PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

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PUBLIC MEETING

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Virtual Meeting Via Webex

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TUESDAY, MARCH 8, 2022

PTAC MEMBERS PRESENT

PAUL N. CASALE, MD, MPH, Chair
LAURAN HARDIN, MSN, FAAN, Vice Chair
JAY S. FELDSTEIN, DO
LAWRENCE R. KOSINSKI, MD, MBA
JOSHUA M. LIAO, MD, MSc
WALTER LIN, MD, MBA
TERRY L. MILLS JR., MD, MMM
SOUJANYA R. PULLURU, MD
ANGELO SINOPOLI, MD
BRUCE STEINWALD, MBA
JENNIFER L. WILER, MD, MBA

STAFF PRESENT

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

A-G-E-N-D-A

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Subject Matter Experts:
- Sherry Glied, PhD; Karen E. Holt; Valinda Rutledge, MBA, MSN; and Christina Severin, MPH

Previous Submitter:
- Jon Broyles, MSc; Gary Bacher, JD, MPA; and Torrie Fields, MPH

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- Gail R. Wilensky, PhD; Jennifer L. Kowalski, MS; Judith A. Stein, JD; and Emily Maxson, MD

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

2 11:03 a.m.

3 * CHAIR CASALE: Good morning, and
4 welcome to day 2 of this Public Meeting of the
5 Physician-Focused Payment Model Technical
6 Advisory Committee, known as PTAC. I am Paul
7 Casale, the Chair of PTAC.

8 * **Welcome and Population-Based Total**
9 **Cost of Care (TCOC) Models Session**
10 **Overview**

11 Yesterday, we began with CMS[1]
12 leadership sharing their strategy for CMS and
13 its Innovation Center, which includes the goal
14 for all Medicare beneficiaries with Parts A and
15 B to be in a care relationship with
16 accountability for quality and total cost of
17 care by 2030. That is one reason we chose to
18 explore population-based total cost of care
19 models as our theme-based discussion for a
20 three-meeting series this year.

21 We had a variety of experts, from
22 academia and payers to one of our own PTAC

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1 Centers for Medicare & Medicaid Services

1 members, Dr. Larry Kosinski, provide their
2 insights on how we can move toward population-
3 based total cost of care models. We learned
4 what the research shows on the impact of
5 population-based models and episode-based
6 models on quality and cost, and where further
7 information is needed.
8 Our guests discussed how population-
9 level efforts can address health equity and
10 what some of the best practices are for
11 improving affordability for patients. We also
12 heard about options for defining total cost of
13 care, state-level innovations, opportunities to
14 align across multiple payers, and how to
15 structure these models so that specialists can
16 participate meaningfully.
17 Also, the team of PTAC members that
18 worked with staff to prepare the agenda and
19 background materials presented information
20 about relevant key issues and how proposals
21 submitted to PTAC incorporated elements related
22 to total cost of care.
23

1 * **PTAC Member Introductions**

2 Because we might have some new folks
3 who weren't able to join yesterday, I'd like
4 the Committee members to please introduce
5 themselves. Share your name and your
6 organization. If you would like, you can share
7 a brief word about experience you may have with
8 population-based payments or total cost of care
9 models.

10 Since we are meeting remotely, I
11 will cue each of you. So I'll start. I'm Paul
12 Casale. I'm a cardiologist, Vice President of
13 Population Health at NewYork-Presbyterian, and
14 I lead NewYork Quality Care, which is the
15 Accountable Care Organization for NewYork-
16 Presbyterian, Weill Cornell, and Columbia
17 University.

18 Next, I'll turn to Lauran.

19 VICE CHAIR HARDIN: Good morning.
20 I'm Lauran Hardin. I'm a nurse and senior
21 advisor for the National Center for Complex
22 Health and Social Needs and the Illumination
23 Foundation. I spent the last 20 years doing

1 care management design under many different
2 value-based payment options and currently work
3 on co-designing models for complex,
4 underserved, under-resourced populations.
5 CHAIR CASALE: Thank you, Lauran.
6 Jay?
7 DR. FELDSTEIN: Hi. My name is Jay
8 Feldstein. I'm President and CEO of
9 Philadelphia College of Osteopathic Medicine,
10 and prior to that, I spent 15 years in the
11 health insurance industry, both commercial,
12 Medicaid, and Medicare.
13 CHAIR CASALE: Great.
14 Larry?
15 DR. KOSINSKI: I'm Larry Kosinski.
16 I am a gastroenterologist, having practiced for
17 35 years. I am the founder and Chief Medical
18 Officer of SonarMD, a value-based transition
19 company in the gastroenterology space.
20 CHAIR CASALE: Thanks, Larry.
21 Josh?
22 DR. LIAO: I'm Josh Liao. I'm a
23 physician and faculty member at the University

1 of Washington School of Medicine, where part of
2 my work is studying and evaluating the impact
3 of payment models on patient and population
4 outcomes.
5 In addition, I am the enterprise-
6 level Medical Director for Payment Strategy for
7 UW Medicine, and in that role I'm fortunate to
8 provide leadership to a number of payment
9 models and arrangements, including total cost
10 of care population-based models.
11 CHAIR CASALE: Great.
12 Walter?
13 DR. LIN: Morning. I'm Walter Lin.
14 I'm an internist and founder of Generation
15 Clinical Partners. We are a medical practice
16 focused on caring for the frail elderly in
17 senior living and helping senior living
18 organizations transition into value-based care.
19 CHAIR CASALE: Thank you.
20 Lee?
21 DR. MILLS: Morning. I'm Lee Mills.
22 I'm a family physician, and I'm Senior Vice
23 President and Chief Medical Officer of

1 CommunityCare of Oklahoma. We operate a fully
2 capitated model across both commercial and
3 Medicare Advantage spaces.
4 CHAIR CASALE: Thank you.
5 Chinni?
6 DR. PULLURU: Hi. I'm a family
7 physician by trade and practicing for about 15
8 years, currently serving to lead Walmart's
9 health clinic outreach and enterprise. And
10 prior to that, I served to lead the value-
11 based-care business line for a large medical
12 group implementing across the risk spectrum, as
13 well as practicing clinically within that risk
14 spectrum.
15 CHAIR CASALE: Great. Thanks.
16 Angelo?
17 DR. SINOPOLI: Angelo Sinopoli. I'm
18 a pulmonary critical care physician -- until
19 just recently was the Chief Clinical Officer
20 for Prisma Health in South Carolina, where some
21 of my responsibilities were our clinically
22 integrated network of about 5,000 physicians,
23 and also was the founder of the Care

1 Coordination Institute.

2 My present role is that of Chief

3 Network Officer for UpStream Healthcare, which

4 is a risk-bearing, value-based organization

5 that partners with primary care docs.

6 CHAIR CASALE: Thank you.

7 Bruce?

8 MR. STEINWALD: Hello. I'm Bruce

9 Steinwald. I'm a health economist in

10 Washington, D.C. I have 50 years of experience

11 in health economics and health policy in

12 academic, government, and private sector

13 settings.

14 CHAIR CASALE: Thanks, Bruce.

15 Jennifer?

16 DR. WILER: Good morning. I'm Dr.

17 Jennifer Wiler. I'm the Chief Quality Officer

18 of UCHealth Denver Metro area. I'm a tenured

19 professor at the University of Colorado School

20 of Medicine, and I'm co-founder of UCHealth's

21 CARE Innovation Center, where we partner with

22 digital health companies to grow and scale

23 their solutions to improve the value of care.

1 My academic area of interest is
2 payment policy, and I was a co-developer of an
3 APM[2] that was evaluated by this Committee prior
4 to me being a member.
5 CHAIR CASALE: Great. Thank you.
6 So, at this time, we'll take a short
7 break to set up for our first listening
8 session, which the Vice Chair, Lauran Hardin,
9 will moderate. So please join us at 11:15. We
10 have a terrific group of guests scheduled for
11 the day. Thank you.
12 (Whereupon, the above-entitled
13 matter went off the record at 11:09 a.m. and
14 resumed at 11:17 a.m.)
15 VICE CHAIR HARDIN: Welcome back,
16 everyone. I'm Lauran Hardin, Vice Chair of
17 PTAC. We have a fantastic group of experts
18 here to present on issues related to
19 population-based total cost of care models.
20 * **Listening Session on Issues Related**
21 **to Population-Based TCOC Models Day 2**
22 We will have our first two

2 Alternative Payment Model

1 presenters present, and then our Committee
2 members will have time at the end to ask those
3 two presenters questions in the Q&A session.
4 Then our remaining three presenters will
5 present, and our Committee members will have
6 time at the end to ask each of those presenters
7 questions in a final Q&A session.
8 You can find all of the presenters'
9 full biographies on the ASPE PTAC website,
10 along with other background information
11 materials for today's meeting.
12 Presenting first, we have Dr. Sherry
13 Glied, who is the Dean of Robert F. Wagner
14 Graduate School of Public Service at the New
15 York University. Please begin.
16 DR. GLIED: Thank you very much, and
17 thank you so much for having me here. I'm
18 going to be speaking at the 30,000-foot level,
19 so maybe it's a good way to frame some of the
20 conversation that comes today.
21 Next slide, please.
22 So our goal here in general is to
23 reduce the cost of care while improving or

1 maintaining health care outcomes. And the way
2 that we think about doing that is to do things
3 like reducing duplication, or monitoring and
4 connecting people so that they avoid increases
5 in severity in the future, or increasing
6 prevention efforts to avoid future care.
7 That is, these are all strategies
8 that focus on the quantity side of the medical
9 cost conundrum. If I were talking about
10 something that was not Medicare, I'd be
11 spending a lot of time talking to you about
12 prices. Since we're talking in a Medicare
13 context, the focus here is around reducing
14 quantities or optimizing quantities.
15 I think it's really important to
16 keep those two ideas very distinct because a
17 lot of the work around cost containment is
18 around the price side, and your goals here are
19 really very much more on the quantity side.
20 And that, I think, is an important distinction.
21 Next slide, please.
22 So we have long thought about this
23 as economists as being about fee-for-service.

1 The reason that we're not getting where we want
2 to be on the cost and quality side is because
3 all of the things that we'd like to do around
4 preventing unnecessary care or avoiding
5 duplication, monitoring -- all of those things
6 are disincentivized under fee-for-service.
7 The more you do, the more you're
8 paid, whether the care is necessary, whether it
9 could have been avoided. And that's why we've
10 moved to this alternative payment mechanism
11 story in the first place. So this is all old
12 history, and you know this.
13 Go on. Next slide.
14 But -- okay -- there is a reason we
15 had fee-for-service, and it's always important
16 when you're moving away from something to think
17 about why it existed in the first place. Fee-
18 for-service has some really big advantages in
19 terms of paying people.
20 It's really easy to monitor
21 performance. It's really easy to know whether
22 something has happened because a payment is
23 clearly tied to a specific patient and a

1 specific process. You can see, if you are an
2 administrator or a bureaucrat, whether that
3 process has happened, whether the patient has
4 been seen.
5 Second, it allows maximal choice by
6 patients of their provider. So it is the best
7 system if you're just going to let people go to
8 see whoever they want. That is an attribute
9 that is highly valued by patients.
10 And so fee-for-service continues to
11 exist when you think about out-of-network
12 payments, even in the private sector, if we
13 think of people going out of network in
14 Medicare. We retain fee-for-service in
15 situations where people are going to any
16 provider they like.
17 Third -- and this is going to turn
18 out to be very important -- it automatically
19 risk-adjusts. If you're dealing with a more
20 severe patient, you get more money. Patients
21 who use more services generate greater payment.
22 And in normal times -- and we're
23 coming out of non-normal times, but I think

1 it's important to remember that so far, our
2 track record has been they happen every 100
3 years -- fee-for-service leaves providers with
4 very little risk. The more they do, the more
5 they get paid. If they do less, they get paid
6 less. They control the amount of risk that
7 they face in their operations.
8 These are very important, valuable
9 properties.
10 Next slide, please.
11 So here's a good question for all of
12 you focused on changing payment systems: how
13 many of these nine countries which we might
14 think of as our peer countries in health care,
15 but who run their health care systems at a
16 much, much lower cost -- right? We know this,
17 and generally have higher-quality outcomes --
18 how many of them use primarily fee-for-service
19 to pay outpatient providers, outpatient
20 physicians?
21 Anyone want to guess? Write your
22 own number down on the panel to see whether
23 you're right. Ready? Okay. Let's reveal.

1 Next slide. Hit the click button.
2 All of those countries are using,
3 basically, fee-for-service in their health care
4 systems to pay outpatient providers. That is
5 the standard way that they're doing it.
6 Next slide, please.
7 Likewise, we talk a lot about global
8 budgets and capitated payment even in the
9 hospital sector. So how many of these
10 countries are using primarily global budgets to
11 pay their hospitals? Again, do your best
12 guess. Go forward, which reveals really just
13 Canada and Sweden. Everyone else is
14 essentially using output-based payments of the
15 kind that we are trying to move away from as a
16 way to pay their hospitals.
17 So I don't say this to justify fee-
18 for-service. That's not what I aim to do --
19 just to say that its strengths are pretty big.
20 That's why lots of countries are using it.
21 That's why they've been used in the past in
22 history.
23 Next slide, please.

1 So let's think about moving away
2 from fee-for-service to alternative payment
3 mechanisms. Let's move to a capitated,
4 bundled, flat-payment component. That's going
5 to generate a new set of problems.
6 We have a much higher burden of
7 monitoring. It is better to measure value than
8 volume, but it's a lot harder to measure value
9 than volume. That's the reality. You have to
10 assign patients to providers. And if you're
11 assigning patients to providers, it creates --
12 can create, doesn't necessarily -- incentives
13 for providers to offload the work they do and
14 the cost of that work to other people.
15 We've seen that, for example, when
16 we moved to managed behavioral health care,
17 which was -- the first big move into managed
18 care was in behavioral health. Behavioral
19 health carve-outs covered talk therapy, and
20 they didn't cover pharmacotherapy. And so we
21 saw these carve-outs essentially pushing
22 patients towards their primary care providers,
23 who provided them with pharmacotherapy that

1 wasn't covered under the contract.
2 Likewise, and in a sort of meta
3 sense, there's been a big push to bundle
4 payment from post-acute care. And we have seen
5 that that works and that there are reductions
6 in the cost of post-acute care, but it may
7 shift the burden of care to families and
8 informal caregiving that we are not measuring.
9 And, in fact, it probably does because we are
10 discharging people home with fewer services.
11 That's not necessarily a bad thing, but we need
12 to be aware of it.
13 Next slide, please.
14 We need a way to risk-adjust because
15 if we don't risk-adjust, providers are
16 incentivized to avoid the sickest patients.
17 Risk adjustment -- I first worked on risk
18 adjustment in 1992. This is a miserable,
19 difficult problem.
20 Every risk adjustment system creates
21 other perverse incentives. Right now, the ones
22 we have create enormous incentives to over-
23 diagnose people, and these incentives are

1 pervasive across the system. And even after
2 you risk-adjust, you have to think about the
3 risk that providers take on when they
4 participate in these systems.
5 And that leads us to move to
6 voluntary participation because it's really
7 hard to force providers to take on risk if they
8 don't want to, and it leads to this
9 multiplicity of models. If you have a lot of
10 different Alternative Payment Models, you are
11 necessarily going to spend more money.
12 Why is that? Because there's a lot
13 of variability in structure and cost to
14 provider organizations. So each organization
15 can select the model that works the best for
16 it, which means it gets the most revenue
17 relative to cost. And that is going to mean
18 that it's going to capture savings that would
19 otherwise accrue to the Medicare program.
20 So each organization has some
21 payment model that would most perfectly fit
22 what it's already doing. And if you move to
23 that payment model, Medicare is going to lose

1 money. It's also really hard to accurately
2 assess the performance of many Alternative
3 Payment Models because of selection problems at
4 the patient and program levels.
5 Next slide, please.
6 So the underlying problem is really
7 tough. A lot of recent economic research looks
8 at the level of inefficiency in the health care
9 system and says, you know, it's actually not
10 that bad. There isn't that much inefficiency.
11 We aren't as much of a mess as we think. We're
12 just as inefficient as the rest of the economy.
13 That means there is lots of reasons
14 to improve processes, just as there are lots of
15 reasons to improve processes in cement
16 manufacturing, which are the ones that people
17 look at, and coffee shops. But these problems
18 are not more pervasive in health care.
19 And that means it's not so easy to
20 fix them, and it's easier to generate positive
21 financial returns by manipulating incentives
22 than by doing really hard work that might
23 improve care, because it's not like it's low-

1 hanging fruit. Improving care is going to be
2 really hard. Manipulating financial incentives
3 is often pretty easy.
4 Next slide.
5 So now we come to this idea of total
6 cost of care, and I have to say I'm on the
7 Board of the Milbank Fund, which has been
8 thinking a lot about total cost of care. And
9 one of the things I've learned about it is that
10 everybody uses that term to mean something
11 different.
12 So I don't know exactly what total
13 cost of care is, but I think the general idea
14 of it is that the unit of analysis is very
15 broad. The best established example of it is
16 Maryland, where you basically take the entire
17 Medicare system, the entire health care system,
18 and you look at the cost of the total cost of
19 care. There are other models at the employer
20 level.
21 I think key features of what this
22 ought to mean is that the population is not
23 discretionary. It is assigned. It is the full

1 population of some unit that is independent of
2 the choice of plan or -- there are no decisions
3 that are made around health care that are
4 around the population that is being considered
5 for total cost of care.
6 So an employer might think about all
7 employees in the firm, or a state might think
8 of all the residents in the state. If you do
9 that, you don't need very sophisticated risk
10 adjustment. You probably can just use age and
11 sex because you're actually looking at the
12 total cost of this entire population.
13 And, ideally, you measure all
14 aspects of the cost of care. So you want to
15 think about the services that are paid for by
16 Medicare. You want to think about all
17 beneficiary out-of-pocket payments. You also
18 probably want to think about things like
19 informal care because if what we're doing is
20 shifting burden to informal care, at least we
21 ought to know that that's what we're doing,
22 whether it's the right thing or not.
23 So some examples going forward --

1 next slide -- Maryland is doing it looking at
2 Medicare beneficiaries, and several states have
3 done it to develop cost-growth benchmarks as a
4 step towards further regulating their health
5 care systems.
6 So Massachusetts has a total cost of
7 care measure. Connecticut has one. Oregon has
8 one. Nevada, New Jersey, and Washington are
9 building these.
10 Yes. Next slide, please.
11 So it's a management tool. It's
12 about selecting -- not avoiding selection, risk
13 adjustment assignment, but it is not an
14 incentive program. It is a monitoring and
15 management tool that the incentives fit within.
16 Do I have any more slides? That's
17 it. Thank you.
18 VICE CHAIR HARDIN: Thank you so
19 much, Dr. Glied. That was very interesting.
20 Next up, we have Karen Holt, who is
21 Vice President of Collaborative Health Systems.
22 Please go ahead.
23 MS. AMERSON: The slides will be up

1 in just one moment. Thanks. It takes a moment
2 to transition.
3 MS. HOLT: (Audio interference) My
4 personal passion has been the opportunity to
5 work with providers in order to help them
6 become successful in managing the care of
7 patients -- good providers who want to do the
8 right thing but don't always have the right
9 tools and technology developed to get them
10 there.
11 Today, the goal of my presentation
12 is really to talk to you about specific
13 opportunities to improve PCPs'[3] ability to
14 successfully manage care coordination in
15 patients.
16 Next slide.
17 So Collaborative Health Systems has
18 been in operation since 2011. We have
19 supported $475 million in savings to the
20 Medicare Trust Fund, to quality and clinical
21 programs for physicians. We have 15 different
22 programs currently today in 22 different

3 Primary care providers

1 states. We're in MSSP[4], Direct Contracting5.
2 We have three IPAs[6] and a Maryland CTO[7] program.
3 We are supporting over 2,000
4 providers, independent providers, and 160,000
5 Medicare patients. Again, the goal of this is
6 really, what are we doing to make sure we're
7 supporting those providers who are independent
8 and being successful in the opportunities of
9 growing and changing medicine?
10 Next slide.
11 As many of you know, administrative
12 and clinical activities of moving value-based
13 care are overwhelming to providers. Increasing
14 financial pressures for the cash-flow
15 challenges -- right -- the cost, technology
16 requirements, are burdens that push many
17 providers into becoming employed.
18 When we see providers become
19 employed, we actually see a change in their --
20 they lose their autonomy for how they practice
21 for -- practice and care for patients, as well

4 Medicare Shared Savings Program
5 Global and Professional Direct Contracting
6 Independent Physician Associations
7 Care Transformation Organization

1 as we know that this change is actually
2 changing the passion for those younger
3 generations to actually move into medicine.
4 So, again, who are we replacing our providers
5 with, or independent providers?
6 Collaborative Health Systems -- you
7 know, it partners with a value-based values
8 coalition that utilizes the Medicare programs
9 to support providers really to be able to move
10 through that risk continuum -- right -- with
11 providing tools, technology, hands-on training,
12 and clinical program implementation to support
13 patients when and where they receive care
14 outside of the practice of the four walls of
15 providers to really be able to drive that
16 value-based care.
17 Next slide.
18 Population health management is the
19 management of patients in all care settings.
20 And the coordination of care requires that we
21 know where patients are and at all care levels.
22 In addition, the successful management of
23 patients with chronic conditions requires that

1 the care is well coordinated between providers,
2 patients, and the care team.
3 This has been a challenge for many,
4 many years. It is not unknown to this
5 organization or to others. But what we do know
6 is that the lack of care coordination costs
7 Medicare billions of dollars of wasteful
8 spending or avoidable complications and
9 hospital readmissions.
10 As well, we all know that care
11 coordination is known -- I apologize. My
12 computer is dinging. Many hospitals, the new
13 requirement for CMS to actually be able to
14 fulfill their ADT[8] roles is requiring those
15 hospitals to be sharing ADT feeds.
16 The challenge with that is that we
17 have providers and groups who are sharing data,
18 but it's not really actionable for these
19 providers. And so we know that they're sharing
20 where a provider can log in to a tool; they can
21 download patients who have admitted into their
22 hospital. And so, gosh, we hope that that

8 Admission, discharge, and transfer

1 patient does remember who their PCP is at that
2 time of admission to really be able to add a
3 username.
4 And again -- so where we see that
5 opportunity is an additional burden, and it
6 requires providers to log in to a tool and be
7 able to know where their patients are instead
8 of being able to have the opportunity to use
9 the technology with algorithms and being able
10 to lift this burden off of providers.
11 As Medicare looks to move more
12 providers into value-based payments, utilizing
13 ACOs[9] as that glide path, we're looking for CMS
14 to support the opportunity to recognize ACOs
15 and IPAs into the payer definition instead of
16 just saying it's a provider who's failed to
17 know when their patients are there -- utilizing
18 these organizations just like they are with
19 health plans, recognizing ACOs and IPAs as
20 being organizations that health care providers'
21 hospitals will actually share that data with
22 directly so that we can support them.

9 Accountable Care Organizations

1 Additionally, we're looking for --
2 it's just not really the hospitals, but really,
3 how do we grow this opportunity for ADT feeds
4 to grow into home health and SNFs[10]? We know
5 that there are organizations like Experian, and
6 patient teams are moving into this opportunity.
7 They're using algorithms, allowing
8 us to use messaging to be able to devise
9 programs so that we're not just communicating
10 with one source, but using real-time data
11 messaging so that we can send messages to
12 multiple places. We'll send it to the
13 hospital, the hospitalist. We'll send it to
14 the home health care company, our care team,
15 the PCP, and outpatient specialist that we know
16 are looking at the claims data that allow for
17 the true care coordination so that all parties
18 know when that patient has admitted into a
19 facility.
20 An additional enhancement would be
21 to really support those -- again, and not just
22 the hospitals, but really using a tool that

10 Skilled nursing facilities

1 allows these algorithms. It is one thing to
2 say that messaging is that we're just sending
3 an ADT feed, but again, that opportunity for
4 real-time data is really the care coordination
5 that allows for us to truly care for these
6 patients.
7 So not just requiring for hospitals
8 to participate with these organizations but
9 allowing the ACOs and IPAs to be a part of
10 that, just like they are with the health plans,
11 right? Touching the right patients at the
12 right time and really giving that care
13 coordination.
14 Next slide.
15 So this is the CHS[11] core model as
16 designed, and this design is really to support
17 providers for what's happening outside its four
18 walls. Again, the point behind this is that
19 really, that our teams, as for those Medicare
20 opportunities through our MSSP, our Direct
21 Contracting, or other type of state programs --
22 opportunities that we're really trying to

11 Collaborative Health Systems

1 support these providers what's happening
2 outside of the four walls of their practice
3 and, again, making sure that we're getting that
4 data back to those providers, so really that--
5 enhancing the practices and their care
6 coordination opportunities.
7 Tools are important, but really, it
8 takes people touching people. And so where
9 we're providing the opportunities for a
10 practice, an independent provider may not be
11 able to afford someone to go to a patient's
12 home. That opportunity that we're allowing for
13 them, really, we need the right level of data.
14 So we know that the significant
15 challenge for us touching the right patients at
16 the right time is the patients who have the
17 highest chronic conditions. They're not --
18 they're moving a lot. They don't have the same
19 phone numbers. There's a lot of changes that
20 are happening there.
21 And so that data that may be in a
22 practice is not always accurate for us to be
23 able to outreach to them. And so really

1 looking for some opportunities for enhancement
2 that, again, that ADT feed for hospitals, when
3 a patient is admitting into those facilities,
4 that they're sharing that level of data with
5 the hospital.
6 How do we make sure that those
7 providers are getting that communication back?
8 Or the patient who has 11 different chronic
9 conditions may not have shared with or been
10 back to see their PCP in the last six months,
11 but they have shared their current address and
12 phone numbers with the hospital system.
13 How do we make sure that that data
14 is actually shared with those organizations,
15 right? Making sure that we're touching the
16 sickest patients and the opportunity to be able
17 to manage their care.
18 Next slide.
19 Great. So thank you, you guys, for
20 your time today and opportunity to share with
21 you the opportunities to grow this program, and
22 the opportunity to increase the care
23 coordination in our ACOs and our IPAs. Thank

1 you.

2 VICE CHAIR HARDIN: Thank you so

3 much, Karen. Very interesting presentation.

4 Now we have about 10 minutes to ask

5 questions. I want to open this up to our

6 Committee members. We have an opportunity to

7 ask questions of Dr. Glied and Karen Holt.

8 Please go ahead, and please remember to unmute

9 yourself as you come forward with a question.

10 MR. STEINWALD: Dr. Glied, it's

11 always a dash of cold water when we look at

12 these international comparisons and realize

13 that what we're attempting to do here is rather

14 contrary to what's done elsewhere.

15 I wonder, though, if it's worth

16 making a distinction -- especially when we look

17 at fee-for-service and how sticky it is, how

18 hard it is to get providers to be willing to

19 unstick themselves -- to make a distinction

20 between how a plan is paid and how the doctors

21 are paid. And can we accomplish much of what

22 we want to do by focusing on the plan as

23 opposed to the individual provider?

1 DR. GLIED: So, certainly, I think
2 that is -- well, first of all, plans are almost
3 always paid by some form of capitation. Right?
4 We pay them a premium. And that's the way
5 we've always paid them. Nobody pays health
6 plans, I think, fee-for-service, although if we
7 make our risk adjustment sufficiently granular,
8 we may almost wind up doing that. But
9 hopefully that's not what we're doing.
10 And I think in those countries that
11 have competing health plans in other countries,
12 they also pay on some form of risk adjustment
13 capitation. I do worry a little bit that our
14 risk adjustment methods generate some really
15 perverse incentives for the plans, and that's
16 something to worry about.
17 But I am with you. I agree. I
18 think that focusing a lot on plans and thinking
19 about letting the plans figure out how to
20 manage within themselves has a lot of positive
21 value. One of the things that I think we have
22 learned is that these micropayment incentives
23 at the level of the provider may be a lot more

1 trouble than they're often worth and that
2 management, in the more conventional sense, may
3 be a better way to address some of the concerns
4 that we have, management including things like
5 buying better data systems and implementing
6 electronic medical records to avoid duplication
7 of care.
8 So I think there are ways to do
9 this. Plans also have more leeway to pick and
10 choose which providers are in them and to look
11 at practice patterns. So yeah. I guess the
12 answer is yes. We economists.
13 CHAIR CASALE: Dr. Glied, thank you
14 for a great presentation. A question -- CMMI[12]
15 has spent a lot of time thinking about how to
16 engage specialists and total cost of care
17 larger population-based models.
18 I'm just curious, in your thinking,
19 whether the approach would be -- create this
20 population-based model, and then under that,
21 the providers and others will sort out how to
22 engage the specialists within that, or having

12 Center for Medicare and Medicaid Innovation

1 more prescriptive models for particular
2 specialties will be a different path for
3 engaging specialists.
4 I'm just curious if you have
5 thoughts as to which approach might be more
6 effective.
7 DR. GLIED: So let me just divide
8 specialists into a couple of categories. I
9 think there are a lot of specialists whose
10 interactions with patients are very episodic
11 and time limited, and they're going to see a
12 lot of patients, and they're not going to
13 establish relationships with them. And their
14 referral patterns are going to be from all over
15 the place.
16 So I think in those circumstances,
17 trying to establish complex payment mechanisms
18 for them may just be very costly in terms of
19 the selection consequences.
20 I think it's actually really hard.
21 I think there are other patients who have
22 ongoing relationships with -- sorry. Other
23 providers, other specialties, have ongoing

1 relationships with patients that last for a
2 while where you might think that a single
3 payment covering a scope of service -- think
4 about OB/GYN.
5 There you've got a very clear path.
6 You're covering this person for -- let's say
7 for a year. And we expect certain things to
8 happen. We have a good sense of what we're
9 looking for. Monitoring is relatively easy.
10 There's a place where I think you have a
11 specialist -- a specialty care scenario that
12 you could think about, on its own, sort of
13 sitting separately, having an alternative
14 payment mechanism for.
15 And I think there's a lot of things
16 that fall between those. And as you are on
17 that continuum, I guess a couple of things I
18 would say is think about how much you are
19 concerned about the downstream communication
20 and interaction.
21 So to what extent is this thing
22 wholly within the province of the specialist,
23 and to what extent is this an interaction

1 across the system? And what incentives and
2 challenges are injected by having those
3 interactions? So do you want them to happen
4 more or less? Do you want your cardiologist to
5 be referring people back into primary care
6 more, or do you want them to be taking on care
7 more?
8 And those sort of subtleties are
9 going to color how you think about the
10 alternative payment mechanism there and whether
11 you want to do it entirely from, well, let's
12 just give the primary care doctor the
13 capitation and let them figure it out with the
14 specialist or let the health plan deal with
15 both of them, or is it actually worth coming up
16 with a separate alternative payment mechanism
17 for, say, a cardiologist who's in regular
18 contact with a patient? And it's very granular
19 in that way.
20 VICE CHAIR HARDIN: Very helpful.
21 Karen, I'm very curious, as a
22 follow-on question to that, what have you
23 learned about in practice about bridging those

1 relationships that is really key and really
2 makes it a very effective system?
3 MS. HOLT: We do have a few of our
4 ADT providers that are providing us
5 notification through -- for SNF, home health,
6 as well as in the hospitals. And what we've
7 found is when we're comparing the patients who
8 are admitting into facilities where we have
9 those notifications, that that continuum for us
10 in being able to manage that patient all the
11 way through -- we see a higher success rate in
12 making sure that we're managing the readmission
13 when we know that they were in the hospital.
14 We know where they went to SNF.
15 We can make sure that we're
16 supporting that they get the right care at home
17 to make sure that they're not readmitting and
18 that that success rate is twofold in being able
19 to make sure that we're managing the cost of
20 that patient.
21 So really looking at that
22 opportunity to be able to grow that initiative
23 for the CMS ADT piece, as it's not just the

1 hospitals. But let's also make sure that that
2 algorithm and being able to have the tools and
3 technology to really be able to score is not
4 just, let's go look for the patient. Let's
5 make sure that there's automation. We're in a
6 world with technology with artificial
7 intelligence.
8 Let's make sure that everybody knows
9 at the same time by being able to write the
10 right type of messages. So we know that it has
11 been successful in really managing that care
12 and keeping readmissions from happening, and
13 truly unnecessary readmissions.
14 DR. KOSINSKI: I'd like to ask a
15 question of Karen. I enjoyed your
16 presentation. How do you maintain patient
17 engagement in your care coordination, and how
18 successful have you been?
19 MS. HOLT: So how -- it's truly --
20 in our matter, there is the reality that we can
21 only touch a certain level of patients, and how
22 we're keeping them engaged in sort of an
23 educational opportunity -- it’s what we're

1 doing with our providers and a masked
2 opportunity to be able to send out education
3 for disease management outside of what's
4 happening in a practice, but really looking at
5 how can we touch those type of chronic
6 conditions?
7 And so there's only an opportunity
8 to manage a certain level of patient at these
9 areas. And so it is using our care
10 coordinators, outreaching to them proactively
11 before they're admitting, using our tools to be
12 able to -- what we call percolate who has the
13 highest opportunity of readmission by looking
14 at their data and making sure that we're
15 proactively getting them into educational
16 opportunities, hoping that we're going to teach
17 them about how to manage their diabetes, manage
18 their ESRD[13].
19 Are they on that continuum moving
20 into ESRD -- to outreach to them to get them to
21 the right level of care.
22 DR. KOSINSKI: Thank you.

13 End-stage renal disease

1 VICE CHAIR HARDIN: We have time for
2 one more question.
3 (Pause.)
4 VICE CHAIR HARDIN: Dr. Glied, I'm
5 very curious how you think about managing
6 carve-outs of value-based payment.
7 (Simultaneous speaking.)
8 DR. GLIED: Managing carve-outs?
9 VICE CHAIR HARDIN: Mm-hmm.
10 DR. GLIED: Is that -- the audio was
11 funny. So I think the total cost of care
12 vision is actually really important there
13 because carve-outs do have these incentives to
14 shift care back into the main contract, and we
15 definitely observe that. And incentive is
16 strong.
17 And wherever it's possible to do it,
18 you can expect the carve-out to be going there.
19 So, I mean, some of this is about who is
20 managing the full contract, and how are they
21 monitoring those places where you might see
22 something happening under the carve-out?
23 A lot of this is just keeping your

1 eye on the ball and being really thoughtful
2 about monitoring a full population and not just
3 that aspect of the contract. So if I think
4 about this total cost of care idea really as
5 being sort of an overarching monitoring tool,
6 why are my costs not going down when the carve-
7 out seems to be spending less money?
8 If the carve-out says that they're
9 spending less money but my costs are not going
10 down in total -- so what's happening here?
11 VICE CHAIR HARDIN: So helpful. And
12 I thank both of you for this rich conversation
13 and information. We really appreciate you
14 joining us today.
15 Our next presenter -- we're going to
16 move to the next section. Our next presenter
17 is Valinda Rutledge, the Chief Corporate
18 Affairs Officer at UpStream.
19 Please remember to unmute yourself,
20 and please go ahead.
21 MS. RUTLEDGE: Great. Thank you.
22 Well, first of all, I'd like to
23 thank PTAC for inviting me to present at this

1 session. I feel very honored to have the
2 opportunity to share my thoughts and experience
3 with this group.
4 Just for background, I'm a nurse --
5 nurse practitioner -- and was a health system
6 CEO for 15 years before Rick Gilfillan and Don
7 Berwick persuaded me to come into CMMI as a
8 founding leader with CMMI. I was one of the
9 leaders that helped write the Bundled Payment
10 for Care Initiative, so I never know whether I
11 should apologize for that or not.
12 I was most recently the EVP of
13 Federal Affairs for America's Physician Groups,
14 where they have over 300 practices with 200,000
15 physicians that are committed to value-based
16 health care. I interacted with many of those
17 practices and began to understand firsthand
18 their challenges in trying to implement total
19 cost of care risk-based models.
20 Just a month ago, I joined UpStream,
21 which is a global value-based risk organization
22 that is focused on supporting primary care
23 through this transition. My presentation will

1 focus on the barriers that are found in the
2 adoption of total cost of care model focused on
3 the primary care practice.
4 So, with that, if you could move to
5 the first slide.
6 So the first slide sort of talks
7 about UpStream, three components of it. And
8 this is from my experiences working with APG[14]
9 over the last four and a half years.
10 We have embedded pharmacists and
11 care coordinator nurses physically in the
12 office, and we also have extended services such
13 as integrated pharmacy that can dispense it
14 with home delivery. Many of these patients
15 with chronic disease, as you know, medication
16 and medication adherence is really a problem.
17 The physicians - get guaranteed
18 advance payments for quality. These payments
19 start where they're at from a quality
20 perspective. So if they're at a four-star now,
21 we pay them a certain amount, and as they move
22 up, we expect them to be a five-star or 4.5,

14 America's Physician Groups

1 probably within six to seven months.
2 We take all the contract risk
3 through substantial capital investment. We
4 feel comfortable with that because we have a
5 model that we think is very successful and has
6 been shown to be successful in the areas in
7 which we have implemented.
8 We have a technology that, of
9 course, goes ahead with it, and we have seen
10 significant improvements in patient outcomes
11 and satisfaction with this model we're
12 implementing.
13 So next slide.
14 So the next -- I'm going to talk in
15 terms of the barriers that I have seen in
16 talking to hundreds of practices over the last
17 four years in terms of adoption and total cost
18 of care, as we recognize 70 percent of Medicare
19 beneficiaries have at least one chronic
20 disease. And they account for 95 percent of
21 the Medicare spend.
22 However, most of us in the industry,
23 including myself as a health system CEO, really

1 focused on the specialist and really focused on
2 the inpatient. Thus primary care is the engine
3 behind care transformation. But we have not in
4 this country put dollars and resources into
5 primary care.
6 The adoption in value-based models
7 has been very slow with primary care. And in
8 fact, anything, it has been the specialists
9 that sort of have been knocking on CMMI's door
10 in terms of getting episodic payments.
11 The primary care physicians have
12 been somewhat reluctant to enter a value-based
13 model. Now, over the last few years, we've
14 seen that change because there have been
15 aggregators that have come forward in terms of
16 helping them support the risk involved.
17 So the barriers can be put into four
18 categories, in my estimation. The first one is
19 financial. The second one is our current
20 payment models. The third is the lack of
21 integrated team approach. And the fourth is
22 the adoption of technology.
23 So the first one, both -- Sherry

1 shared with this -- is the losses of taking on
2 total cost of care and having downside risk go
3 straight to the personal income. So, if any of
4 us really believed in something and we wanted
5 to do it for our patients, but we had a worry
6 that it would actually impact our personal
7 income and our family's income and our ability
8 to provide resources for our family, we would
9 probably be reluctant with that. And that's
10 what we're seeing.
11 Second is, when you look at their
12 percent of business, the traditional Medicare
13 percent of business for most of primary care
14 practices, this is only 15 to 20 percent. So
15 you're talking about taking a personal risk on
16 your income on a small piece of your business.
17 Even if you may philosophically believe in it
18 and not believe that fee-for-service is the way
19 to go -- but to take on that risk for small
20 amount of your business is very, very
21 disturbing.
22 Also, we don't have a proven care
23 model. It's not like clinical practice, in

1 which there are best practice standards and
2 they follow them. In their estimation,
3 everything seems to be experimental. We know
4 some things work in terms of decreasing post-
5 acute care.
6 But in terms of really knowing that
7 if I follow A to Z, it's going to make a
8 difference in terms of the overall utilization
9 in that patient, makes them -- they're not sure
10 that that is out there. And so that makes them
11 feel uncomfortable.
12 And there's the cost of the initial
13 infrastructure. For them to enter into it,
14 they need the cost of the initial
15 infrastructure. Now, CMS has tried to overcome
16 that by putting some PMPM[15]s in it on the front
17 end. But again, it's not like someone hands
18 you a million dollars or 500,000 on the front
19 end to set up care coordination teams. They're
20 going to give it to you on a PMPM, but for you
21 to be effective, you've had to develop a team
22 approach.

15 Per-member per-month

1 The next is the fee-for-service.
2 And Sherry was talking about this. The fee-
3 for-service is the underline of everything.
4 And for the exception of a few codes, which I
5 will be talking about, it represents billable
6 time from work done by a single provider.
7 And so it is not set up for team
8 codes other than care coordination, management
9 codes, TCM -- Transitional Care Management,
10 advanced care planning. Those kind of codes
11 are set up as team codes. For the most part,
12 our fee-for-service codes are the work done by
13 a single provider.
14 And even the advanced ACO models
15 like ACO REACH[16] -- how they set up the
16 capitation is they take your fee-for-service
17 codes that you have embedded -- that you send
18 no claims code into the MAC[17] to determine what
19 your capitation amount will be for the next
20 year. So we're saying we want to get away from
21 fee-for-service, but fee-for-service becomes
22 the infrastructure of how we build the new

16 Realizing Equity, Access, and Community Health
17 Medicare Administrative Contractor

1 model with capitation.
2 This year, I can give you a good
3 example of how, suddenly, we're doing both
4 things at the same time. We're saying -- CMS
5 is saying I really, really support value-based.
6 We need to move away from fee-for-service.
7 However, there is a code called a
8 split visit code, which is if a physician is
9 seeing patients in a facility and they're
10 working with a non-provider practitioner like a
11 PA[18] or an NP[19], nowadays what they've -- they
12 modified the code. And so the code is now put
13 in at who spends most time with the patient.
14 So, if the non-physician provider,
15 the NP and PA, spent more time with the
16 patient, then they put in the code at 85
17 percent of what the code would be, the E&M[20]
18 code. If the physician spends the majority of
19 time with the patient, then it's put in at 100
20 percent. But they're working as a team.
21 They're working as a team.

18 Physician assistant
19 Nurse practitioner
20 Evaluation and management

1 The split visit code decides whoever
2 spends most time with that patient and does not
3 recognize the team approach. So we continue to
4 say we want to get away from fee-for-service,
5 but everything we have is built on individual
6 clinical encounters for an individual provider.
7 Second, we have an inability to
8 connect the dots between coordination of care
9 codes, CCM[21], TCM, remote patient monitoring,
10 advanced care planning -- these are rarely used
11 by the primary care practice, really rarely
12 used.
13 In fact, I asked one of my friends -
14 - has one of the largest primary care practices
15 in an area, very complex patients. He's very
16 experienced, and he really believes in value-
17 based. And I asked him, how many times does he
18 bill under CCM? He says, not a single time.
19 He does not bill at all under CCM,
20 and I asked why. And he says, because it seems
21 so complex; there's so many requirements to
22 bill under that. So, in fact, CMS increased

21 Chronic Care Management

1 the rates for CCM to improve adoption. And so
2 the workforce shortage has continued to limit
3 the use of that.
4 The next is the adoption of
5 technology. We're having difficulty in
6 independently applying technology. The
7 practices modified their face-to-face
8 interaction into virtual during the pandemic,
9 but they continue to lag in the adoption of new
10 technology.
11 So next slide. I'm going to go
12 through quickly in terms of the solutions.
13 The first solution is to increase
14 incentives. We need the development of more
15 independent primary care groups. We need to
16 look at tax or financial provisions to help
17 them set up their practices.
18 We need to engage patients as
19 partners, to develop compacts and contracts
20 with those patients, in which patients sign
21 saying, I agree to this care plan, and this as
22 a position is what I am supporting.
23 We need to reduce regulatory

1 requirements. We get waivers through total
2 cost of care models, but they're burdensome in
3 terms of documenting. We need blanket waivers
4 with minimum burdensome documentation. We need
5 the funds to address social determinants of
6 health, and we've talked about different ways
7 to do that.
8 We need to minimize the risk by
9 having the benchmark modified for the high
10 performers. They did that in Pathways to
11 Success. They have a greater weight on
12 geographic with the high performers. However,
13 the most you can get is a 50/50 weight.
14 We need education and technical
15 assistance programs, including a central
16 repository for independent docs to go in and
17 identify best practices. And we need financial
18 support for them to develop or buy analytic
19 tools as independent physicians.
20 And then, last, we have to overcome
21 the inertia. I wouldn't say lower the fee-for-
22 service schedule. I would say adjust it so we
23 accelerate the movement to value. Maybe go
24 back and relook at that split visit code and

1 say, if you're in a risk-based contract, we're
2 going to look at it in total when you get 100
3 percent if you're working together.
4 And then strengthen the architect of
5 the MIPS[22] program. The MIPS program, as this
6 PTAC is aware, has become very, very minimal in
7 the impact to move people to value. And most
8 of it is because there's very little penalties,
9 and everyone uses the uncontrollable
10 circumstances.
11 And the 5 percent advanced APM bonus
12 goes away December 31st, 2022. Congress is
13 aware of it. They would like to make a change
14 and continue it, but we must maintain that.
15 So, with that, thank you.
16 VICE CHAIR HARDIN: Thank you so
17 much, Valinda. That was very interesting.
18 Next up is Christina Severin, who is
19 President and CEO of Community Care
20 Cooperative.
21 So, Christina, please unmute and --
22 MS. SEVERIN: Can you hear me okay?

22 Merit-based Incentive Payment System

1 CHAIR CASALE: Yes, we can hear you.
2 MS. SEVERIN: Thank you. Thank you
3 for having me here today. Happy to bat
4 cleanup.
5 As introduced, my name is Christina
6 Severin. I'm the President and CEO of
7 Community Care Cooperative, or C3, as we call
8 ourselves. We are an FQHC[23]-based nonprofit
9 organization, and we are headquartered out of
10 Massachusetts, doing business in Massachusetts,
11 mostly in a Medicaid ACO but also some Medicare
12 ACO and some commercial, and now have
13 diversified our product offerings to also offer
14 Federally Qualified Health Centers, the Epic
15 EHR[24], in addition to other shared services.
16 Next slide, please. Next slide.
17 So a little bit of background on
18 health centers and on us. We were formed in
19 2016 in response to the Massachusetts Medicaid
20 program, which is known as MassHealth, moving
21 from our traditional MCO[25] model to an
22 Accountable Care Organization model.

23 Federally Qualified Health Center
24 Electronic health record
25 Managed Care Organization

1 In 2018, we launched the full
2 program with 15 FQHCs and 110,000 members. And
3 in '19, we grew to 17 health centers and
4 125,000. And today, we have -- can't quite
5 keep the PowerPoint current; 18 is now 20 FQs.
6 We have about 200,000 members and three risk
7 contracts. And, as mentioned, we're also now -
8 - we have licensed the Epic EHR, which -- all
9 of you, I'm sure, are familiar enough with the
10 market to understand that the Epic product, has
11 been a hard product for FQHCs to be able to
12 obtain.
13 So we used our -- the same C3
14 playbook of if we bring independent FQHCs
15 together, we can leverage our scale to make
16 things possible that have not been possible in
17 the past. This has been true with risk-taking
18 on total cost of care in the core ACO business,
19 but also, now, the other accoutrements that are
20 coming along with this business, such as being
21 able to license down Epic.
22 Next slide.
23 This is our vision, mission,
24 strategy, and core values. I'm just going to

1 read the strategy. So this is a trifecta
2 strategy for C3. It's focused on uniting FQHCs
3 at scale in order to transform primary care,
4 improve the financial position of health
5 centers, and advance racial justice at health
6 centers, at C3, and in society.
7 Next slide.
8 As a reminder, there is very strong
9 evidence to support that health centers
10 outperform other primary care settings on
11 quality and on total cost of care. This slide
12 is about quality, and it is a reminder that the
13 publicly available data concludes that health
14 centers outperform the rest of the national
15 market on two quality measures here.
16 One is patients with hypertension
17 whose hypertension is well controlled, and
18 people with diabetes whose hemoglobin A1C is
19 being successfully controlled.
20 And then on the last section of the
21 slide is the third quality metric on this
22 slide, which is about patient satisfaction,
23 where health centers also outperform the
24 market. You can see the first line is users

1 satisfied with hours, 96 against 37, FQ to
2 nation. And the second one is overall
3 satisfaction with care, 98 against 87, FQ
4 against national respectively.
5 Next slide.
6 This slide is complex. No worries.
7 I'm going to talk you through the punch line.
8 I said health centers outperform the national
9 market on quality and cost. Prior slide was
10 quality. This one is cost.
11 This was a study published in the
12 American Journal of Public Health, November
13 2016. The study examined two cohorts
14 prospectively over time. The study was looking
15 at total cost of care. The study found that
16 the cohort who got their primary care in an
17 FQHC had total cost of care that was about 24
18 percent less expensive than the total cost of
19 care in any other primary care setting.
20 This article was actually published
21 right when we were in the middle of starting up
22 the company. So, as you can imagine, this was
23 a thesis that we were working off of, and this
24 was very reassuring as we were getting ready to

1 embark on a total cost of care journey.
2 Next slide.
3 So how we got started. Next slide.
4 So this was a group of health
5 centers at the beginning. This was a start-up
6 nonprofit. We had zero dollars in our bank
7 account, and so we needed to develop a plan.
8 And so part of the plan -- we were looking at
9 bidding on a five-year contract that had a
10 total cost of care with corridors that expanded
11 over time.
12 For example, this year, we're in the
13 last year of this five-year contrast. We will
14 renew it. This year, our total cost of care
15 exposure is 100 percent up/down, two-sided.
16 We knew going into this -- my
17 background is I ran a different ACO for a
18 Harvard teaching hospital system. I ran a
19 Medicaid health plan. I worked in public
20 hospitals, and I worked in FQHCs. So I knew
21 that we needed to have a way to harness lots of
22 different data assets. Some of those data
23 assets have been discussed by other panelists
24 today.

1 Our data assets include we harvest
2 all clinical data from EHRs at night. We get
3 these so-called ADT transactions in real time.
4 Refresh three milliseconds throughout the day.
5 We have paid claims files from all of the
6 carriers that we do business with, including
7 Massachusetts Medicaid.
8 We have member self-reported data.
9 We have SDOH[26] data. We normalize and harmonize
10 all of that data in an enterprise data
11 warehouse, and that is the big data set that
12 allows us to do lots of things like a rules-
13 based approach to workflow automation,
14 stratification, performance analytics,
15 research, et al.
16 Next slide.
17 This is just a pictorial of that.
18 The circle is around the enterprise data
19 warehouse, and you can see these are the data
20 assets that are coming in to the enterprise
21 data warehouse, FQHC clinical data, hospital
22 ADT data. We have national feeds from Quest

26 Social determinants of health

1 and Labcorp. We have the paid claims data.
2 And as stated, we have member self-reported
3 data.
4 Interestingly, we also do business
5 with a BH[27] carve-out. I wasn't planning on
6 mentioning it, but since it was raised by other
7 panelists, I will mention it. That was a blind
8 spot. We were not getting ADT transactions
9 there.
10 We were able to work with that
11 behavioral health carve-out who issues prior
12 authorizations for inpatient stays -- inpatient
13 behavioral health stays. We're able to work
14 with that BH carve-out to translate that prior
15 authorization transaction essentially into a
16 hospital admit ADT ping. So we're able to have
17 a real-time BH inpatient census based on that
18 unique transaction.
19 Next slide.
20 As mentioned, when we were a start-
21 up, we had zero dollars in the bank. And this
22 shows you coming into year one. We had to come

27 Behavioral health

1 up with a little bit over 14 million in order
2 to prove to our regulators -- and in
3 Massachusetts, there are many financial
4 regulators -- that if we had a bad outcome on
5 this total cost of care contract in terms of
6 incurring deficits, that we had the financial
7 wherewithal to repay those liabilities.
8 And so we used a multifaceted
9 approach to be able to sort of have a portfolio
10 strategy to skin the cat on coming up with that
11 14 million, as displayed here in this
12 waterfall. So we bought excess loss insurance
13 that covered about five million of that.
14 We have a system of responsibly
15 sharing risk with our provider organizations,
16 our FQs. We're going to talk about the details
17 of that in a moment. That moved five and a
18 half million off of our balance sheet. We had
19 a partner who was offering us a service, a
20 vendor who was willing to take a little bit of
21 risk, that underwrote about a million.
22 That left us with 2.7. The contract
23 with Mass Medicaid did come with some financial
24 support, and we were able to meet that 2.7

1 through the contract. This was good enough for
2 our actuaries to sign off on our repayment
3 mechanisms and to pass muster with the many
4 regulators, including Mass Medicaid in
5 Massachusetts.
6 Next slide.
7 Similar to other panelists today, we
8 also have a model of care. Four core
9 components. A lot of detail. Of course,
10 within the four of these, not planning on
11 talking about them today. Of course, happy to
12 take any questions on our areas of practice
13 transformation, pop health care management, and
14 the miscellaneous things we do.
15 I would say of all of the things
16 that we do, focusing on closed-loop referral
17 for social determinants of health and practice
18 transformation are probably the most
19 existentially powerful in terms of trying to
20 make real change in this local health care
21 ecosystem.
22 Next slide.
23 So going to move to wrap up now on
24 how it's going. Next slide.

1 As you can see here, things have
2 been good for us financially, and we've
3 outperformed the market.
4 Next slide.
5 The growth in our balance sheet --
6 you know where it started, at 55. I think,
7 actually, right now, it's at 58. So things are
8 good.
9 Next slide.
10 Growth in membership has also been
11 excellent.
12 Next slide.
13 As mentioned, we have these other
14 business lines, Epic and pharmacy services.
15 Next slide. Next slide.
16 In closing, I would say -- we'll
17 make this the last slide -- that we agree that
18 getting off of the fee-for-service chassis is
19 existentially important. Is primary care
20 capitation perfect? No, it is not. But all of
21 our health centers very much agree that it is a
22 more progressive way to embed prospective
23 payment, even if it's not a prospective payment
24 on the entirety of total cost of care.

1 So we are moving to primary care
2 capitation. We hope to have 80 percent of our
3 visits in primary care capitation by the end of
4 next year.
5 Thank you very much.
6 VICE CHAIR HARDIN: Thank you so
7 much, Christina. As our last presentation, we
8 now have some representatives of a previously-
9 submitted proposal, to the PTAC. We have Jon
10 Broyles, CEO of the Coalition to Transform
11 Advanced Care; Gary Bacher, Chief of Strategy,
12 Policy, and Legal Affairs, Capital Caring
13 Health; and Torrie Fields, Chief Executive
14 Officer of Votive Health. C-TAC submitted the
15 advanced care model, ACM, service delivery and
16 Advanced Alternative Payment Model in 2017.
17 Please go ahead and remember to unmute yourself
18 as you present.
19 MR. BROYLES: Thank you. I'm going
20 to do some framing at the outset and then turn
21 it to my colleague, Gary Bacher, who was part
22 of the team from 2017 that submitted and spoke
23 before the PTAC. C-TAC is a large alliance of
24 nearly 200 organizations. You may not know C-

1 TAC but you likely know our members, AARP,
2 American Heart Association, American Hospital,
3 large systems and health plans. And our focus
4 is on transforming the experience of the
5 patient and family from the point of diagnosis
6 through to the end of life. So we're here
7 speaking on behalf of the patient and family.
8 Next slide, please.
9 So our story today begins, you know,
10 from 2017 where we were last before the PTAC,
11 and two things happened after that. One is you
12 asked a lot of great questions, tough questions
13 that helped us refine our proposal. We worked
14 with the American Academy of Hospice and
15 Palliative Care, directly with CMMI to advance
16 key elements of the proposal that we reviewed
17 with you into new payment models and heavily
18 informed the CMMI primary care's initiative so
19 number one, thank you for your feedback and
20 know that you are having impact.
21 The second thing is that we had a
22 realization that as sophisticated as the model
23 of care that we submitted was, it wasn't enough
24 -- next slide, please -- because to really

1 reach those who are completely outside the
2 system, we have to work not just through
3 Medicare eligible providers but really
4 intentionally, in partnership with the
5 community. And that brings us to the story of
6 Shirley Roberson. Shirley was a colleague of
7 mine, a friend, in fact, and recently a board
8 member of C-TAC. She lived with advanced
9 cancer for over a decade, and during that time,
10 she really taught us that trust is key, the
11 relationship with the patient is the key to the
12 entire discussion around total cost of care.
13 And really, she -- it was during many ups and
14 downs, many challenges with social isolation,
15 challenges with transportation, food, pain for
16 her that her cancer was causing, that her faith
17 community really stepped up. And Shirley would
18 often say to me, "When you feel like giving up,
19 it's the community that's going to keep you
20 going." And that's always stuck with me.
21 And now she thought of community as
22 including her oncologist who would not just
23 help her with her pain but also remember to
24 give her a hug and check in and see how her

1 heart was doing. But it also included their
2 agency on aging and included her church,
3 Hartford Memorial Baptist. And I think as we
4 think about where to go next, where the
5 greatest opportunity for innovation lies, we
6 believe that it's reaching those who are
7 completely outside the system, those who have
8 been underserved for too long, and those who
9 need investment and trust and trusted
10 relationships.
11 So as we think about how to get
12 there, we have to think seriously about
13 investing in the organizations that folks like
14 Shirley believed in, not just as a charity, not
15 just as community benefit but as true partners
16 as we move this $4 trillion health system that
17 we have towards more person-centered care.
18 And I'm going to turn it to my
19 colleague, Gary Bacher, to talk about some of
20 the practical elements behind our
21 recommendations there.
22 MR. BACHER: Great. Thank you, Jon.
23 So thank you again for having us. It's a
24 pleasure to get to come before the panel again.

1 As Jon mentioned, we got to do this a few years
2 ago.
3 There are a couple of important
4 themes to pull through that came from the
5 earlier discussion with the PTAC, and I had the
6 pleasure following our PTAC presentation to
7 actually become the Chief Strategy Officer for
8 CMMI and help oversee the architecting and
9 development of a wide range of the models that
10 are being used today. I think there are two
11 important themes that emerge kind of from the
12 conversation we had with the PTAC earlier and
13 part of our work today. So one is we're strong
14 believers in the power of total cost of care
15 for a lot of the conversations that have been
16 conducted today. But it's also important to
17 ask about total cost of care for who and to
18 think about the different subpopulations that
19 are being served under any particular model to
20 make sure that things, in a sense, don't get
21 over-averaged, so paying attention to important
22 subpopulations, not necessarily carving them
23 out but being aware in model design that if
24 you're taking care of a substantial portion of

1 people that are of a particular subpopulation,
2 it may be important to kind of make sure that
3 the model parameters are flexible enough that
4 it can accommodate those populations to make it
5 feasible to successfully serve those people.
6 Second point is -- has to do with
7 nested models, and I say this all the time.
8 One of the things that I remember from the PTAC
9 discussions was the discussion around does it
10 make sense to have broader nested models or
11 standalone models. And the idea as we talked
12 about -- at the time, we were proposing a model
13 to focus on the seriously ill, which really did
14 inform a lot of CMMI's work. And one of the
15 discussion points was, well, why would you want
16 a standalone model to focus on the seriously
17 ill if you already have many longitudinal total
18 cost of care models where their incentives are
19 already being placed to actually focus on the
20 seriously ill, people with advanced illness?
21 And we thought and we still think that that's
22 actually a very, very valid point, but there
23 are also some issues where if build it or --
24 they won't necessarily come.

1 And so one of the questions is how
2 do you really have the right balance between
3 broader population-based models where you are
4 creating the right incentives or even minimum
5 requirements to be able to offer certain kinds
6 of services, a minimum of services, for
7 instance, that should be used to make sure that
8 everyone that has serious illness receives the
9 right care, how do you do that, and balancing
10 between a nested design where you have that as
11 part of a broader longitudinal model versus a
12 standalone model.
13 And our view is in general, we
14 should try to avoid -- and I'll use the term
15 disintermediating those that would be taking
16 total cost of care and total quality
17 responsibility for a population but at the same
18 time, you want to make sure that there are for
19 those patients that are not going to be aligned
20 to some kind of a longitudinal model, that
21 there is, for instance, a standalone
22 opportunity so they can receive services that
23 are important to their care.
24 And then another point that we've

1 taken away is really systematically identifying
2 and addressing and assessing populations'
3 needs. And Jon made this point very well. The
4 importance of actually focusing on those around
5 people that are giving them the support, and so
6 really honing in on caregivers who do amazing
7 work but recognizing that they suffer a great
8 burden and how can we, in the different models,
9 actually, for instance, do a better job of
10 supporting caregivers.
11 That leads to the final point which
12 is how do we do a better job of bridging the
13 divide between health care in the community,
14 the divide that Jon spoke about. And if you
15 think about our models, most of them really
16 have a sort of a medical provider construct to
17 them. So very typical in a model, there will
18 be a participant provider and a preferred
19 provider, but we don't really have formal room
20 for the community in our models. And so
21 beginning to think about how do we do that and
22 how do we actually create new infrastructure on
23 the ground. Sometimes we refer to it as a hub
24 or a marketplace where we can, for instance,

1 bring together health care organizations and
2 community-based organizations and provide
3 support for those community-based
4 organizations, whether it's with contracting or
5 data management and reporting.
6 And then finally, the one hard issue
7 we're going to have to address is ultimately
8 how do we pay for these services, because if
9 we're talking about Medicare beneficiaries,
10 Medicare has a big gap in terms of its
11 coverage. And that's because it really doesn't
12 pay for non-medical services. It doesn't
13 really have a clear payment stream for services
14 that meet people's social determinants of
15 health. It doesn't have a payment stream that
16 meets what in the Medicaid world, what we would
17 call long-term services and supports. And it
18 doesn't really have payments for long-term
19 care. And so we really have to begin to figure
20 out, given those deficits and those caps, how
21 do we, for instance, find ways to pay for
22 services that would close the gaps that people
23 have. And a lot of that, I think, begins with
24 bridging the design between the health care

1 world and the community.

2 So with that, I'm going to turn it

3 back to the panel. Thank you very much for

4 having us.

5 MR. BROYLES: And I'll just say, to

6 end our presentation, that we've included two

7 emerging community-led models that are

8 partnering with health systems in the appendix

9 of our slides, the Alameda County Care

10 Alliance, and the Coalition for Serious Illness

11 Care in Arizona. So thank you.

12 VICE CHAIR HARDIN: Thank you so

13 much, Jon and Gary. You can tell from these

14 presentations, we've covered a lot of really

15 rich and interesting ground. I'm going to open

16 it up now for the Committee to ask questions.

17 You can raise your hand to be added to the

18 queue, but please go forward Committee members.

19 MR. STEINWALD: I'll start. Jon and

20 Gary, as I recall your 2017 proposal, one of

21 your objectives was to break down the silos

22 between curative and palliative care. Have you

23 been able to accomplish that in the work that

24 you've been doing in the places where you're

1 operational?
2 MR. BROYLES: That's a great
3 question, Bruce. I'd say it's an ongoing
4 journey, but we have made lots of progress, and
5 we'd like to share what we've learned with you.
6 I turn to Gary to comment and then we also have
7 our colleague, Torrie Fields, who has been
8 working on this issue really closely at the
9 operational level. And Torrie, maybe you can
10 speak to this after Gary.
11 MR. BACHER: So one thing I'll
12 mention, there's actually a couple of the
13 models that CMMI has put in place that directly
14 address the idea of concurrent care. So two
15 examples of that would be in both Direct
16 Contracting of what will become the REACH ACO
17 Model, and then also in the Kidney Care Choices
18 Model, there's actually a concurrent care
19 hospice waiver. And a lot of that inspiration
20 really came from the idea that we should be
21 looking at ways to make it easier for people at
22 the periphery to be able to access hospice and
23 a lot of that, you know, there also has been
24 the Medicare Care Choices Model, or MCCM, which

1 was designed also sort of to test what the
2 effectiveness of being able to provide people
3 some degree of conventional care in addition to
4 supportive care. So there have actually been
5 several models that have moved in the direction
6 of trying to provide more flexibility for
7 concurrent care, and I think it'll be really
8 important to see what those lessons are.
9 So in the KCC Model and Direct
10 Contracting Model, the KCC or the DCE, can
11 allow the beneficiary to continue having
12 Medicare pay for conventional services while
13 the beneficiary actually elects hospice. And
14 that's one of those waivers that's built into
15 each of those models. But Jon, I'll turn it
16 over to you and Torrie to provide some
17 additional perspective.
18 MR. BROYLES: Torrie?
19 MS. FIELDS: Sure. Thanks for
20 having me today. My background is largely in
21 the private sector and also in the Medicaid
22 Managed Care space. And from that perspective,
23 there's been a lot of movement since 2017
24 really looking to build out more holistic

1 models and concurrent models for people with
2 serious illness. So the Blue Cross Blue Shield
3 plan has spent a lot of time really working on
4 this and embedding palliative care services or
5 advanced care planning into their Accountable
6 Care Organization models to require that these
7 populations are then assessed for different
8 services and are actually being delivered those
9 services like palliative care and hospice.
10 And those models are largely on a
11 sub-delegated arrangement where there is an ACO
12 who is actually paying a per enrolled member
13 per month for those services, and they're
14 included in total cost of care. There is a
15 paper that just was recently released about the
16 California model, and the five health plans who
17 actually delivered palliative care services
18 across this model all saved money but also
19 improved population outcomes. They also proved
20 that you could have a multi-payer collaborative
21 across the states and do the same thing. So I
22 think that's also worth noting.
23 And on the Medicaid side, there are
24 now two states who are implementing palliative

1 care benefits as a concurrent care model both
2 for adults and for kids, California being the
3 first one that did that on a state mandate
4 through legislation. Hawaii is working now on
5 submitting a state plan amendment that includes
6 palliative care as a benefit. If that gets
7 approved, then there are multiple states' state
8 Medicaid programs who are looking to do the
9 same thing. And as part of that, what we have
10 to do and what my team has done for some of
11 those state Medicaid agencies is to actually
12 look at their total population, stratify them
13 based on their risk and their need, and
14 actually look at that seriously ill population
15 differently to determine what the gaps are in
16 their care.
17 So there has been a lot of momentum
18 and movement on the private side, and as Gary
19 was saying, in the model side, but value-based
20 insurance design for hospice is also an
21 additional place where the carve-in is being
22 tested and health plans are testing palliative
23 care services with that.
24 VICE CHAIR HARDIN: Thank you so

1 much, Torrie. I'm going to go next to Larry
2 Kosinski with his question.
3 DR. KOSINSKI: Thank you. I have a
4 question for Valinda. The CCM codes have not
5 had traction for their entire existence, but
6 there was a change in this -- in the last
7 year's final rule that opened up opportunities
8 for PCM[28] codes. And we're seeing independent
9 companies develop products now around the
10 promotion of PCM codes, so we should expect to
11 see an increase in their use.
12 The problem I have with this, these
13 are not first dollar claims. Patients are
14 going to be hit with deductibles and copays --
15 MS. RUTLEDGE: Yes.
16 DR. KOSINSKI: -- on them, and I
17 don't know how you place -- I'm interested in
18 your input -- I don't know how you insert a PCM
19 or CCM code into the chronic care of a patient
20 when they're going to get hit with monthly --
21 MS. RUTLEDGE: Right.
22 DR. KOSINSKI: -- copays and hits in

28 Principal Care Management

1 their deductible. I just don't see it as a
2 solution.
3 MS. RUTLEDGE: Right. There have
4 been several medical associations, and
5 certainly APG was one of them, in which we
6 pushed for CMS to not have that be one of the
7 copays like annual wellness visit, do you mean,
8 is not a copay and yet it's classified, Larry,
9 under that. If you look under, you know,
10 clinical code services in which you have ACP,
11 you know, advanced care planning, PCM, CCM,
12 annual wellness visit, you are exactly correct.
13 That should have no copay.
14 And, you know, I think that is an
15 opportunity for advocacy. I do know that there
16 are some physicians that have said, I feel
17 guilty, you know, doing a CCM code and charging
18 the patient 20 percent. We have found there is
19 success and decrease in hospitalizations and
20 readmissions using the code, so you're exactly
21 correct. I think it is an effort of CMS not to
22 have it on one of the lists of no copay.
23 MS. FIELDS: If I may add, Valinda?
24 Can I just add? On the advanced care planning

1 component of that, the copays have been a huge
2 deterrent for people with serious illness. And
3 what we're finding is that 50 percent of the
4 population who have an advanced care planning
5 billing code dropped is by a specialist outside
6 of the annual wellness visit. So the initial
7 intention of trying to couple these things with
8 primary care or an annual wellness visit just
9 really has not worked out.
10 VICE CHAIR HARDIN: So helpful.
11 Chinni, you're next.
12 DR. PULLURU: Now my question is for
13 Christina. You spoke about sort of some of the
14 quality as well as economic value in your
15 organization, and what I wanted to ask is how -
16 - what is your strategy for managing
17 specialists as well as post-acute spending?
18 How do you bring them into your total cost of
19 care methodology?
20 MS. SEVERIN: Yes. I mean figuring
21 out how to engage specialists in the total cost
22 of care methodology is a -- it's a difficult
23 nut to crack, so I will not tell you that we
24 have completely solved that. I would say that

1 when we look at the patient population, the
2 needs of the patient population, the resulting
3 spend pattern by major category of service that
4 the majority, because -- and our biggest ACO
5 product line which is Medicaid -- of course, in
6 Medicaid, you know, 80 percent of what shows up
7 as health care need is not pathology -- not
8 clinical pathology-based, it's not about
9 physical health.
10 But in some respects, in the
11 Medicaid population, some of those really
12 difficult to solve issues with specialists are
13 slightly less germane. Probably the best
14 example is the need for access to the
15 specialist under the behavioral health
16 umbrella. This is a place where health centers
17 and organizations like health centers have some
18 advantage, because there is a lot in the
19 behavioral outpatient continuum of care that
20 may reside inside of the FQHC, access to
21 ongoing therapy, integrative behavioral health
22 clinicians and psychiatrists who do
23 prescribing, that it's all part of primary care
24 team. So that sort of building out what lives

1 under the house of primary care and making that
2 increasingly expansive has been a good way to
3 address some of these specialty issues by no
4 longer really classifying them as specialty in
5 bringing them into the primary care home.
6 Another idea that we have been
7 working and we're testing with regards to all
8 of the other specialists is the use of
9 telehealth, both e-consult, so asynchronous e-
10 consult where it's clinician to clinician via
11 email essentially using e-consult as a primary
12 modality to get the need met around specialist
13 care with, of course, then an exit ramp for
14 individuals who need face-to-face specialist
15 care immediately or where the e-consult has
16 determined that the patient now needs a visit
17 with the specialist.
18 In certain markets, the other thing
19 that we've been able to do when we find that
20 there's a significant difference in the quality
21 of specialty services is redirect care over to
22 a different system. This is not done through
23 traditional methods of network management or
24 prior authorization. This is really done with

1 speaking with clinicians and having clinicians
2 develop different patterns of referrals based
3 on where they are most comfortable having their
4 patients go. Getting back to the issue of
5 trust, we find that the best way to advise
6 patient -- to have patients go to preferred
7 specialists, if you will, is through the
8 clinician, the PCP, the behavioral health
9 provider, the nurse practitioner, et cetera,
10 having more of a clinical comfort with those
11 particular specialists and developing those
12 relationships.
13 VICE CHAIR HARDIN: Thank you so
14 much, Christina. Walter, you're next.
15 DR. LIN: Thanks, Lauran. So this
16 is a question for Valinda. Valinda, on your
17 solution slide, you mentioned the idea of
18 curating a central repository, which is
19 actually very timely as this committee was only
20 this morning discussing the development of a
21 library of care transformation and practice
22 redesign best practices garnered from, you
23 know, other disease-specific and episode-based
24 kind of models like the oncology care model and

1 the ESRD care model.
2 My question is how has UpStream
3 populated its essential repository with
4 strategies and best practices and disseminated
5 these practices to its participating providers?
6 MS. RUTLEDGE: Yes. So I'm going to
7 defer the question since I've only been in
8 UpStream for a month; okay? So can you ask me
9 that question in about six months; okay?
10 DR. LIN: Fair enough. Okay. Thank
11 you.
12 MS. RUTLEDGE: I can answer it from
13 an APG perspective that, you know, we tried
14 through a lot of webinars and having a central
15 repository in the website to be able, because a
16 lot of our members were independent practices,
17 and they had very little access to know what
18 was working. They weren't a part of large
19 organizations that big health systems could
20 purchase to be able to go in, so we tried to
21 provide that. But certainly having a national
22 database that would be open to everyone would
23 be optimal.
24 VICE CHAIR HARDIN: Thank you,

1 Valinda. Jennifer, you're next.
2 DR. WILER: Thanks to all of our
3 presenters for excellent presentations. My
4 question is going to be for Christina, although
5 a number of you have talked about this issue.
6 My question is around -- Christina, impressive
7 results with your organization. And being a
8 risk-bearing entity, I was wondering if you
9 could address the two specific concerns that
10 we've heard regarding barriers to participating
11 and total cost of care programs. One is the
12 infrastructure cost, so you describe an
13 impressive data analytics program and plan,
14 which I am assuming required a lot of capital.
15 And then also this concern around diminishing
16 returns in a program around performance and how
17 you thought about those not only in developing
18 your program but also in maintaining the
19 successes you've seen.
20 MS. SEVERIN: Yes. So on the first
21 one, barriers to entry because of
22 infrastructure costs, there are definitely
23 infrastructure costs. I would say initially
24 for us, based on our scale and start-up, we had

1 to spend approximately $5 million in building
2 infrastructure.
3 One of the ideas that we have put
4 forward -- and this comment is particularly
5 relevant to entities in the health care market
6 who have traditionally had less access to
7 capital because perhaps they're a safety net
8 organization, or they are a 501(c)(3), or there
9 have been other constraints on building up the
10 balance sheet that some of these programs, both
11 local programs that might be run by local
12 Medicaid authorities or commercial carriers, or
13 federal programs also come with start-up
14 capital. When you think about sort of the
15 intricacies of risk-based capital and
16 requirements that the Department of Insurance
17 will have on an HMO[29], this is based on how much
18 risk the HMO is bearing. When an HMO gets
19 involved in doing business with a provider
20 organization on total cost of care, this is a
21 risk transfer.
22 So I think that one could argue that

29 Health maintenance organization

1 a source of start-up funds for building
2 infrastructure would be the health plan sort of
3 having a redistribution of the risk-based
4 capital that has been held against that account
5 before it was a total cost of care risk account
6 over to the provider organization who wants to
7 enter into risk as a capital investment in that
8 organization's ability to build their
9 infrastructure.
10 On the second point around the law
11 of diminishing returns for high performers,
12 it's a really, really important point. In the
13 Massachusetts Medicaid program, the state has
14 taken some very good steps, not that it
15 couldn't go further, and we advocate for it
16 going further, in having a market blend into
17 the development of benchmark so that if we are
18 beating the market, right, and we're managing
19 that in our own experience, that we have a way
20 of having a blend of our experience with the
21 average cost of what's happening in the market
22 so that it has the ability to lift up our
23 budget. This has been critically important to
24 us at this point in the program given our

1 success. If we could choose, we would choose a
2 purely market-driven rate. So I think that
3 that is a way for that to happen across the
4 board locally, nationally, public payers,
5 private payers to be able to have higher
6 performers choose between experience-rated
7 benchmarks or market-rated benchmarks or a
8 blend.
9 VICE CHAIR HARDIN: Thank you so
10 much, Christina. We have one more question
11 from Paul. This has been really rich
12 discussion. I'm sure we could talk for hours.
13 But Paul, can you ask our final question before
14 we go to the break?
15 CHAIR CASALE: Yes. Thank you, and
16 I also want to thank all the presenters for
17 those great presentations. This question is
18 for Valinda. And Valinda, I know -- well,
19 first, let me say I'm grateful for your work
20 for BPCI[30] because in my former role leading
21 population health in a tertiary community
22 hospital with multiple specialty groups, I saw

30 Bundled Payments for Care Improvement

1 firsthand the engagement of the specialties in
2 BPCI, BPCI the classic, and then with advanced.
3 So I think we've learned a lot for --
4 absolutely.
5 So now as we're thinking towards
6 these population-based total cost of care
7 models, and I know you've been involved in some
8 of these listening sessions, and I'm sure
9 you've been thinking a lot about it, I guess my
10 question is, still, and from your perspective
11 and in your roles how best to engage
12 specialists going forward as we move to these
13 larger total cost of care models?
14 MS. RUTLEDGE: So, you know, Paul, I
15 really believe that episodic payment models are
16 the best for specialists and you need them, or
17 you're just not going to get the level of
18 engagement that you need in terms of moving
19 them to value-based. Total cost of care models
20 are the ultimate way that we need to be there.
21 I have recommended that they really
22 look and look at lessons learned. Particularly
23 in APG, we have a lot of members that were out
24 in California that have had decades of

1 experience in terms of taking capitated
2 delegated risk in the MA[31] population. And as
3 they took it, they started with different
4 relationships with the specialists. The
5 specialists, they would do things like, you
6 know, you have to meet a time, a framework, or
7 a service, or patient satisfaction to get on
8 the list. And they found that that was just
9 not enough, that they actually had to figure
10 out a way to sub-cap it or look at a bundle
11 payment with them.
12 And I had recommended to CMMI that
13 you take the lessons from that. And so whether
14 that ends up being nesting, does it end up
15 being something that's a blend of both but
16 certainly, I think the specialists need to have
17 one, an episodic payment to be engaged, and
18 two, the overall platform in terms of total
19 cost of care does not -- they are not engaged
20 in an ACO. So somehow I think take the lessons
21 that have decades of experience and sub-capping
22 and having the specialists be their partners in

31 Medicare Advantage

1 that and not treat them in terms of
2 commodities, unless you achieve these service
3 goals, we're going to kick you off the list,
4 you know. That didn't work. It doesn't work
5 with anyone. People want true partnerships.
6 CHAIR CASALE: Thank you.
7 VICE CHAIR HARDIN: What a great
8 note to end on. Thank you so much, Valinda.
9 My great thanks to each of you, each of our
10 experts for sharing your time and experiences
11 with us. At this time, we'll take a break
12 until 10:15 a.m. Pacific, which is 1:15 p.m.
13 Eastern. We'll return with a roundtable panel
14 discussion, and I hope to see you then. Thank
15 you all so much.
16 (Whereupon, the above-entitled
17 matter went off the record at 12:51 p.m. and
18 resumed at 1:16 p.m.)
19 * **Panel Discussion on Definitional**
20 **Issues Related to Population-Based**
21 **TCOC Models**
22 CHAIR CASALE: So welcome back. I'm
23 excited to kick off our afternoon panel. I
24 think all of our panelists have their video

1 turned on and are ready to go. So to further
2 inform us about issues related to population-
3 based total cost of care models, we've invited
4 a variety of esteemed experts from across the
5 country. They represent many points of view,
6 including providers, payers, academic policy
7 researchers, and patient advocates.
8 This morning we learned about a
9 handful of specific initiatives and some
10 research findings. I think these panelists
11 will offer some additional perspectives that
12 will help us explore our theme. PTAC members,
13 you'll have an opportunity to ask our guests
14 questions as well.
15 The full biographies of our
16 panelists can be found on the ASPE PTAC website
17 along with other materials for today's meeting.
18 So I'll briefly introduce our guests and their
19 current organizations. First, we have Jennifer
20 Kowalski who is the Vice President of the
21 Public Policy Institute at Anthem. Dr. Emily
22 Maxson joins us from Aledade, where she is the
23 Chief Medical Officer. Next, we have Judy
24 Stein. She is an Executive Director and

1 Attorney at the Center for Medicare Advocacy,
2 which she founded. And lastly, we have Dr.
3 Gail Wilensky, an Economist and Senior Fellow
4 for Project HOPE.
5 So, let's get started. In Medicare
6 Alternative Payment Models, all Medicare Part A
7 and Part B services are typically included in
8 benchmarks labeled "total cost of care." Based
9 on your experience, what types of services are
10 typically included in this calculation, and
11 what kinds of additional services could be
12 appropriate for inclusion in future population-
13 based total cost of care models, and what would
14 be the rationale for including this? Dr.
15 Wilensky, I'd like to start with you.
16 DR. WILENSKY: The costs that are
17 included are the costs that are part of Part A
18 and Part B. Therefore, you would include
19 hospital inpatient and outpatient. You would
20 include physician expenditures. More recently,
21 txhetxhe use of both outpatient, as well as
22 inpatient, prescription drug expenditures.
23 The question that has been around
24 for a long time is that there are a variety of

1 services that are not included in Part A or
2 Part B. Some of them are included in Medicare
3 Advantage plans, vision, and some of the
4 hearing, or alternative health types of
5 payments. And one of the questions that has
6 been raised is should the definition be broader
7 to include health care that is not a part of
8 traditional Medicare, or should it be focused
9 primarily on traditional Medicare as that which
10 is under the direct purview of the CMS and
11 Medicare programs?
12 CHAIR CASALE: Great. Thank you,
13 Gail. Jennifer?
14 MS. KOWALSKI: Sure. Thank you very
15 much for having me today. And at Anthem, we're
16 using these models in both the Medicare space
17 as well as the commercial space, so I might
18 offer sort of a little bit higher level
19 approach to this. We sort of think about it in
20 two prongs when we think about, you know, what
21 services or what spending should be included in
22 a total cost of care model.
23 And I would describe the first prong
24 as sort of what degree control does the

1 provider have over impacting the services or
2 spending to be included? So for instance, if
3 you want to think about prescription drugs, if
4 you think about a primary care provider, what
5 levers do they have to control the spending on
6 the drugs that are prescribed outside of their
7 office? So if there's a whole set of
8 specialists that an individual might see
9 outside of that provider's office, you know, do
10 they have any degree of control over what's
11 being prescribed and, you know, the costs of
12 those drugs? And in some cases, the answer to
13 that is no, and so perhaps it doesn't make
14 sense to include that in the total cost of care
15 benchmark. On the other hand, you may have
16 contractual alignment between a PCP and a group
17 of specialists, you know, probably more common
18 in some of the fully capitated models where the
19 PCP can build out a specialist network. And in
20 that case, perhaps it does make more sense to
21 hold the PCP accountable for the drug spending
22 in those scenarios.
23 And likewise, when we start to think
24 about some of the non-medical benefits that are

1 being added to help plan benefit designs today,
2 so if you start to think about transportation
3 or some of the things to address health-related
4 social needs like maybe a patient with COPD[32]
5 needs an air conditioner, for instance. Should
6 the PCP be on the hook or accountable for, if
7 you will, those types of costs as part of a
8 total cost of care calculation? And again, I
9 think the answer goes back to what sort of
10 control does the provider have over the
11 spending on those types of services? Is the
12 plan largely, you know, the one making the
13 decisions about who gets what and when and to
14 what extent, or is the provider, you know,
15 maybe a large health system that said, hey,
16 give us a care management fee that includes,
17 you know, some of these services, and as part
18 of that management, we want to be the ones to,
19 you know, provide transportation or to provide
20 and address some of these social drivers of
21 health type things? And in those cases, you
22 know, it probably does make more sense to

32 Chronic obstructive pulmonary disease

1 include that in the total cost of care measure.
2 And I think related to this is the
3 second prong which is, you know, what level of
4 capabilities and services does the provider
5 really have to support the patient population,
6 to support a clinically complex population, and
7 so how much financial risk can you expect the
8 provider to take on for that set of services?
9 And then I just want to address,
10 before I wrap up on this question, you know, to
11 some extent, the services and components that
12 are included in total cost of care models have
13 to differ across payers, across lines of
14 business. So if we go back to the prescription
15 drug example again, if you think about the
16 commercial insurance populations of a large
17 employer group population, in a fully-insured
18 product, individuals generally get their
19 medical and drug benefits from the same health
20 plan. So we can put the drugs in the total
21 cost of care calculation for those individuals.
22 But in self-insured employer arrangements, more
23 commonly, employers kind of break up who
24 manages which parts of the benefit. So you may

1 have a health plan managing the medical side,
2 but you may have a totally separate PBM[33]
3 managing the drug side. And so operationally
4 speaking, it's much more difficult to include
5 drugs in the total cost of care calculation in
6 those cases. So I think we'll get into some of
7 this in the second question, but there is some
8 variability for a variety of reasons.
9 CHAIR CASALE: Great. Thank you,
10 Jennifer. Judy?
11 MS. STEIN: Yes. Thank you, and
12 thank you for having me today. I don't pretend
13 to be an expert in total cost of care economic
14 issues. My expertise is in 36 years of
15 representing Medicare beneficiaries. So from
16 the beneficiary's point of view, all these
17 models are, at best, confusing and not
18 understood. And it is increasingly concerning
19 the incredible number of mergers of large
20 health organizations. In Connecticut, we have
21 -- for example, where my organization is based,
22 in both Connecticut, Washington, D.C., and then

33 Pharmacy benefit manager

1 attorneys around the country. But increasingly
2 our health care is run by two very large
3 hospital organizations which have kind of eaten
4 up primary care practices, SNFs, nursing homes,
5 and home health agencies. And that tends to
6 limit access to care for beneficiaries, for
7 patients, to those affiliated providers.
8 So I'm concerned that the continued
9 look to total cost of care as has been
10 experienced within these large affiliated
11 hospital systems and as understood or
12 experienced, I should say, within Medicare
13 Advantage by beneficiaries, has not been shown
14 to increase quality or choice, real choice
15 between -- by beneficiaries to access to a full
16 range of providers that they might want to see
17 and that they can understand from the beginning
18 of the year to the end will be available to
19 them both within the geographic area and in the
20 Medicare traditional world versus Medicare
21 Advantage throughout the country.
22 So I'm very interested in what the
23 risks, if you will, quote, unquote, are to
24 beneficiaries and what the advantages are to

1 patients and will they pan out in practice
2 because finally, I'll say that the appeal
3 system, the review systems, the ability to
4 speak directly to providers versus, in Medicare
5 Advantage, the Medicare Advantage plan, and now
6 to the AI[34], the proprietary entity that may be
7 making determinations regarding coverage, has
8 become more and more opaque even for
9 professionals who represent beneficiaries.
10 So there are some warning signs that
11 this is not the way to add to choice or quality
12 of care for the people who need it. Thank you.
13 CHAIR CASALE: Thanks, Judy. Emily?
14 DR. MAXSON: Thank you. I just want
15 to emphasize the Part D question. We at
16 Aledade bring together previously unaffiliated
17 primary care practices and form Accountable
18 Care Organizations and help them succeed in the
19 transition from fee-for-service to value-based
20 care. And we're managing contracts beyond
21 Medicare, including Medicaid and commercially
22 insured patients. And so what we find is that

34 Artificial intelligence

1 there is an amazing amount of appropriate
2 pharmaceutical stewardship to be had. And if
3 we don't include Part D prescriptions in total
4 cost of care, we miss out on the opportunity to
5 shed light on that and to bring that management
6 that can benefit patients to bear.
7 We do this for commercially insured
8 patients, and there are a lot of generic
9 opportunities for switching that bring lower
10 cost share to the patient, and I do think that
11 beneficiaries could benefit. I know that it's
12 administratively complex, but it may be worth,
13 if we're considering different services to
14 carve into total cost of care and include that
15 aren't there already, it may be worth figuring
16 out that administrative complexity so that we
17 may better manage Part D prescriptions and
18 their associated costs.
19 CHAIR CASALE: Great. Thanks,
20 Emily. I'll now open it up to PTAC members for
21 any follow-up questions. You can either raise
22 your hand or simply start speaking.
23 As you're thinking about potentially
24 some questions, just to add on to this Part D

1 question because, Jennifer, you had mentioned
2 primary care, if they don't, if it doesn't
3 appear they have sort of control over the
4 drugs, you know, maybe it doesn't make sense
5 for them to be accountable. You can think of
6 oncology as an example. But on the other hand,
7 as they're thinking about total cost of care
8 models in general, it seems that it becomes
9 more complicated if you sort of parse it by,
10 you know, sort of drug categories or specialty
11 categories. So -- and Emily, you may have --
12 and others may have a comment as well about
13 this, particularly around Part D, which is
14 something we talked about yesterday, as well
15 with some of the panelists. I'm just curious
16 your further thoughts on that.
17 MS. KOWALSKI: Yes. I think that's
18 a great point, and I don't want to give the
19 impression that we never include drugs. We
20 certainly do --
21 CHAIR CASALE: No.
22 MS. KOWALSKI: -- in some of our
23 models. I think the other thing to note is
24 that in total cost of care models, cost is not

1 the only metric, right? There's a whole set of
2 quality measures as well. And so, while you
3 may not necessarily be holding a provider
4 accountable with spending, you may still be
5 holding them accountable on things like
6 medication adherence or generic utilization or
7 things that are more easily, you know, measured
8 or that they can be, you know, more accountable
9 for without the financial risk so tightly tied
10 to it. So I think there are multiple ways to
11 sort of come at some of the same aims, and it
12 doesn't always necessarily need to be part of
13 the cost of care benchmark.
14 DR. WILENSKY: I think you need to
15 be careful about what happens to the costs that
16 are excluded. I am sympathetic to having costs
17 included that are outside the control of a
18 particular group or payer. But to the extent
19 that these are significant costs, and the
20 example of oncology drugs certainly would be
21 one of those examples, you really then are
22 finding yourself excluding what might be the
23 determinative factor of real importance in
24 total cost of care. And so I think that it is

1 -- it's not obvious which way you are better
2 off in terms of understanding what the
3 variations in total cost of care are and who
4 would be accountable if not putting it in the
5 single metric.
6 CHAIR CASALE: Any other comments
7 before we move to another --
8 DR. MAXSON: Sure.
9 MS. STEIN: Yes. Oops, excuse me.
10 DR. MAXSON: Oh, please. After you.
11 MS. STEIN: Let me explain one area
12 of Medicare and health care where there's kind
13 of a total cost of care that we're, at the
14 Center for Medicare Advocacy, very familiar
15 with. Both -- well, the models are both at the
16 nursing home/SNF level and at the in-home
17 health.
18 Let me talk about home health for a
19 minute. In January 2020, the patient-driven
20 grouping model came in, PDGM. It pays the
21 agencies now for 30 days or six and -- we'll
22 say 30 days for all the care that is provided
23 to Medicare beneficiaries under -- that are
24 available under the Medicare program. So it's

1 one payment, one type of payment based on the
2 various services that are received by the
3 beneficiary.
4 What will happen sometimes very
5 often is that you follow the money, so it used
6 to be that people could get home health aides
7 which are part of that pocket of services that
8 are available under Medicare, as well as
9 therapy and nursing which are also coverable.
10 But as the payment system came into
11 play, we found more and more that the services
12 were not provided or were provided at the
13 beginning of service which the agencies are
14 paid more for or for people who have
15 hospitalizations, because they're paid a little
16 bit more for that. And then as the 30 days
17 went on, they did not necessarily receive the
18 full package of care that had been ordered by
19 their doctor.
20 And very concerningly, increasingly,
21 even before COVID, there were less and less
22 home health aides available and therapy because
23 the agencies are no longer paid more under this
24 payment model to provide those services.

1 So an err of caution with regard to
2 what is included in this total cost of care and
3 is it truly the care that is then going to be
4 provided to the beneficiaries in need.
5 CHAIR CASALE: Yes. Thank you.
6 Before moving to Emily, on that note -- and you
7 brought this up initially around certainly the
8 -- a lot of confusion potentially for
9 beneficiaries -- any thoughts on how best to
10 inform beneficiaries about their choices or
11 when, you know, they may now be in a total cost
12 of care model moving forward?
13 MS. STEIN: As you may know, most
14 beneficiaries, if they're in a Medicare
15 Advantage plan, don't make a choice after their
16 initial decision. That's according to the
17 Kaiser Family Foundation. Between 20 to 30
18 percent never make a change. Twenty percent of
19 those who are in such plans didn't choose but
20 were set in such plans by their former employer
21 or their -- sometimes the state or
22 municipality. It's very hard because the plans
23 aren't standardized. I think standardizing
24 choices may not be popular in some areas but

1 for beneficiaries, it's very, very important.
2 You can choose Medigap plans much more easily
3 because there are not 50 of them. For most
4 people, there are a dozen, and they are
5 standardized. I think that's important.
6 Cutting down on what's allowed to be
7 marketed versus people getting education from
8 the Medicare agency is important. Having
9 clarity with regard to what's an ACO, what's a
10 Medicare Advantage plan. I mean there are just
11 so many myriad models these days, it is, in
12 fact, very confusing. And I think that's part
13 of the problem that professionals need to take
14 into consideration, because it gets to a point
15 where -- I'll give you an example. Two years
16 ago I was asked by my daughter to go to the
17 store and get some granola bars for my
18 grandchildren as they were coming to visit. I
19 stood in front of the granola bars and realized
20 there were dozens upon dozens of granola bars.
21 I had no idea if these kids preferred the chewy
22 kind, whether the parent did or didn't want
23 chocolate chips in them, et cetera. It may
24 sound like a silly metaphor, but we need to

1 understand that choice -- there's a book called
2 Paradox of Choice by a professor at Swarthmore
3 -- this is an increasing problem. It is
4 difficult to make a choice. And when there is
5 so much choice, the average beneficiary has 39
6 MA plans alone to choose from this year, it's
7 almost impossible to properly educate, and I
8 consider that my organization's job in part.
9 Thank you.
10 CHAIR CASALE: Yes. Thanks, Judy.
11 Appreciate that. Emily, I don't know if you
12 want to make some comments on the--
13 MS. STEIN: Well, I can wait for the
14 next question. It's really--
15 CHAIR CASALE: Okay. Great --
16 great. Thank you. Okay. So next question, do
17 you think there should be a single standardized
18 definition of total cost of care in future
19 population-based total cost of care models, why
20 or why not? So this time, Jennifer, we'll
21 start with you.
22 MS. KOWALSKI: Okay, great. Thank
23 you. I think I probably hinted at my answer to
24 this one in my response to the first question a

1 bit but no, I don't think there should be or
2 really can be a single standardized definition
3 for total cost of care, at least not if we're
4 thinking about, you know, there's going to be
5 one thing that applies to every plan and every
6 provider and every line of business out there.
7 And, you know, this is for, to some extent,
8 some of the reasons I started to get into in
9 the previous discussion, you know, there's
10 different degrees of provider readiness in
11 terms of taking on some of this risk. There's
12 different expectations and different incentives
13 that we might want to put in place in terms of
14 providers' ability to be accountable for
15 services and spending. There's different
16 benefit structures across employers, across,
17 you know, Medicare versus Medicaid versus
18 commercial and so forth.
19 In addition, I'd note that like in
20 our experience, particularly in the commercial
21 space, we have a starting point. You know,
22 there's sort of a template that we use for
23 these types of models but, you know, if you
24 think about the large self-insured employers,

1 you know, they're -- they have a desire to
2 customize sort of every aspect of their
3 benefits, including, you know, what these sort
4 of models look like. Sometimes large health
5 systems, you know, are far more advanced on
6 these sorts of value-based arrangements. They
7 want to be able to customize to their own
8 particular capabilities. And so there needs to
9 be some room. You know, there needs to be some
10 room for that. There needs to be some room for
11 innovation, but there certainly does not need
12 to be unlimited variation.
13 I think we can probably think about,
14 you know, grouping providers or grouping lines
15 of business into, you know, kind of a couple of
16 situations of, you know, how much risk can they
17 take on, what suite of services might they be
18 accountable for, able to take control for, and
19 at least have some, you know, commonalities and
20 starting points across, you know, some, you
21 know, x number of groupings for instance.
22 CHAIR CASALE: Great. Thanks,
23 Jennifer. Emily?
24 DR. MAXSON: I'll take the opposite

1 perspective. I would love to see a single
2 standardized definition of total cost of care,
3 especially for Medicare models and across
4 Medicare models. I think that using multiple
5 versions of total cost of care ends up creating
6 the possibility that providers are needing to
7 choose between models. And sometimes they
8 would opt to do this based on perceived
9 favorability of the benchmarking, which gets
10 you into an arbitrage situation rather than
11 really focusing on the tools that they need to
12 transform care.
13 Even if we had a standardized
14 definition of total cost of care, we would
15 still have plenty of room for experimentation
16 with new payment and service delivery models.
17 I think we saw this with Direct Contracting.
18 We had a lot of organizations that we witnessed
19 really carefully dissecting the Direct
20 Contracting benchmarks to see whether they were
21 going to be more favorable than Medicare shared
22 savings programs, and then were going to make
23 decisions based on that. And it really didn't
24 end up as a productive use of energy and

1 resources.
2 The other thing that I wanted to
3 mention related to the previous question and
4 tying into this one is that we've learned a lot
5 in engaging providers in this space. And when
6 we started doing this, we really recognized
7 that we needed to encourage a frame shift, so
8 that practices could really embrace the total
9 cost of care. We know that physicians are used
10 to being evaluated on process measures that
11 they know are in control, right? So did every
12 patient who walked into their office get a
13 blood pressure? Did the PCPs prescribe the
14 appropriate medicine? And it was less natural
15 at the beginning for our PCPs to think about
16 taking accountability for whether the patient
17 with severely poorly controlled blood pressure
18 actually took that medicine, whether they
19 followed the dietary recommendations that they
20 received, whether they needed the emergency
21 room, and whether they actually avoided that
22 stroke or heart attack.
23 And once you really get buy-in from
24 this practice group or these providers that

1 anything that happens to the patient is your
2 responsibility and that of the Accountable Care
3 Organization, you see creativity and innovation
4 start to emerge. And I worry that carving out
5 certain disease states or overly customizing
6 and allowing different cost of care definitions
7 and carve-outs disincentivizes truly jumping
8 into the value-based care canoe when you have
9 one foot in each, value-based care and fee-for-
10 service.
11 CHAIR CASALE: Great. Thanks,
12 Emily. Gail?
13 DR. WILENSKY: I think that within
14 the components of total cost of care, there
15 ought to be standardization but because some
16 models may include a different number of
17 components, that it is desirable to not only
18 have a single metric of total cost of care. So
19 I would say that it is a useful concept when
20 viewed in terms of the components, but it would
21 become too rigid and probably not useful for
22 some of the models that are being tried on
23 occasion to have a single standardized cost of
24 care, so continue the flavor that that raises

1 but not apply it in a rigid manner.
2 CHAIR CASALE: Great. Thanks, Gail.
3 Judy, any other further comments on?
4 MS. STEIN: No, except that I think
5 from the point of view of what is beneficiary
6 facing, as less complicated and clearly
7 understandable and, therefore, some
8 standardization would be valuable so that they
9 know what they're comparing to.
10 DR. WILENSKY: Judy and I have had
11 these conversations for probably the last 30
12 years.
13 CHAIR CASALE: Yes. I'm going to
14 open it up to PTAC members, and I apologize.
15 There were two members who had questions for
16 the first, but I suspect they may carry over.
17 So Bruce, I'm going to turn to you for your
18 question.
19 MR. STEINWALD: Question for -- I
20 hear an echo. Do you hear an echo? No. Okay,
21 good. -- for Gail Wilensky as an economist and
22 a former Medicare administrator. What's your
23 take on the argument about large models versus,
24 that are primary care-oriented for the most

1 part, and smaller models that are specialty-
2 oriented, can they co-exist, and how can they
3 best be made to co-exist?
4 DR. WILENSKY: Well, they need to
5 co-exist. The only alternative is to look at
6 those organizations that include all of the
7 physicians, primary care and specialty care.
8 To the extent that you can have some agreement
9 of the minds on definitions, on operationally,
10 how to define the concepts in ways that are not
11 inconsistent with the care that are being
12 provided, you might be able to reduce a little
13 of the tension. But there is an awful lot of
14 friction between how much of what goes on in
15 the specialty world ought to be under the
16 responsibility and purview of the primary care
17 physicians. I mean this has been going on for
18 a long while.
19 To have them be too separate and
20 independent loses the whole point of thinking
21 about a total cost of care. But you get into
22 this dilemma of how to have attribution to
23 groups who have no control or responsibility.
24 So it is going to be a blend of trying to get

1 it right so that you don't miss the important
2 components of control.
3 CHAIR CASALE: Sorry, I muted
4 myself.
5 DR. WILENSKY: Yes.
6 CHAIR CASALE: Larry, I think you
7 had a -- thank you, Gail -- Larry, I think you
8 had a question?
9 DR. KOSINSKI: Yes, I do. I've
10 really enjoyed this discussion. The different
11 flavors from each of the speakers has been
12 enticing to listen to. Judith keeps catching
13 my attention because my personal focus is a
14 patient-focused one. And, how do we move
15 design from provider-focused to patient-
16 focused? That really should be our challenge.
17 As a physician, I should be prescribing the
18 right drug for the right patient at the right
19 time for the right reason, not because the
20 health plan wants me to use a biosimilar and
21 oh, by the way, if I use that biosimilar, I may
22 make more money, but the patient still pays the
23 same copay and deductible, and the patient may
24 not know they're getting a different drug. So

1 how -- in our design of these programs and in
2 talking about total cost of care, don't we owe
3 the beneficiary a definition of total cost of
4 care so that when they're in the market looking
5 at other health -- other plans, other
6 alternatives, they can tell what they're
7 getting for their -- for the money that's being
8 spent?
9 DR. WILENSKY: I'd like to respond
10 to -- it's an issue, I think, that goes to what
11 Larry has raised, that's come up before in
12 related discussions, and that is trying to
13 distinguish between having agreed upon
14 definitions of component terms but allowing the
15 total to have some variation depending on the
16 components that are included. I say that
17 because I think you do need to have it
18 understood that when you use a particular term
19 with regard to cost of the type of health care,
20 that that should be the same across different
21 plans, different organizations, but
22 recognizing, especially because Medicare
23 excludes, in traditional Medicare, a variety of
24 components of care that may be included in MA

1 plans or other type of plans and in any case
2 are certainly included in the conceptual total
3 cost of care model, that if the components are
4 standardized, it can be easier to clarify which
5 components are a part of a definition of total
6 and which are not. So it's an attempt to try
7 to have some balance between the issues that
8 Larry raised. I don't know whether he thinks
9 that helps or not.
10 DR. KOSINSKI: It does -- it does
11 help -- it does help. We almost need a
12 Monroney sticker like what's on the -- a
13 sticker of a new car in a showroom --
14 DR. WILENSKY: Yes.
15 DR. KOSINSKI: -- so that you know
16 what you're getting in this MA plan, and you
17 can be an informed consumer.
18 DR. KOSINSKI: That’s not a bad
19 analogy.
20 MS. STEIN: Yes. But the problem is
21 that there are not only all those different
22 cars on the lot at Hyundai, but also the ones
23 over there at VW and at Chevrolet and at -- and
24 traditional Medicare is standardized. You can

1 tell what it is, but all those other, if you
2 will -- I'll drop the metaphor -- MA plans have
3 all different pieces to them, and they are
4 allowed and do market actively.
5 I mean I'm now Medicare age. My
6 husband's a family doctor, by the way. He's
7 Medicare age. We are pummeled with this stuff
8 and blessingly, my mother is still alive and
9 she says to me, "I don't know, Judy. Is there
10 something different this year" -- this was last
11 year -- "because I'm seeing all these ads with
12 Joe Namath and I'm wondering, you know, whether
13 I should, in fact, make a change this year."
14 So I think it's -- the marketplace
15 for selling insurance, health insurance, to
16 people who are, by definition, older and may
17 have disabilities and/or age into disabilities
18 really need to step back and look at -- Gail
19 won't be surprised -- at what we're doing here
20 and whether it's best, and can you teach all of
21 this, or is it the paradox of choice, and what
22 people really want is to know this is going to
23 be covered and in practice, it's going to be
24 covered because, you know, I deal with all the

1 people who go to the doctor or try to get the
2 drug and not this year or not this month, and
3 they want to choose between the doctor.
4 My mother wants to be able to go see
5 the cardiologist she's comfortable with. And
6 having had flaming blood pressure problems and
7 lost much of her family to it, she was really
8 scared when this year she chose a certain plan
9 with professional advice, not mine, my
10 colleague's, and a month after -- and in the
11 end of January finds that, oh, that plan no
12 longer covers that drug. It was on the plan
13 finder, and it was on the plan's own website.
14 These are the problems that real-
15 life people live with that need to be taken
16 into consideration when we theoreticians think
17 through the various models that seem like they
18 might make sense. The consumer will not -- and
19 I am one -- will not understand this space, and
20 it doesn't always serve them well.
21 CHAIR CASALE: Yes. Thanks, Judy.
22 And, you know, I think that speaks to, in a
23 way, CMMI's current thought about smaller
24 number -- and this is in the fee-for-service

1 side of things -- smaller number of large
2 models as opposed to, you know, the 50 or so
3 models that are currently -- in order to try to
4 engage beneficiaries as part of that.
5 Before we leave this question,
6 Jennifer, I'm just curious. As you had
7 articulated your thoughts around total cost of
8 care, is this -- are you thinking this has sort
9 of a transitional period, or is it sort of the
10 ultimate goal for 2030, again, thinking where
11 CMMI is headed around having sort of a more
12 clear definition, you know, sort of a unified
13 definition around total cost of care?
14 MS. KOWALSKI: am I thinking that
15 there can't be a standardized definition ever
16 or that in 10 years we can have one? Is that
17 the question?
18 CHAIR CASALE: Yes. As you're
19 thinking around total -- yes, are you feeling -
20 - are you thinking that, yes, could we ever
21 have one, or is it that we need this transition
22 period to ultimately get to one?
23 MS. KOWALSKI: I mean yes, I don't
24 think we're ready for one now. Maybe at some

1 point in the future if we've moved enough, you
2 know, providers along the spectrum to where
3 everyone is, you know, really comfortably
4 taking risk, then perhaps that makes sense. I
5 sort of like Gail's approach, which is let's
6 define the components consistently perhaps and
7 -- but the actual what's in and what's out can
8 be a little bit variable depending upon, you
9 know, the underlying factors of the provider,
10 the line of business, the model.
11 I mean I also think that when you're
12 thinking about it from a health plan
13 perspective, you know, in a Medicare Advantage
14 plan and a commercial plan, the plan is
15 ultimately, in a way, taking on risk for the
16 total cost of care, right? We're paid a
17 capitated amount, so we're still managing that
18 patient, we're still managing spending. There
19 is a responsible entity for, you know, managing
20 to a budget, if you will, and then we work with
21 the providers in terms of what they're
22 comfortable, kind of, taking on in terms of
23 accountability for their patients. That's a
24 little different from a fee-for-service model

1 where, yes, CMS is the ultimate accountable
2 party, but they're sort of looking to an entity
3 that's not a health plan to take on some of
4 that management for them.
5 And then I think you do need to
6 think maybe more about, if you keep this out or
7 you keep this in, what are the incentives
8 you're creating in terms of who's managing this
9 cost or what are we doing in terms of access
10 and so forth and where does that beneficiary
11 and fee-for-service go to, you know, if there's
12 -- is there an appeals process like there is in
13 an MA plan or in a commercial plan, right, like
14 what's sort of the options for the beneficiary
15 to learn more about what they're getting, not
16 getting, and how to get it covered. Does that
17 answer your question?
18 CHAIR CASALE: Yes. That's great.
19 Thanks, Jennifer. Jen, do you have a question?
20 DR. WILER: I do. Thanks again to
21 the panelists for a wonderful discussion. We
22 talked a lot about consolidation of options in
23 the marketplace, not as a means to restrict
24 access or choice but actually to improve

1 quality of choice I'll describe it as. We've
2 heard that, as Paul just said, from CMMI
3 leadership and also CMS leadership that that's
4 ultimately their goal.
5 So my question for the panel is, you
6 know, since we're using a lot of metaphors
7 today, you have a magic wand and you get the
8 opportunity to consolidate the current choices
9 within the marketplace, or organize them might
10 be a better description, how might you go about
11 thinking about solving that problem, or if you
12 prefer to answer the question to be actually
13 tactical around, you know, what programs might
14 you eliminate and why?
15 MS. STEIN: I'll try. I may as well
16 jump in. I feel like I'm -- anyway, a voice
17 that may be sounding -- ringing a bell that is
18 hard. At any rate, I think that when we --
19 first of all, traditional Medicare, we've been
20 trying to figure out what's the right name for
21 it. It is so rarely fee-for-service, which has
22 become like a four-letter word. So it's really
23 unfair to refer to the traditional Medicare
24 program as fee-for service. It's really made

1 up of a wide variety of capitated rates and
2 different care settings except for in some
3 instances, of course, physician services. But
4 hospital, home health, nursing home, they all
5 have capitated rates. And all those capitated
6 rates have produced problems for patients,
7 because it's -- one thing that needs to be
8 looked at -- and I'll get directly to your
9 question -- is when you pay a capitated rate,
10 you can't tell whether that service was
11 actually provided for the capitated rate and
12 especially not with the data that is currently
13 available.
14 Back to the home health arena; for
15 example, the patient may have had an order for
16 home health aides, PT[35] and ST[36] and nursing,
17 such as one of my clients, for a 60-day period,
18 and that may have been provided for the first
19 three weeks, and that's based on how the
20 capitated rate is paid. But by the end of the
21 60 days, many of those services are no longer
22 being provided and may have been removed

35 Physical therapy
36 Speech-language therapy

1 gradually over time with or without the
2 authorized practitioner's understanding of
3 that.
4 So I want to -- I am using this time
5 to make it clear that traditional Medicare is
6 not fee-for-service, and it's dangerous to keep
7 calling it that, with all much, much respect,
8 because it misunderstands right away what we're
9 comparing to. And also, that capitated rates
10 are not the be all and end all with regard to
11 fraud and/or just misuse.
12 Having said that, the traditional
13 Medicare program and all these models ought to
14 be -- there ought to be parity. They ought to
15 be paid the same amount per beneficiary. If the
16 private models are going to, as was promised,
17 be better for the program and for taxpayers,
18 they should not need four cents more on the
19 dollar to provide those services. They ought
20 to be standardized like the Medigap plans were
21 back in the 1990's, so that people can
22 understand what their options are.
23 A Plan A Medigap plan is a Plan A
24 plan whether it's from Golden Gate or, you

1 know, New England Services United or whatever
2 the name is. You can compare. We can make a
3 chart, show it to our beneficiary and give our
4 audiences, these are your options, this is what
5 Medicare offers, these are the gaps, these are
6 what the gap plans will cover, can you afford
7 that.
8 Now we have to sandwich in always
9 asking about their income, where they live,
10 what their family and their medical history is
11 in order to understand what Medicare Advantage
12 plan might or might not serve them, where do
13 they travel, a lot more personal, by the way,
14 digging into someone's history. I wouldn't
15 think many people who value privacy would like
16 professionals to have to do that in order to
17 choose the right plan for folks.
18 So there needs to be simplification
19 and standardization. If any of you, as I have,
20 have had to choose health insurance for your
21 employees, you know what it's like to make a
22 choice every year. Most people who've had the
23 good fortune of being employed have not done
24 that for themselves all these years. And when

1 they're faced now with Medicare, instead of it
2 being a blessing and a simplification, it's
3 hugely confusing. I have a friend who has a
4 law degree and two PhDs who left me a message
5 that he had a Medicare crisis, and the crisis
6 was he had to make a -- decide what to do when
7 he turned 65.
8 So we need to standardize. If
9 you're thinking about the beneficiary, there
10 ought to be parity of payment between all these
11 plans on a level playing field, and if MA can
12 offer meals, people in traditional Medicare
13 should be able to get a meal. If MA is going
14 to be able to do medically necessary oral
15 health care and actually provide it, so should
16 people in traditional. Otherwise, you're
17 saying there's choice when you're actually
18 putting a thumb on the scale. Medigap is
19 expensive. In most states, once you make a
20 choice, you can't choose again. It looks
21 cheaper right away to get into a Medicare
22 Advantage plan. It may not be. You may travel
23 and get in an urgent situation and be covered
24 right away but not for the rest of what goes on

1 with your care.
2 So there's many things to think
3 about, but standardization and parity as much
4 as possible so that the consumer can understand
5 this and know that the same value is existing
6 regardless of their Medicare model is
7 imperative.
8 DR. WILENSKY: I'll buy the
9 standardization of terms, not the parity
10 because I think some models are more efficient
11 than others and can use those funds
12 differently. The notion of having people be
13 able to more easily understand the components
14 of the program is an appropriate one. I think
15 there ought to be ways. We can, of course. It
16 does occur. It just doesn't occur to the same
17 extent that Judy would like to see it. I think
18 it's fair to say let's see how we can make it
19 an easier comparison to -- for the beneficiary
20 or the beneficiary's advisors who, after all,
21 are actually usually the people that are
22 helping the beneficiary make a choice, not some
23 independent third-party person as much as it is
24 likely to be a family member or a trusted

1 source through the person's church or senior
2 community. But there are, I think, things we
3 can do to increase the amount of
4 standardization so it's a little easier to be
5 able to make these choices. The fact is there
6 are some differences in efficiency and
7 advantages to some plans over other plans that
8 will be important to some people but not to
9 others.

10 CHAIR CASALE: Thank you.

11 DR. WILENSKY: There are also some
12 efficiencies in traditional Medicare that are
13 not --

14 CHAIR CASALE: Yes.

15 DR. WILENSKY: -- not to be
16 forgotten.

17 CHAIR CASALE: Thank you. And Jen -
18 - before we leave Jen's question, I don't know
19 if Jennifer or Emily had any comments specific
20 for Jen's question. And if not, we can -- no,
21 okay.

22 All right. Chinni, I think you had
23 a question before we --

24 DR. PULLURU: Yes. I just wanted to

1 hear the panel's thoughts actually on -- our
2 strategic vision is to support the vision of
3 everybody, all Medicare members being in
4 advanced payment or value payment methodologies
5 by 2030. Now, what are the goalposts that you
6 would recommend, or how do you recommend that
7 transition occur? We want to make sure we, you
8 know, we're thoughtful about what the position
9 we take as far as that's concerned.
10 CHAIR CASALE: Emily, you have --
11 DR. WILENSKY: I think you need to
12 decide on a limited subset of advanced payment
13 methodologies that would be acceptable. We are
14 still in a phase of Medicare
15 development/payment development. It goes
16 actually beyond Medicare and is true for
17 private sector payers as well where we are
18 still struggling with defining the quote,
19 unquote, best advance payment methodologies.
20 Hopefully, by or before 2030, we'll be able to
21 have agreement on a subset that we would like
22 to maintain going forward. It would make
23 everybody better off, physicians, other health
24 care providers, and certainly beneficiaries.

1 CHAIR CASALE: Thanks, Gail. Emily,
2 do you have any thoughts on that?
3 DR. MAXSON: Yes. I was going to
4 say that to the extent that we can use data to
5 empirically derive that answer, to me, I think
6 that that would be powerful. I would start
7 with where are our Medicare patients are
8 getting their primary care today? How many of
9 them are getting primary care, and how many
10 still need to be better engaged in the system
11 so that we cannot only get them to value-based
12 care in an advanced payment model but get them
13 access, period, and then start to think about
14 the offerings that we have in each of those
15 arenas.
16 I think that the data is bearing out
17 for physician-led and NP/PA provider-led
18 accountable care models in advance of some of
19 the hospital and health system-led models. And
20 so we need to understand how to catch up for
21 patients who do get their primary care and will
22 be quarterbacked in the health system or
23 hospital-based model. And I think we can start
24 there and would agree with Gail that we need to

1 make sure that these models are really rich for
2 all patients regardless of where they seek
3 their care and make sure to not leave behind
4 our patients who are disenfranchised from
5 health care currently.
6 Chair Casale Thanks, Emily. So I'm
7 going to move to the next questions and sort of
8 combine the next two questions. So in
9 discussing how to enhance provider readiness to
10 participate in population-based total cost of
11 care models, from your perspective, what are
12 some of the provider-level barriers to
13 participating in these models; and also, as you
14 think about these models, any experiences on
15 how to structure payments to influence provider
16 participation. So what are some of the
17 barriers that you feel are there for provider
18 participation, and then thoughts on how to
19 structure payment to encourage participation.
20 So Jennifer, I'll start with you.
21 MS. KOWALSKI: Great. Let me just
22 very briefly -- before I talk about a few of
23 the barriers, maybe I'll just mention there are
24 four main ways that we are forming questions, I

1 guess, that we ask providers to start to gauge
2 their readiness and, you know, they have to do
3 with, is the provider kind of ready to make
4 this transition over the next 12 to 18 months;
5 is there some urgency and enthusiasm there; do
6 they have a plan in place in terms of, you
7 know, the resources, the services, the supports
8 that they need; what gaps have been identified
9 that we might need to help them fill; are they
10 aligned with leadership in terms of making this
11 shift; and do they have some budget to support
12 a transition? And so, you know, providers who
13 can answer yes to those questions are sort of
14 more ready to move. Ones who can answer yes to
15 like the enthusiasm and leadership alignment,
16 you know, maybe need more support from us in
17 terms of specific planning or budgeting.
18 And so I think that gets into some
19 of the barriers that we see, the first being
20 that, you know, the provider maybe doesn't have
21 yet some of those factors in place that we view
22 as important enablers of success in taking on
23 more risk and, you know, some of those might be
24 some sort of electronic infrastructure to help

1 identify care gaps, you know, perhaps links to
2 the EMR[37]. Oftentimes, you know, we see it
3 valuable to have a care team around the
4 providers that, you know, do some of the
5 patient management and other sorts of services.
6 You know, are they successful in
7 whatever value-based arrangement they have
8 today? You know, if they are doing some sort
9 of pay for performance type model, are they
10 consistently, you know, getting to where they
11 need to be on that, that they're, you know,
12 demonstrating the ability to take on more risk
13 and financial risk, downside risk as well? So
14 I would say lack of those things is a barrier
15 that we'll work with them to address.
16 Another common barrier that we see
17 is often the patient panel size, and this is,
18 you know, more true obviously for the
19 independent providers relative to the large
20 health care systems. They may be too small to
21 take on financial risk on their own without,
22 you know, coming into some sort of bigger

37 Electronic medical record

1 model, or they might not have the economies of
2 scale to do some of the population health
3 management that we'd like them to do, at least
4 not without a partner of some sort.
5 And then another barrier that I
6 would highlight can sometimes be what I'll call
7 local market dynamics. So, you know, on the
8 one hand, you have the small providers who
9 have, you know, some challenges, but then on
10 the other hand, you may have a very large
11 dominant, you know, monopolistic, if you will,
12 health system in a market. And while they have
13 the right economies of scale or the right
14 ability to take on financial risk, they -- if
15 they're not sort of interested in, you know,
16 kind of moving to more of a risk-based
17 arrangement, they often don't really have to,
18 right, because they're a must-have provider in
19 terms of the health plan's network. You know,
20 there isn't that same sort of feeling of gee, I
21 need to, you know, be engaged in a risk-based
22 arrangement if I want to remain in the network,
23 because they know that plans need them in the
24 network. And that's not to say that there

1 aren't plenty of large, you know, dominant
2 provider systems that are participating in
3 these models, but we do see that as, you know,
4 sometimes a barrier to getting those larger
5 systems on board.
6 So to address the second part of the
7 question in terms of how do we, you know,
8 structure financial arrangements, I think
9 generally speaking, you know, there's the
10 financial piece but there's also the resources
11 or the enablement piece. So as providers can
12 take on more risk, there's the opportunity for
13 more reward. I can't speak for, you know, what
14 other payers are doing, but I think generally
15 as providers take on upside and downside risk,
16 we share more of the savings with them. And so
17 we generally work with providers to put them on
18 a glide path, right, so providers that want
19 into the spectrum may need some more hands-on
20 support from us, maybe that software, maybe
21 that's help with care management or reports on
22 care gaps and, you know, we can give them not
23 only, you know, financial incentives but some
24 of those resource incentives that help them

1 move along the glide path towards greater risk
2 and greater reward over time.
3 And then at the far end of the
4 spectrum, there are providers that have already
5 made their own investments in this
6 infrastructure and staffing and so forth, and
7 they just want to be, you know, able to do
8 better or to, you know, to get greater
9 incentive to make those investments pay off.
10 And so what they'll need from the health plan
11 is data, the contract, and they're sort of
12 ready to go.
13 And then maybe I'll just wrap up and
14 say, you know -- and this sort of gets to one
15 of the questions that I think just came up --
16 that said, our experience sort of suggests that
17 at some point, there's sort of a saturation
18 point or a point of diminishing returns in
19 terms of provider participation or in terms of
20 patient attribution in the models. And, you
21 know, maybe this will change over time but, you
22 know, generally speaking, the more providers or
23 patients you get into these models, the more
24 cost savings you see and so forth. But at some

1 point, an extra provider or an extra panel of
2 patients doesn't really equal the same sort of
3 benefit or cost savings, and maybe that's
4 because you reached a point where all of your
5 sort of willing-to-be engaged providers are in,
6 the pool or the providers that are left are
7 just sort of too small to make a difference or,
8 you know, not really ready to be engaged. And
9 so we probably need kind of different
10 solutions, and I don't know what those are, but
11 we probably need different solutions for that
12 last x percent where to date we see that
13 getting them in isn't making the same
14 difference as the first, you know, y percent
15 is.
16 CHAIR CASALE: Great. Thanks,
17 Jennifer. Gail, your thoughts?
18 DR. WILENSKY: About -- I was trying
19 to think back when I had initially thought it
20 was time to limit the number of variations and
21 decide how to define value-based payment and
22 move on. And I think it was about 2017 or
23 2018. My inclination is it's time for at least
24 the public payer, Medicare, to make some

1 decisions about how best to measure value-based
2 payments, implement that, and stop having quite
3 so many variations. When I stop to think about
4 the burdens we must put on individual
5 providers, physicians and nurses, and other
6 provider types or institutional providers, I
7 occasionally cringe.
8 So I think that it has been
9 important to try to increase and improve our
10 knowledge about how best to redefine some of
11 these concepts, but I think maybe it's time to
12 do it. And that in and of itself would allow
13 for a lot less burden on those that are
14 providing care. Obviously, there will be
15 points of time where there will be an agreement
16 that some concepts need to be redefined or
17 changed, and we should do that.
18 Based on my earlier comments, it
19 probably won't come as a surprise to say I am
20 much more comfortable having standardization of
21 the component parts than what they have to all
22 add up to where I would allow for more
23 variation for all sorts of reasons because of
24 state of knowledge, state of practice,

1 attributes at the part of the country, or
2 interest on the part of the beneficiaries. But
3 I think having more standardization is the
4 direction we need to move.
5 CHAIR CASALE: Great. Thanks, Gail.
6 Emily, your thoughts on provider-level barriers
7 and thoughts on payment structure?
8 DR. MAXSON: Sure. I definitely
9 agree with a number of the comments that
10 Jennifer has made, especially that many
11 providers need help to transition to value-
12 based care and that entry-level access to
13 claims-based data is insufficient. The data
14 and the insights you can get from it are pretty
15 inaccessible to many who seek to transform care
16 and also essential to stratifying appropriate
17 clinical initiatives.
18 I think one thing that I'd like to
19 really emphasize is what happens when you try
20 to bring specialists into Medicare shared
21 savings programs and other non-hyper-focused
22 specialty-oriented APMs. It's really difficult
23 to assign accountability to specialists who
24 participate in a Medicare shared savings

1 program ACO, because most specialists are
2 participating in care but not driving it. And
3 they impact total cost of care, but they're not
4 quarterbacking it and because attribution is
5 assigned at the NPI[38] level, if you take
6 specialists into traditional total cost of care
7 models, you end up accountable for patients you
8 are literally managing end to end, and lots of
9 patients really aren't managing end to end. So
10 think about for that example, escalations in
11 the frequency of specialist visits for
12 nephrology and oncology patients who are
13 undergoing an acute escalation or episode,
14 right? You're going to have plurality of
15 services in a specialist's hands even if
16 someone else is following their blood pressure,
17 their coexisting diabetes, et cetera.
18 And so, I think the more we can
19 anchor to primary care practices who are best
20 positioned to quarterback the total cost of
21 care, the more successful we'll be, which just
22 means it is important to empower high-value

38 National Provider Identifier

1 referral and specialist management. We need to
2 leverage all available data to help patients
3 get the highest-value care possible when they
4 leave their PCPs' offices.
5 So, I think Jennifer and others
6 really covered the need for workflow redesign
7 and a really different take from practices who
8 are totally optimized to take in patients and
9 care for what comes into their offices and not
10 really hone towards population health and
11 understanding the attributes of the patients
12 who aren't coming in. And so, we need to
13 overcome those barriers. It's years and years
14 of training and practice to operate a business,
15 and the business of health care is complicated,
16 and shifting towards taking care of a total
17 cost of care of an entire population is quite
18 different.
19 The more that we can incentivize
20 innovation in the form of advanced payments or
21 starters, there is also great fee-for-service.
22 And I don't necessarily think that fee-for-
23 service is a four-letter word. I think that
24 there can be really productive fee-for-service

1 when the design is optimized and oriented
2 towards what the patient needs to get out of
3 it. I think annual wellness visits are a great
4 example of transitional care management, are
5 really high-value visits that can prevent
6 readmission if done well. And we've made a lot
7 of progress with care management. And so I
8 think when we do appropriate design of services
9 that are reimbursed, it is easier for practices
10 who are trying to survive in both models to
11 leverage the fee-for-service to the best
12 benefit of the patient population. So
13 investing more in primary care where we can
14 then expect dividends in the form of reduced
15 emergency room utilization and unnecessary
16 hospitalizations and readmissions seems to be
17 in our best interest.
18 CHAIR CASALE: Great. Thanks,
19 Emily. Looking at the time -- and this has
20 been terrific discussion -- I'm going to move
21 to the next question which I think is a really
22 important one and be sure we get everyone's
23 input.
24 So, equity is a focus for us here

1 and was actually our last theme-based meeting
2 along with social determinants of health. So,
3 in your opinion, what are the potential equity
4 implications of holding APM entities
5 accountable for total cost of care in
6 population-based models? And asking that both
7 in general and for beneficiary subpopulations
8 such as historically underserved populations
9 and individuals with chronic conditions. So,
10 with that, I'll start with you, Judy.
11 MS. STEIN: We certainly haven't
12 found the key to fixing our inequitable society
13 and certainly not our health care delivery
14 system. And I am concerned that more and more
15 diversity and how one receives one's health
16 care and how you define quality within those
17 health care models will not best serve
18 vulnerable people with chronic conditions and
19 underserved folks. And I know that
20 Commonwealth and Kaiser and others have shown
21 that Medicare Advantage has, in fact, not
22 demonstrated, in fact, that it serves those
23 populations better. And our experience as
24 attorneys, mostly for people with longstanding

1 chronic conditions, shows that, in fact, people
2 who have such conditions often have problems
3 with health insurance. They're not favored, if
4 you will, to continue getting the care they
5 need for the period of time and with the
6 intensity that is required. And I think that
7 reality ought to be seriously studied as these
8 models are built so that we know that we're
9 incorporating the needs of people who need
10 perhaps more intense care and/or care for the
11 longer term and more health education.
12 CHAIR CASALE: Great. Thank you,
13 Judy. Emily.
14 DR. MAXSON: I'd like to start with
15 the Medicare HCC[39] risk adjustment model. There
16 was a great paper by Brian Powers that was
17 published a couple of years ago now that the
18 systematic evaluation of how our Medicare HCC
19 risk adjustment model, and many like it,
20 systematically underestimates the risk of Black
21 patients versus white patients, and that is at
22 the same HCC risk score. And for those who

39 Hierarchical Condition Category

1 aren't deeper initiated in this, the HCC risk
2 adjustment methodology is actuarial, and it
3 takes into account all of the patient’s and
4 the patient population’s diagnoses that have
5 been seen in the calendar year, evaluated, and
6 billed. And so what you see is that because of
7 delays in diagnosis and health care in-access
8 that's really borne by the 400-plus years of
9 structural racism in our country, at the same
10 HCC risk level, a Black patient is much more
11 likely to be sicker than the white patient.
12 And it's just true that a lot of organizations
13 use HCC score as a stand-in for clinical acuity
14 and absent of any other indicator and use that
15 score to identify and stratify patients for
16 additional clinical services and benefits.
17 So I think a first step would be
18 that we really need to adjust our risk
19 adjustment methodology to account for this
20 finding and potentially reduce disparities in
21 the provision of extra clinical services and
22 attention to patients by risk adjustment level.
23 I've been encouraged by the progress
24 with the Area Deprivation Index. I think it

1 might be a step in the right direction as a
2 payment innovation, and I'd love to see more in
3 payment innovation that honors that social
4 complexity is expensive but also makes further
5 downstream resources available rather than
6 simply bonusing up the care of socially complex
7 and economically disadvantaged populations.
8 So the more that we can actually
9 care for these populations by making social
10 determinants of health screenings more
11 mainstream, potentially paying for them with
12 good fee-for-service and connecting patients to
13 resources -- a lot of good data on community
14 health workers, how can we incentivize that and
15 make that mainstream here. How do we pay for
16 the downstream resources once we identify
17 patients and need and embrace that and advance
18 payment models?
19 CHAIR CASALE: Great. Thanks,
20 Emily. Gail?
21 DR. WILENSKY: Yes. A few closing
22 thoughts. I was a little surprised by Judy's
23 comments with regard to the use of Medicare
24 Advantage and its various names by lower-income

1 individuals since for a long time, and to some
2 extent still today, minorities and lower-income
3 individuals have disproportionately made use of
4 Medicare Advantage as a way to increase the
5 benefits that were provided, and as a Medicare
6 Advantage proponent for its potential ability,
7 not always realized, to integrate services in a
8 way that is even more complex for the
9 traditional Medicare programs to do. I have
10 been happy to see that.
11 A comment with regard to the social
12 determinants of health and how to try to bring
13 them more into the Medicare program, or the
14 Medicare program more into the concept of
15 social determinants of health. You decide
16 which way best to go do it. It would be
17 enormously helpful if we could see some
18 significant consolidation of the many programs
19 that exist sponsored by the federal, or federal
20 and state, or federal, state, and local
21 governments into a smaller group of services.
22 There are many overlapping and competing
23 programs, and they make it much more difficult
24 and complicated to unify the services that we

1 are trying to provide to needy populations. I
2 think our potential for being able to
3 incorporate the social determinants of health
4 or at least some aspects that are most directly
5 related to medical care would improve
6 considerably if we were able to do that.
7 It is frustrating to me that it's an
8 issue that I know I personally have been
9 speaking and writing about now for 30 years,
10 and I do not see a lot of evidence of movement
11 in that direction and some of this funding so
12 much better and more wisely if we could find a
13 way to have more rational consolidation. I'm
14 open as to who gets to be the consolidator.
15 CHAIR CASALE: Great. Thanks, Gail.
16 Jennifer?
17 MS. KOWALSKI: Thanks. Yes. I mean
18 I'd like to kind of loop back, I think, related
19 to what Emily was talking about, you know, how
20 do we think about the various levers that might
21 exist to drive improvements in health equity
22 through these total cost of care or value-based
23 payment models? And I think to start, we first
24 probably need better, more comprehensive, and

1 more complete data to know where the
2 inequities, you know, truly exist and how to
3 best address them in the first place. I think
4 as plans, as, you know, CMS, we probably have
5 good data on the communities that we're
6 serving, disparities at the geographic level,
7 but I would say we really don't have nearly as
8 complete data as we'd like to have on
9 individual-level data so even race, ethnicity
10 of members and health plans or, you know,
11 better information about health-related social
12 needs. There's certainly movement to collect,
13 you know, whether it's the Z Codes, but I think
14 that's still pretty spotty.
15 So, you know, how do we encourage,
16 you know first, better identification of where
17 the needs exist at the individual level and
18 then actual, you know, improvement upon those
19 health inequities within value-based care
20 models? You know, I think one thing you can
21 think about is how do you include some measures
22 around this in the so-called kind of quality
23 gate of your total cost of care models? But I
24 think we also have to be careful to balance

1 that with how do we ensure that we're not
2 unduly penalizing and disadvantaging those
3 providers who may see a greater share of
4 patients who have those health-related social
5 needs or who are seeing populations who are
6 historically underserved, have more chronic
7 conditions, and so forth? You know, how do we
8 ensure that they're not being sort of
9 downgraded, not because of true performance but
10 because of inequities in their own practices?
11 And likewise, we have to think
12 about, you know, what's fair to ask primary
13 care providers to take on. Some things may not
14 really be within their capability to do within
15 the medical setting when we think about this
16 broader set of social needs. You know, large
17 health systems have the infrastructure in some
18 cases or want to have infrastructure to address
19 these things. Smaller practices, independent
20 physicians, they just may not be able to do
21 those things.
22 So I think we have to think about
23 what's the right structure, what's the -- or
24 what's the right flavor to improve health

1 equity and what circumstances do we want
2 providers to be accountable for some of these
3 things and to take the lead, when might it be
4 the health plan, when might it be a partner or
5 a vendor, when might it be the government or
6 some other entity that's situated to be
7 responsible for these things. So I think it is
8 a goal that we're all working toward for sure,
9 but we need to be thoughtful about, you know,
10 where the resources are and how best to deploy
11 them.
12 CHAIR CASALE: Great. Thanks,
13 Jennifer. And I realize we're over time but if
14 our panelists -- we'd like to -- this
15 discussion has been really rich, and we'd like
16 to continue for another 15 minutes if all our
17 panelists are available. If so, maybe I'll
18 open it up to PTAC members if you have any
19 questions on this topic of equity.
20 DR. WILENSKY: I can stay on for
21 about another five minutes --
22 CHAIR CASALE: Okay.
23 DR. WILENSKY: -- but I need to pick
24 up another Zoom.

1 CHAIR CASALE: Okay.
2 MS. STEIN: Same. I have another
3 call. I can stay --
4 CHAIR CASALE: Okay.
5 MS. STEIN: -- for another five or
6 so. Thank you very much.
7 CHAIR CASALE: Okay.
8 VICE CHAIR HARDIN: I was just going
9 to follow on Gail's comment about
10 consolidation, Paul. I think that's such an
11 interesting comment nationally. So I work
12 deeply with underserved and marginalized
13 populations, and the proliferation of
14 organizations trying to meet social needs, and
15 the under-financing and the under-resourcing of
16 those organizations is a real issue. And the
17 coordination into integrated networks with
18 supportive leadership and contracting and
19 financing is so important as we look at meeting
20 equity and meeting social needs in our
21 communities. So I just wanted to follow on
22 that comment. I felt the consolidation piece
23 is critical from what I'm seeing on the ground
24 in different communities. I don't know if you

1 wanted to say any more about that, Gail.
2 DR. WILENSKY: Just as somebody who
3 has worked with a variety of these
4 organizations because of the various hats that
5 I have worn over the years, it has come up
6 numerous times, the concept that there are
7 overlapping programs that tend to make dealing
8 with as conceptual -- broadly conceptual idea
9 of the social determinants of health more
10 complicated because they have their own
11 constituencies, they have their own groups that
12 they have to report to in terms of a power
13 structure, to use a phrase, that if there could
14 be more consolidation, it would allow for a
15 much better integration. And since the whole
16 concept of social determinants of health really
17 is to integrate the medical and social service
18 components that are necessary to improve health
19 and well-being, it is part and parcel of the
20 objective.
21 So it is very hard because each of
22 these groups have their own political
23 constituencies, or they frequently will have
24 their own interest groups who support them, and

1 the political, both "big P" and "little p"
2 challenges of trying to have consolidation is
3 formidable. I've been at a couple of groups
4 that have made faint-hearted attempts to try
5 this, but it really is keeping us from
6 accomplishing the goal.
7 Many people for many reasons have
8 commented it's not that we don't spend enough
9 money, it's how we spend it and how the care is
10 provided that gets in our way. I think there
11 is widespread agreement across people of very
12 different political persuasions. It's figuring
13 out how to crack this that has proven so
14 challenging. So thank you, Lauran.
15 VICE CHAIR HARDIN: Yes. I
16 completely agree.
17 CHAIR CASALE: Any other -- and I
18 know we're pretty much out of time. Any PTAC
19 members' last-minute questions for this great
20 group of panelists? Okay. If not, I want to
21 thank, on behalf of the Committee and our
22 audience, each of you for your insights today.
23 We're grateful. You've certainly been generous
24 of your time and sharing your expertise. And

1 we -- if you can stay on for the remainder of
2 our meeting, we would certainly welcome you and
3 again, want to thank you all for participating.
4 So, with that, I'm going to move to the public
5 comment period. We --
6 MS. STEIN: Thank you very much,
7 Paul and everybody. I really appreciated
8 participating. Thank you very much.
9 CHAIR CASALE: Thanks, Judy.
10 Thanks, Jennifer and Emily.
11 * **Public Comment Period**
12 We have one person who has signed up
13 for public comment. I will introduce them, and
14 then our moderator will unmute so that you can
15 speak. So I want to open up to Sandy Marks,
16 Senior Assistant Director of Federal Affairs at
17 the American Medical Association.
18 MS. MARKS: Thank you. So last
19 fall, CMS Innovation Center staff asked AMA to
20 identify barriers that prevent ACOs from
21 partnering with specialists and ways to
22 encourage specialists to engage in an
23 integrated model like an ACO without financial
24 risk-sharing becoming a point of contention.

1 They also wanted feedback on related questions
2 dealing with attribution, overlap, and
3 improving care coordination and equity. To
4 address these questions, we drafted a payment
5 model proposal which we are calling Payments
6 for Accountable Specialty Care, or PASC.
7 Here's how it would work.
8 Specialists would enter into
9 voluntary agreements with ACOs to improve care
10 for ACO patients with certain health conditions
11 in a way that would help the ACO meet its
12 overall quality and spending goals. For each
13 patient referred by an ACO primary care
14 physician to a specialist with a PASC
15 agreement, the specialist would get an enhanced
16 condition services, or ECS, payment to help
17 support comprehensive diagnostic workups and
18 use of patient-physician shared decision and
19 clinical pathways to arrive at an accurate
20 diagnosis, patient education about their
21 condition, treatment plan, and self-management
22 to improve outcomes and prevent exacerbations,
23 and assistance to get tests, medications, or
24 therapies that require scheduling or prior

1 authorization.
2 With concurrence of the primary care
3 physician, additional payments called continued
4 ECS payments and special ECS payments would be
5 made if the specialist needs to continue
6 treatment after the initial month or for
7 patients whose care is significantly more
8 challenging due to social determinants or other
9 factors.
10 Specialty societies and
11 organizations representing ACOs would help
12 develop a standard template for the PASC
13 agreements specifying how appropriate patients
14 for referral to the specialist would be
15 selected, how specialists would coordinate with
16 primary care, quality or utilization measures
17 related to the condition and target performance
18 levels, and data the ACO would provide to
19 support care for the conditions listed in the
20 agreement.
21 Much more detail is provided in a
22 discussion paper that we've shared with CMMI.
23 Some benefits of the PASC approach are that
24 more specialists might decide to participate in

1 ACOs, more ACOs would engage with specialists,
2 primary care physicians would have a basis for
3 choosing specialists for referrals and getting
4 feedback from and coordinating care with them.
5 Performance measures would be appropriate to
6 the conditions in the agreement so there would
7 not be repayments tied to factors that
8 specialists cannot influence.
9 We'd be happy to share the
10 discussion draft if you'd like to learn more.
11 Thank you.
12 CHAIR CASALE: Thank you, Sandy. So
13 I'll check with the host before we move on.
14 Are there any other folks who wanted to
15 contribute?
16 MS. AMERSON: No additional
17 comments.
18 CHAIR CASALE: Hearing none, that is
19 the end of the public comments. We are now
20 going to take approximately a 15-minute break
21 and then return for the Committee discussion,
22 so we'll plan to return at 3:00, and we'll
23 begin our Committee discussion at that time.
24 Thank you.

1 (Whereupon, the above-entitled
2 matter went off the record at 2:41 p.m. and
3 resumed at 3:02 p.m.)
4 CHAIR CASALE: Thank you for
5 returning.
6 * **Committee Discussion**
7 Now, the Committee members and I are
8 going to discuss what we have learned today, as
9 well as from yesterday, from our guest
10 presenters, the roundtable discussion, the
11 background materials. As you know, this two-day
12 meeting is part one in our three-meeting series
13 on population-based total cost of care models.
14 After the series, we will submit a
15 report to the Secretary of Health and Human
16 Services. So, the report will include our
17 findings from the June and September theme-
18 based discussions as well.
19 But while this topic is fresh in our
20 minds, we want to discuss what we learned
21 yesterday and today about definitions,
22 structural issues, and opportunities related to
23 designing population-based total cost of care
24 models.

1 There's a lot of information to sift
2 through. For our Committee members, please
3 check the pocket of the binder for the meeting
4 materials. There are potential topics for our
5 deliberation.
6 And then, of course, we can begin
7 the discussion either raising your hands
8 through Webex or simply start with your
9 comments.
10 We had this list up yesterday around
11 potential topics. And I think we don't need to
12 keep that list up, as we all have a hard copy
13 of the information.
14 And we'll plan to go to
15 approximately 3:45 in our discussion and
16 deliberations.
17 So, let me open it up to PTAC
18 members for any initial thoughts or comments on
19 the discussion either from yesterday or today
20 or on the combination of them. Hey, Larry,
21 yes. You're on mute maybe. I don't know.
22 Still on mute.
23 (Pause.)
24 CHAIR CASALE: While Larry's getting

1 it off mute, Bruce, do you have a question or a
2 thought?
3 MR. STEINWALD: So, my broad
4 question is kind of related to the fact that
5 Medicare Advantage came up several times in
6 both yesterday and today's discussion. And I
7 think Gail Wilensky even said that she was a
8 big believer in what Medicare Advantage could
9 be. I don't think she said it quite that way.
10 But she likes the concept but doesn't like the
11 reality of it all is my interpretation.
12 So, my question is, how would a
13 total cost of care model that was sufficiently
14 well educated, had good sources of data, had
15 good methods, had social determinants of health
16 as one of its objectives, how would that differ
17 from a Medicare Advantage plan that was
18 designed to focus on total cost of care?
19 And it seems to me -- and I wonder
20 if we're going to go in a direction, is that a
21 direction we could consider going in?
22 CHAIR CASALE: Comments from other
23 Committee members on this --
24 MR. STEINWALD: Or not.

1 CHAIR CASALE: Yeah, I don't know.
2 I was going to sort of not pick on, but sort of
3 ask, Lee, given your experience, do you have
4 any thoughts as to whether this is a direction
5 we might want to even consider or whether
6 that's not really --
7 DR. MILLS: Well, a lot of reach
8 conversation and robust models around Medicare
9 Advantage out there. It's really in where some
10 of the most innovative things pushing the edge
11 of what's appropriate as medical benefit and
12 what's effective, especially with social
13 determinants, is being done.
14 So, I think the call this morning
15 for less confusion and some standardization
16 around it makes perfect sense. I agree with
17 the consumer perspective of having helped my
18 parents weed through that marketplace, which is
19 very confusing and challenging.
20 But we don't want to lose view or
21 grip of it's that very mission to provide all
22 Medicare benefits plus additional things, often
23 at no cost to the beneficiary. And it is, it's
24 creating innovation.

1 So, I'm not sure what the
2 parsimonious choice in the middle of all that
3 is. But it was points well made this morning.
4 DR. PULLURU: I think on the
5 provider network side, the salient difference
6 is often access, the ability to access.
7 So, Medicare Advantage is typically
8 much, you know, can be a narrower network,
9 particularly in, when the provider takes on, or
10 when the payer takes on risk versus Medicare.
11 So, I think that -- and then the way the
12 attribution works. So, you know, that's a
13 salient difference that we would have to solve
14 for.
15 And then the other difference would
16 be, I believe, regulatory, you know, Medicare
17 Advantage functions with the ability to have
18 some waivers in place rather than things that
19 allow for it to integrate care. And maybe that
20 is a model that we look at and say, you know,
21 are some of those components something that
22 should translate to larger Medicare?
23 And, you know, the question I asked
24 about goalposts, I think that maybe those are

1 things we think about as goalposts in order to
2 lead, you know, sort of lead the country to
3 that sort of goal in 2030.
4 CHAIR CASALE: Thank you, Chinni.
5 That's helpful. Larry, you're still on mute.
6 You're still on mute.
7 DR. KOSINSKI: I’m still on mute?
8 CHAIR CASALE: No, now you're off.
9 Now you're off.
10 DR. KOSINSKI: I'm off. I'm talking
11 into my phone. It's got to be right.
12 So, I really enjoyed the two days.
13 I learned a lot. And what I have as takeaways
14 in my mind from what I heard specifically today
15 was that total cost of care can be defined,
16 probably should be defined, that episode-based
17 models should not just be eliminated but should
18 be, a way should be figured out to have them
19 nesting inside larger models.
20 And then the third thing that I
21 think is important, it came out yesterday in
22 our discussion around high beta when we were
23 talking about my high beta concept, and it came
24 out again today, is I'm struck with our future

1 as designing episode models around patients
2 rather than around types of providers.
3 And that's challenging, but it would
4 -- if we could succeed in doing that, we would
5 bridge that gap between primary care and
6 specialty care and designate responsibilities
7 accordingly.
8 It's a big task. And maybe it's
9 aspirational more than reality. But those were
10 my three takeaways.
11 CHAIR CASALE: Thanks, Larry. Very
12 helpful. Other thoughts from Committee members
13 on what you heard over the last two days or
14 anything specifically today?
15 DR. PULLURU: I think the other
16 thing to add to what Larry said that seemed to
17 really stand out is that yesterday and today,
18 to limit the subset of APMs and to harmonize
19 them seems to be a very common theme in that
20 sort of movement to total cost of care.
21 CHAIR CASALE: Yeah, I agree. And
22 then bringing in the beneficiary perspective,
23 the thought, you know, the challenge around
24 them understanding if they move into a model,

1 you know, what that model is, again, not even
2 talking about Medicare Advantage and all the
3 plans there, but just thinking through the
4 advantage of having a smaller number of larger
5 models, thinking of the education piece,
6 because we know certainly the challenges around
7 engaging the beneficiary understanding around
8 whether they're in any kind of model on the
9 fee-for-service side, whether it's a bundle or
10 a larger population-based model.
11 Other comments? Walter, did you
12 hear anything on physician incentives that was
13 interesting to you or thought-provoking?
14 DR. LIN: Not so much on that, Paul,
15 but what did strike me from today's
16 presentation, especially Christina Severin's
17 from C3, and this actually kind of gets to
18 Bruce's question about Medicare Advantage, I
19 think one kind of key tool that Medicare
20 Advantage plan providers have access to is
21 real-time, robust data.
22 You know, you should show that slide
23 of all the data sources integrating into a data
24 warehouse, you know, the claims data, the ADT

1 data, the labs data. And it just struck me how
2 important that was to help these new payment
3 models succeed, you know.
4 And I think it's almost kind of --,
5 I mean, that without which it's really hard to
6 improve care and, at least in a timely way.
7 And this was also our experience when we were
8 involved with Model 3 BPCI, part of the BPCI
9 classic program.
10 It was kind of really hard to
11 improve care when you're getting your data nine
12 months later, and, you know, you have multiple
13 true-ups before you get your final data.
14 So, anyways, I just -- that was
15 really striking just how important data is and
16 kind of -- I'm not sure how we solve that
17 problem, but I just wanted to raise that point.
18 CHAIR CASALE: Yeah, thanks, Walter.
19 So, it was an interesting discussion.
20 I know we've referenced carve-out
21 several times in our thoughts around total cost
22 of care. And I think several of the speakers
23 raised the concern around how to use carve-outs
24 and how unintended consequences in terms of how

1 providers or others may determine what's in and
2 out of a carve-out.
3 And so, again, I think this gets
4 back to this whole, one of the questions around
5 engaging, you know, having payment models
6 inside of total cost of care model and how that
7 would work.
8 MR. STEINWALD: Yeah, you remember
9 Mike Chernew's example of waste as an asset?
10 And that was one of his points is , how do you
11 allocate the elimination of the waste? And if
12 you have a carve-out, they are going to try to
13 take credit for as much of that as they can and
14 take it away from, you know, the basic plan.
15 I liked also, though, the notion
16 that with the right platform and if it's big
17 enough that a lot of these decisions can be
18 made organically, that the decision of whether
19 to have a nested model or some other way of
20 accommodating a certain patient subpopulation
21 can be made within the entity as opposed to
22 imposed on the entity.
23 At least at the conceptual level, I
24 very much like that approach much better. And

1 I'm interested in what others have to say.
2 DR. WILER: Bruce, I agree with you.
3 I found a number of things interesting over
4 these last two days. But one thing that kept
5 bubbling up for me was this idea of essential
6 versus ideal elements that would need to be in
7 future state of either programmatic development
8 or consolidation in the marketplace.
9 What I heard around essential
10 elements are, one, access to data as was
11 previously (audio interference) access to data
12 which Walter previously described.
13 In addition, I heard often around
14 this idea of a non-fair playing field with
15 programs being voluntary to participate, as
16 opposed to involuntary, and incentives that
17 keep high performers in the game, and that any
18 program to be successful needs those elements.
19 CHAIR CASALE: That's great, Jen.
20 Thank you. Other comments on what you heard
21 over the last few days or themes you'd like to
22 bring out?
23 DR. KOSINSKI: Can you hear me?
24 CHAIR CASALE: Yes.

DR. KOSINSKI: A couple of great terms that I wrote down when I heard them, pharmaceutical stewardship. And there may be a way of compensating a provider group for pharmaceutical stewardship. I thought that was an interesting thought.

I also thought that I think Emily Maxson I was very impressed with. And she said most specialists are participating in care but not driving it. And there's probably a lot of truth to that.

And then what still permeates everything, what we heard from Liz Fowler in the beginning, can we bring something together with CMMI, MedPAC, and PTAC, how do we define transformational care, and how do we define success?

Just things to remember, some very good concepts, though. I love the pharmaceutical stewardship.

DR. PULLURU: One of the things that I thought was interesting was the first speaker today, Sherry, who spoke about fee-for-service and, you know, just thought about things in a

1 way that I hadn't thought about before. You
2 know, it's a four-letter word, and so the way
3 she articulated that.
4 And I think that one of the things
5 that we can potentially think about as a
6 Committee as well is, you know, there's total
7 cost of care. And, obviously, we all want to
8 drive there, define it, social determinants of
9 health, equity.
10 All these things need to be worked
11 on. But also, what are things that could be
12 accretive to fee-for-service that lend itself
13 to building up infrastructure for total cost of
14 care?
15 Like someone today mentioned
16 increasing care coordination codes and
17 decreasing just the one-off sort of fee-for-
18 service codes, because I think that would
19 incent provider and organizations to sort of
20 build that care team.
21 CHAIR CASALE: Yeah, Chinni, I
22 agree. I was struck -- she did articulate that
23 whole fee-for-service quite well actually.
24 I think we all sort of knew those,

1 you know, that we often say, oh, we need to
2 move from fee-for-service to value-based. But
3 given what's going -- you know, sort of not
4 promoting fee-for-service but understanding
5 some of these sort of strengths of fee-for-
6 service as it relates to simplification and et
7 cetera. And --
8 MR. STEINWALD: But she left -- I'm
9 sorry. Go ahead.
10 CHAIR CASALE: Yep, go ahead, Bruce.
11 MR. STEINWALD: She left out
12 something very important, which is the other
13 countries manage the level of fees much better
14 than we do. And we have this paradoxical
15 situation where the providers in those other
16 countries that use fee-for-service would love
17 to have Medicare's fees.
18 CHAIR CASALE: Yeah.
19 MR. STEINWALD: And yet, within the
20 context of the U.S., Medicare is seen as a
21 stingy payer.
22 And so, there's a lot of things that
23 are different between those other systems than
24 ours that result in our spending much more per

1 capita than they do, and that includes the
2 Medicare population.
3 CHAIR CASALE: Yeah, no, no, I
4 agree. I just -- but to Chinni's point, are
5 there sort of strategies within fee-for-service
6 that help to build this infrastructure that as,
7 you know, for organizations or practices as
8 they prepare to move towards more of either
9 total cost of care or other kind of payment
10 model, and recognizing Larry's comment, which
11 is an important one, about, you know, any
12 burden to the beneficiary on certain fees on
13 care management and others?
14 But it often will at least get the,
15 begin to get the providers in the mindset
16 around activities for coordination of care,
17 which, of course, is foundational to move to
18 any kind of, you know, alternative payment.
19 MR. STEINWALD: There's nothing
20 wrong with the concept of paying people for
21 what you want them to do, which I think is what
22 she was getting at.
23 But, you know, the other side of
24 that coin, and I think she mentioned that too,

1 was, well, maybe you pay less for the things
2 that don't take you in the direction that you
3 want to go.
4 But in our system, it's been very
5 hard to pay less. It's not so difficult to pay
6 more for some things, very difficult to finance
7 the payment of more for some things by paying
8 less for others.
9 CHAIR CASALE: Other comments and
10 thoughts? Jay, do you have any thoughts on
11 what you've heard today?
12 DR. FELDSTEIN: Well, actually,
13 almost what I didn't hear today that I thought
14 was rather interesting, and maybe, you know,
15 the group can comment on it.
16 You know, for the last 15 years,
17 we've lived in a relatively low inflation
18 environment. And even though people would
19 always point to health care being, you know,
20 higher inflation than CPI[40], you know, we're
21 entering a phase of hyperinflation.
22 So, in terms of what our ability to

40 Consumer Price Index

1 pay for in the upcoming years in models, social
2 determinants of health, you know, I think we
3 need to be cognizant from an outcome
4 perspective of what works and what real value
5 is, and that we just need to be cognizant of
6 that moving forward, because I don't think --
7 you know, the health care dollars are going to
8 compete in a different space moving forward to
9 a degree they haven't in the last 10 to 15
10 years.
11 And I think everybody needs to be
12 cognizant of that whatever model we choose or
13 push forward, what is the real economic impact.
14 MR. STEINWALD: Jay, hyperinflation?
15 Yikes.
16 DR. FELDSTEIN: We're just going to
17 be in an inflationary environment that we
18 haven't seen for a while, and we haven't
19 operated in.
20 DR. PULLURU: Yeah, I mean, that's
21 brilliant. And I think that it will also lend
22 itself to increased payment for providers, not
23 just physicians I'm talking about, but more
24 ancillary medical staff that need to make the

1 function, need to make the system work, because
2 post-COVID, we've seen that already.
3 DR. FELDSTEIN: I mean, we've lost,
4 you know, close to 25 percent of the workforce,
5 I mean, from a nursing shortage standpoint,
6 physician staffing shortage standpoint. You
7 know, just to have the individuals in place to
8 deliver the services is going to be a challenge
9 in a lot of systems.
10 CHAIR CASALE: Yeah, it's a great
11 point, yeah. It may go beyond the scope of our
12 Committee, but important point though --
13 DR. FELDSTEIN: Well, you know --
14 CHAIR CASALE: -- in the context of
15 --
16 DR. FELDSTEIN: -- as we have two
17 more --
18 CHAIR CASALE: Yeah.
19 DR. FELDSTEIN: As we have two more
20 sessions --
21 CHAIR CASALE: Yeah.
22 DR. FELDSTEIN: -- you know, there
23 may be some discussion for -- with a panel.
24 DR. PULLURU: I think the earlier

1 call for having actuarial representation at
2 both the June meeting and September meeting,
3 you know, makes so much sense in light of some
4 of these pressures.
5 CHAIR CASALE: Yeah.
6 MR. STEINWALD: You just reminded me
7 to request a -- thank you for saying that.
8 Could we get ASPE or NORC to provide us with
9 the specific responsibilities that the
10 actuaries have? I know it's set forth in
11 legislation, but it might be expanded upon in
12 regulation or through other methods.
13 I know that they have the
14 certification responsibility, but I don't
15 really know much more than what we've talked
16 about today, which was enough. But we could
17 learn more, I think, if we had the right source
18 of information.
19 CHAIR CASALE: Yeah, I'm sure they
20 can provide that to us. Josh, any thoughts? I
21 know you've been listening closely I'm sure
22 over the last couple days.
23 DR. LIAO: Yeah, no, I think I echo
24 a lot of what's been said. I've been quiet now

1 because I don't disagree.
2 And I think one of the things, and I
3 mentioned it a few times in our comments even
4 yesterday, is, you know, just this thing that,
5 I hope all of us are clear-eyed about this idea
6 of coordinating and nesting requires imposing
7 some structure that takes away flexibility.
8 So, I kind of triage every comment
9 that I hear about we need to let people pick
10 which conditions and which patients and how
11 much risk to take on and how to create the
12 network. That is -- at some level there's a
13 tension at least with that in saying we want to
14 lay these tracks down around this episode or
15 that thing would have been a broader model.
16 And at the risk of perpetuating that
17 point, I don't think there's a one-size-fits-
18 all there. But I think as we test models, it's
19 important just to keep that top of mind.
20 CHAIR CASALE: So maybe we're asking
21 the wrong question about how to engage
22 providers, getting back to the earlier point,
23 how do we engage patients, because, you know,
24 that, you know, if you have a model and you

1 engage the patients then that will drive and
2 allow the flexibility.
3 DR. LIAO: I think so. And I think,
4 you know, hope this is accurate. But I would
5 imagine if we looked at every ACO in the
6 country, there are differences, right, for the
7 patient population and for the environment.
8 And I think I took away from today
9 the importance of making sure people know what
10 they're getting, the beneficiaries and
11 individuals. And yet that variation, if we
12 want that, that's what some of the current
13 state is.
14 The moment we start like appending,
15 you know, an episode model with requirements
16 and, you know, specifications, that provides
17 consistency, but there's limitations there,
18 too.
19 CHAIR CASALE: Yeah.
20 DR. WILER: Josh, I think your
21 comments are really important. And, you know,
22 it makes me mindful that the stated goal that
23 we heard from CMMI leadership was from the
24 patient lens around participation, 100 percent

1 participation of patients in value-based
2 arrangements.
3 But what about the provider
4 community? Our models are focused on
5 providers. Is there the same expectation that
6 providers are 100 percent engaged? They seem
7 to be to your description, Josh, right.
8 Potentially from what we've heard of
9 polarity, it's not possible to have both
10 flexibility and 100 percent participation of
11 those two entities, much like the comments
12 previously made before that one entity's waste
13 is another entity's opportunity.
14 DR. LIAO: That's right. And to
15 maybe still turn back to this idea of the
16 essential elements here.
17 You know, I think this is an
18 essential consideration I would say, because I
19 know we haven't been talking about it the last
20 couple days.
21 But in my work from my perspective,
22 you know, when we think about models, there are
23 voluntary models, which tend, that tend to kind
24 of be related to you can choose, again, and not

1 and that gets, Jen, to your point about what
2 the provider has, you know, if there's 100
3 percent participation.
4 You can mandate participation,
5 right, and you can get 100 percent
6 participation. It creates a whole host of
7 other issues all of us are aware of.
8 And so somewhere in what we're
9 talking about the last couple days, there is
10 some rough analog to that. How much do we want
11 to impose on the payment models to get
12 providers and, you know, patients and
13 beneficiaries engaged? And there's a tradeoff
14 somewhere there. So --
15 CHAIR CASALE: Great. Thank you,
16 Josh.
17 DR. PULLURU: You know, one thing
18 that we might want to think about in our
19 models, and that was a really good point, Josh,
20 something I haven't thought about personally,
21 is when you do this nesting, and to Josh's
22 point there's less flexibility, but is that
23 less flexibility because of the attribution
24 methodology?

1 I mean, should we take a step back
2 and say that, you know, maybe there needs to be
3 some revisiting the attribution methodology
4 because it does lend itself to those swings and
5 making it more difficult to induce harmonized
6 models?
7 DR. LIAO: I think just reacting to
8 that I would say, you know, one of the comments
9 that came up from the earlier part of our
10 session today was this idea of, you know, APMs
11 you have to attribute, right, in some way. And
12 there are some challenges there.
13 And I think it's been well
14 documented when you have beneficiaries who are
15 receiving care under bundled payments and ACOs,
16 you know, that attribution thing becomes, who's
17 responsible for the care becomes the challenge.
18 Those are the types of challenges I think will
19 come up if we do nesting or coordinate plugging
20 in, you know, models within each other.
21 I'm not saying it's not an issue
22 today. But part of the flexibility that exists
23 in ACOs and other population-based models that
24 exist now is that you don't need to have that,

1 right, that an ACO can decide as that
2 accountable entity, I will spin up this
3 service line, this initiative, and it will
4 involve these specialists and these parts of
5 the clinical team.
6 But it creates less feasibility.
7 So, some comments from earlier today I think
8 were very appropriate in that point.
9 I think kind of a related point,
10 Chinni, is that when I think about it, one of
11 the premises of having a nesting of the models,
12 I think it was Valinda who said this, you know,
13 I think -- she was just pretty clear about it.
14 She said I think the way to engage specialists
15 is through an episode-based model. And we can
16 debate that.
17 But if we believe that that's the
18 way to engage specialists, then not having it
19 leaves that uncovered so to speak, right. If
20 we think there's a better way, that's what I'm
21 hoping the sessions that we do, you know, going
22 forward, and through PTAC will address, because
23 that's the need to test to challenge the
24 question to agree with or not.

1 DR. PULLURU: Because one of the
2 challenges that we had, you know, we had about
3 100,000 patients in a Medicare ACO. And, you
4 know, quarter upon quarter I saw -- I saw
5 almost a quarter of our patients swing, so 25
6 to 30 percent of our patients swung in and out
7 of our ACO attribution, because we had other
8 hospital systems that, for example, had
9 cardiologists. And they would gain that
10 plurality and eventually swing out.
11 And so, you know, if we're engaging
12 specialists, and having that sort of structure
13 change, could help better engage specialists in
14 that ACO model.
15 CHAIR CASALE: Yeah, I agree. I
16 think that's an ongoing question. Throughout
17 the June and September, we need to continue to
18 think through important questions, and do we
19 need these additional models or not, and in
20 what areas? And if we don't need them, then
21 what are the other ways that would work to
22 engage, you know, specialists in these total
23 cost of care models?
24 DR. LIAO: Yeah, I think looping

1 back to an earlier comment, I think engagement
2 is one thing, communication, and those comments
3 about participating versus driving. Like we
4 talked about this, but accountability I think
5 is really important. I think we have an
6 opportunity in the forthcoming meetings to
7 think about it.
8 As we hear about delivery models,
9 yes, it's the nuts and bolts of what's
10 happening and who's doing what. But also, if
11 we can get underneath that to say who really
12 assumes accountability, who feels that they
13 have accountability over this part of care, I
14 think will be incredibly important, because you
15 could imagine two worlds , one in which you,
16 both in which you engage specialists, but one
17 you imply that attribution proscriptively, so
18 it's Dr. A or Dr. B or Clinician C.
19 And it will if you don't do that.
20 And I think that just takes us to very
21 different outcomes.
22 (Simultaneous speaking.)
23 DR. LIN: On that point, you know,
24 engaging specialists, I think it was Emily

1 Maxson from Aledade who said that really their
2 focus is on having the primary care provider
3 drive the care as opposed to the specialists.
4 I know that in my own clinical
5 practice, I feel like the specialists that I
6 refer my patients to is a reflection of the
7 care that I provide my patients. And so, I try
8 to be very thoughtful, especially since, you
9 know, I take care of a very frail, elderly
10 population where goals of care discussions are
11 really important. And not all specialists are
12 kind of tuned in to that particular aspect of
13 the frail elderly's care.
14 And so, you know, just the thought
15 that, you know, I think Valinda did say
16 calculating specialists or having somehow
17 primary care providers be very involved with
18 kind of the specialist spend I think is an
19 interesting idea.
20 MR. STEINWALD: You know, as an
21 older person, I'm, you know, a consumer of
22 health care services. I'm more than just an
23 analyst.
24 And I have two primary care

1 providers. One is in general internal
2 medicine, and I get an annual physical and
3 occasionally other services. My other primary
4 care provider is an orthopedist. And he's the
5 person I'm likely to see more often during the
6 course of the year. So how do you reconcile
7 that? I don't go to my primary care internist
8 to send me to the orthopedist anymore.
9 But when you're in a plan
10 environment, how do you deal with a participant
11 like me who sees a specialist because that's
12 where most of the need arises and doesn't see
13 the primary care doctor all that often?
14 DR. LIAO: I don't have an answer
15 for that. I would say -- but I think as a
16 general internist and not an orthopedist, I
17 don't have an answer to that.
18 But I do think it raises this,
19 another point I want to highlight just for the
20 discussion, which is that, you know, when we
21 talk about beneficiaries or individuals
22 receiving care under some form of
23 accountability, that is neither at odds nor
24 completely consistent with everything in their

1 care being under that, right.
2 So, imagine if, to use Bruce's
3 example, one of his two clinicians was in a
4 payment model, assumed accountability, but the
5 other didn't. I mean, his care is under
6 accountability, some of it, not all of it.
7 Does it need to be? And how would you help
8 connect those proverbial pipes?
9 And so I think we could be in that
10 situation, because I don't know that it's just
11 orthopedists. I think we've heard from
12 multiple people, you know, nephrology,
13 oncology. I mean, there are multiple
14 specialties where that might be the case.
15 But if four out of my five
16 clinicians are within a payment model or two
17 out of five, is that good? Is that sufficient?
18 I just think that's an issue we're pointing at
19 also.
20 DR. LIN: Some ACOs, I'm not sure
21 about Aledade, but some ACOs have kind of taken
22 a page from the MA playbook and establish
23 networks of specialists, right, within their
24 ACO to refer to to address that problem.

1 CHAIR CASALE: But even with that, I
2 think, doesn't the data suggest that for most
3 ACOs, maybe 50 percent of the care is outside
4 their ACO or something like that? I mean, it's
5 a large percentage of the care that's actually
6 within, you know, the providers in their ACO.
7 (Simultaneous speaking.)
8 DR. KOSINSKI: You know, one of the
9 issues that arises there is hospital-based ACOs
10 employ its certain sets of specialists. The
11 patient really doesn't have a choice in who
12 they're going to be able to go to.
13 And, you know, if you talk to a lot
14 of commercial health plans, they'll tell you
15 that this is an issue that they have a
16 difficult time dealing with in some of their
17 ACO population.
18 DR. MILLS: Yeah, I was going to
19 make a similar comment, which is just the
20 challenge of network, or to think of it another
21 way, the challenge of geography in linking your
22 specialists into any value-based paradigm,
23 which is potentially in, you know, some very
24 large urban centers where you have more

1 specialists than you need, it's easy to use the
2 power of the primary care doctor's referring
3 pen to a high-quality, lower-cost specialist
4 network. It's very thoughtful and approaches
5 care the right way.
6 But in the vast majority of
7 geographies, that is not true. And you simply
8 have to play the specialists you have access
9 to.
10 So that gives rise to this idea of
11 essentially there's, you know, there's
12 individual sections of this total cost of care
13 concept which are separately standardized and
14 separately valued.
15 And in working in a given geography,
16 there may be some subtotal cost of care model
17 which is the best you can do given the
18 parameters you have. And how that's valued and
19 operated, of course, the devil is in the
20 details.
21 DR. KOSINSKI: That's probably why
22 you got 50 percent of the care being provided
23 outside of the network.
24 DR. MILLS: Yeah.

1 DR. PULLURU: And particularly in
2 areas where there isn't a wide uptake of APM
3 models, it's in those areas typically, there
4 aren't any specialists you can refer to that
5 would be willing to take that on. So, it
6 becomes that much harder.
7 DR. MILLS: Yeah. Now the, you
8 know, Aledade and similar models have been
9 successful because in the less urban, more
10 rural, large tracts of the country, they are
11 working with the only specialists they have.
12 But then they have the power of
13 relationship with those specialists. And they
14 are, you know, a large part of that
15 specialist's incoming patient stream. And
16 there's a relationship to maintain. But that's
17 a harder tool to wield frankly.
18 DR. PULLURU: Well, and then it
19 brings to light, you know, should incentives
20 follow the virtualization of that or
21 digitalization of that, you know?
22 For example, if you're looking at,
23 you know, companies like Rubicon that have
24 digitalized, you know, over 250 specialties,

1 you know, should -- right now the reimbursement
2 for telehealth, you know, has a mandatory in-
3 person care requirement.
4 And so that takes that geography and
5 makes it sort of a stranglehold. Maybe we take
6 that off, you know. And those are things to
7 look at.
8 CHAIR CASALE: Other thoughts about
9 today or yesterday or --
10 DR. LIAO: I just have one final, I
11 mean, kind of appended to Lee's comment, which
12 I think is that, you know, there are all these
13 forces, right, that -- you know, if a sub-
14 specialty group signs up to be a part of an
15 ACO, they declared it in that participation
16 that they're signaling some interest or a
17 willingness to take accountability or partner
18 in that care.
19 You know, the other way for groups
20 like that to signal it would be to sign up,
21 right, formally as a participant in a payment
22 model, like BPCI, for example.
23 And I think going back to that prior
24 point, like when you think about geography and

1 the supply of clinicians and groups and kind of
2 factor in like the natural way this can happen,
3 and Lee articulated some of those, right, if
4 you have market share, if you have existing
5 relationships, the one way around that, I'm not
6 saying it's desirable, but it may come up in
7 the next few meetings is, again, mandating
8 participation for some total or sub-total part.
9 I mean, you can apply a very strong
10 policy there. And again, there's a host of
11 issues that come up there. But short of that,
12 I think you're not going to get away from those
13 unique market and geographical factors that Lee
14 gave us insight to.
15 And so that in some ways is at odds
16 with getting scale, either at the provider or
17 the beneficiary level.
18 DR. WILER: We know, right, at the
19 end of the day that unpredictability increases
20 risk. Increased risk is, has already been a
21 barrier to participation or an intolerance to
22 participate. So, if that's not mitigated, it's
23 hard to imagine how this 100 percent goal will
24 be achieved.

1 CHAIR CASALE: That's great. We
2 only have just a couple minutes. I just want
3 to be sure. Any final thoughts from any of the
4 Committee members on --
5 DR. LIN: Paul, one quick kind of
6 aha moment for me from these two days was
7 actually just from our last panelist
8 discussion.
9 You know, we've really focused on
10 kind of defining total cost of care with this
11 meeting. And I just thought the whole idea of
12 standardizing definitions around components of
13 total cost of care while leaving some
14 flexibility for each organization to choose
15 those components and kind of have different
16 definitions of total cost of care to remain
17 flexible was really interesting. You know, and
18 that's not something I had thought of before.
19 CHAIR CASALE: Yeah, I agree. I
20 thought, I found that very interesting as well,
21 Walter. And I hadn't thought of it in that
22 way.
23 But it may be a way forward in terms
24 of having flexibility and not a strict

1 definition of total cost of care that has to
2 apply, you know, across, but have enough
3 structure so that people understand what the
4 definition is for that particular group.
5 MR. STEINWALD: Yeah, I agree, too.
6 And I think it's maybe an avenue for us to
7 provide some concrete information in our
8 eventual report to the Secretary that makes a
9 real contribution to the goal eventually.
10 CHAIR CASALE: Yeah. Any other
11 final thoughts? All right.
12 * **Closing Remarks**
13 So, I want to thank everyone
14 for participating today, our guest
15 presenters, panelists, members of the
16 public, and, of course, my PTAC colleagues.
17 We explored many different facets of
18 population-based total cost of care models.
19 Again, a special thanks to my
20 colleagues on PTAC. A lot of information
21 packed into the two days. Appreciate
22 everyone's active participation and thoughtful
23 comments.
24 We will continue to gather

1 information on our theme through a Request for
2 Input. We're posting it on the ASPE
3 PTAC website and sending it out through
4 the PTAC listserv. You can offer your
5 input on questions by April 15th.
6 * **Adjourn**
7 Now that we have a better handle
8 on defining the relevant concepts
9 and understanding the broad issues, the
10 next step is studying implementation.
11 So, our June public meeting will
12 focus on the best practices for care delivery,
13 improving quality, and measuring the success of
14 population-based total cost of care models. I
15 certainly hope that everyone will join us then.
16 So, before we adjourn, I want
17 to express my deep appreciation to the entire
18 ASPE team and the NORC staff for all of their
19 work in making these past two days of
20 meetings so successful.
21 So, with that, the meeting is
22 adjourned. Thank you.
23 (Whereupon, the above-entitled
24 matter went off the record at 3:46 p.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Public Meeting

Before: PTAC

Date: 03-08-22

Place: webex

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