) and sent to the PTAC listserv. Co-Chair Hardin noted that PTAC will prepare a report to the Secretary with the Committee’s findings and recommendations from the public meeting.

**The public meeting adjourned at 2:06 p.m. EST.**

**Approved and certified by:**

//Lisa Shats//

5/8/2023

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

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Date

//Lauran Hardin//

5/5/2023

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Lauran Hardin, MSN, FAAN, Co-Chair  
Physician-Focused Payment Model Technical  
Advisory Committee

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Date

//Angelo Sinopoli//

5/8/2023

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Angelo Sinopoli, MD, Co-Chair  
Physician-Focused Payment Model Technical  
Advisory Committee

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Date