

Physician-Focused Payment Model Technical Advisory Committee

Panel Discussion: *Perspectives on Developing a Pathway Toward the 2030 Goal of Having All Beneficiaries in Care Relationships with Accountability for Quality, Outcomes, and TCOC*

Panelists:

Subject Matter Experts

- [J. Michael McWilliams, MD, PhD](#) – Warren Alpert Foundation Professor of Health Care Policy, Professor of Medicine, Department of Health Care Policy, Harvard Medical School
- [Ezekiel J. Emanuel, MD, PhD](#) – Vice Provost for Global Initiatives and Professor, Department of Medical Ethics and Health Policy, University of Pennsylvania
- [Timothy G. Ferris, MD, MPH](#) – Founding Senior Vice President of Value Based Performance for Mass General Brigham, Inaugural Chief Transformation Officer for the National Health Service (England), Adjunct Professor of Medicine, Harvard Medical School
- [Alice Hm Chen, MD, MPH](#) – Chief Health Officer, Centene

***Panel Discussion: Perspectives on Developing a Pathway Toward the
2030 Goal of Having All Beneficiaries in Care Relationships with
Accountability for Quality, Outcomes, and TCOC***

J. Michael McWilliams, MD, PhD

Warren Alpert Foundation Professor of Health Care Policy, Professor of
Medicine, Department of Health Care Policy, Harvard Medical School

Pathway Toward Population-based Total Cost of Care Models

J. Michael McWilliams, MD, PhD

Professor of Health Care Policy and Medicine

Harvard Medical School and Brigham & Women's Hospital

September 16, 2024

Disclaimer: The views I present are my own and do not necessarily reflect those of any organization with which I am affiliated, including the Center for Medicare and Medicaid Innovation (CMMI)

Key Points

- Goal is success (participation one measure)
- Need long-term vision for payment system (and Medicare!), then back solve
- Complexity has gotten out of hand
- Program design critical (MSSP)
 - Increase savings rates
 - Improve benchmarking
 - Minimize ACO-specific ratchets (move off historical benchmarks)
 - Do not claw back all collective success – allow “wedge” to form as ACOs save
 - Avoid knee-jerk zeal for downside risk (overblown esp in voluntary program)
 - Share savings with beneficiaries to foster demand for efficiency
 - Risk adjustment...
- Can randomize program changes to inform design (learning system)
- Intersection of TCOC + PC pop-based payment needs definition
- Portfolio: MSSP + limited episodes (fewer models designed better)
- Multi-payer problem – big issue but so is getting it right in Medicare

*Panel Discussion: Perspectives on Developing a Pathway Toward the
2030 Goal of Having All Beneficiaries in Care Relationships with
Accountability for Quality, Outcomes, and TCOC*

Ezekiel J. Emanuel, MD, PhD

Vice Provost for Global Initiatives and Professor, Department of Medical
Ethics and Health Policy, University of Pennsylvania

Ezekiel Emanuel, MD, PhD

- 2011- *present* – Vice Provost for Global Initiatives and Levy University Professor, University of Pennsylvania
- 2017- *present* – Co-Director, Penn’s Healthcare Transformation Institute
- 2009-2011 – Special Advisor on Health Policy to the Director of the Office of Management and Budget and National Economic Council. Worked on developing the ACA.
- Breast Oncologist

What is causing VBP stasis?

- Transitioning to VBP is difficult and slow.
- Providers are required to change their financial and operations management.
- Physicians have refined their practice finances and workflows to FFS and are hesitant to transition without better data.

How can we reach 100% participation?

- In order for more practices to adopt VBP, they need:
 - Timely, accurate, accessible, and actionable financial data.
 - Confidence they can achieve financial success.
- CMS should facilitate the development and adoption of low-cost solutions by supporting integration with open-source packages and requiring commercial payers – MA plans, exchange plans at a minimum – to adhere to the same data standard.
- This could create new, competitive market solutions for financial modeling, and spur much-needed foundational innovation in health care finance and operations.

***Panel Discussion: Perspectives on Developing a Pathway Toward
the 2030 Goal of Having All Beneficiaries in Care Relationships with
Accountability for Quality, Outcomes, and TCOC***

Timothy G. Ferris, MD, MPH

Founding Senior Vice President of Value Based Performance for
Mass General Brigham, Inaugural Chief Transformation Officer for
the National Health Service (England), Adjunct Professor of
Medicine, Harvard Medical School

Perspectives on Developing a Pathway Toward the 2030 Goal of Having All Beneficiaries in Care Relationships with Accountability for Quality, Outcomes, and TCOC

TIMOTHY G. FERRIS, MD, MPH

-
- Founding Senior Vice President of Value Based Performance for Mass General Brigham
 - Inaugural Chief Transformation Officer for the National Health Service (England)
 - Adjunct Professor of Medicine, Harvard Medical School
 - Former PTAC Member, 2015-2019

Key Takeaways

Increasing number of older US population with treatable conditions will require substantial additional resources (funding and people)

- Biotech Innovations add patient benefit, cost, and delivery burden
- Substantial changes in health care delivery will be required

Defining accountability

- Burden of existing accountability substantial: conditions of participation, licensing criteria and board certifications, patient experience survey results, quality metrics, ACOs
- Accountability is needed for structural issues affecting health care delivery (e.g., capacity); high value insurance (e.g., overhead versus patient care); tax burden of beneficiary shifting (e.g., MA to FFS); and provider price increases

Systems of care provide better care than unconnected individuals

- Hold delivery systems accountable without increasing the cost burden
- Reward lowering provider unit cost through technology adoption that increases throughput
- Quality metrics should be aggregated at practice (not payer)
- Outcomes registries for procedures
- Better alignment of payment with work (hospital and physician)

Appendix

References

1. Timothy G. Ferris. Unit cost and hope: Increased NHS resilience through tech-enabled transformation. *Future Healthcare Journal*, Volume 11, Issue 1, 2024. <https://doi.org/10.1016/j.fhj.2024.100021>.

2. Michael Porter. What is Value in Healthcare? *N Engl J Med* 2010;363:2477-2481

***Panel Discussion: Perspectives on Developing a Pathway Toward the
2030 Goal of Having All Beneficiaries in Care Relationships with
Accountability for Quality, Outcomes, and TCOC***

Alice Hm Chen, MD, MPH

Chief Health Officer, Centene

Centene

Leading government-sponsored and commercial healthcare programs

28.5
Million Members

Across

50
States

13.1M

Medicaid members
across **30 STATES**

1.1M

Medicare members
across **37 STATES**

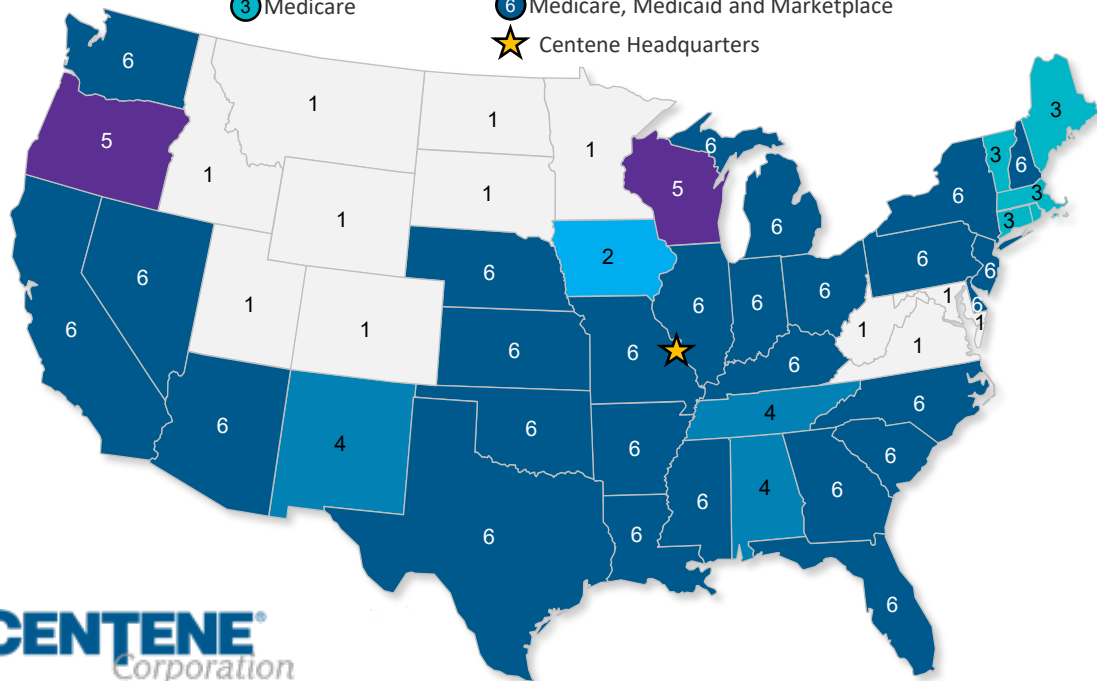
4.4M

Marketplace members
across **29 STATES**

6.6M

Prescription Drug Plan
members across **50 STATES**
and the District of Columbia

- ① Medicare PDP
- ② Medicaid
- ③ Medicare
- ④ Medicare and Marketplace
- ⑤ Medicaid and Medicare
- ⑥ Medicare, Medicaid and Marketplace
- ★ Centene Headquarters



Alice Hm Chen, MD, MPH

PRACTICE → POLICY → PAYMENT

- PC internist, clinical practice in safety net
- Medical Secretary, On Lok Senior Health Services
- Medical Director, General Medicine Clinic
- Chief Integration Officer and founding director of eConsult, San Francisco General Hospital
- Deputy Secretary for Policy and Planning at California Health and Human Services Agency
- Chief Medical Officer at Covered California
- EVP, Chief Health Officer for Centene Corporation
- Co-chair of the Health Care Payment Learning & Action Network's Executive Forum

Key Takeaway | Measure Alignment

| Measure Abbr | Measure (n= 170) | NCQA Medicaid Health Plan Rating (n=56) | Marketplace QRS (n=45) | Medicare (n=48) | MAC QRS (2026) (n=23) | # of Medicaid MY24 State P4P Programs (n=54) | Uniform Data System (UDS) CHC Clinical Measures (n=18) |
|--------------|--|---|------------------------|-----------------|-----------------------|--|--|
| AAB | Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolit | Y | Y | | | 1 | |
| BPD | Blood Pressure Control for Patients with Diabetes < 140/90 | Y | | | | 3 | |
| BCS | Breast Cancer Screening | Y | Y | Y | Y | 10 | Y |
| COA-MR | Care for Older Adults Medication Review | | | Y | | | |
| COA-PA | Care for Older Adults Pain Screen/Assessment | | | Y | | | |
| CCS | Cervical Cancer Screening | Y | Y | | Y | 12 | Y |
| WCV | Child and Adolescent Well-Care Visits | | Y | | Y | 15 | |
| CIS | Childhood Immunization Status Combination 10 | Y | Y | | | 8 | Y |
| CIS | Childhood Immunization Status Combination 3 | | | | | 10 | |
| CHL | Chlamydia Screening in Women | Y | Y | | | 8 | |
| COL | Colorectal Cancer Screening | Y | Y | Y | Y | 2 | Y |
| CCP | Contraceptive Care - Postpartum Women | | | | Y | | |
| CBP | Controlling High Blood Pressure | Y | Y | Y | Y | 15 | Y |
| EED | Eye Exam for Patients with Diabetes | Y | Y | Y | | 6 | |
| FMC | Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions | | | Y | | | |
| GSD | Glycemic Status Assessment for Patients with Diabetes (A1c < 8) | Y | Y | Y | Y | 12 | A1c > 9 |
| INR | International Normalized Ratio Monitoring for Individuals on Warfarin | | Y | | | | Y |
| KED | Kidney Health Evaluation for Patients with Diabetes | Y | Y | Y | | 3 | |
| LDM | Language Diversity of Membership | Y | | | | | |
| OEV | Oral Evaluation, Dental Services | | Y | | Y | | |
| OMW | Osteoporosis Screening in Women Who had a Fracture | | | Y | | | |
| POD | Pharmacotherapy for Opioid Use Disorder | Y | | | | 4 | |
| PCE | Pharmacotherapy Management of COPD Exacerbation (Bronchodil | Y | | | | 1 | |
| PCE | Pharmacotherapy Management of COPD Exacerbation (Corticoste | Y | | | | 3 | |
| PCR | Plan All Cause Readmissions | Y | Y | Y | | 6 | |
| PPC | Postpartum Visit | Y | Y | | Y | 21 | |
| PRS | Prenatal Immunization Status - Combination Rate | Y | | | | 3 | |
| RDM | Race/Ethnicity Diversity of Membership | Y | | | | 1 | |
| DSF | Screening for Depression and Follow-Up Plan | | Y | | Y | 1 | |
| SNS-E | Screening for Social Drivers of Health/Social Need Screening and Intervention | | Y | | | 2 | |
| CWP | Strept Test For Pharyngitis | Y | | | | 1 | |
| PPC | Timeliness of Prenatal Care | Y | Y | | Y | 21 | |
| TRC | Transitions of Care | | | Y | | | |
| LBP | Use of Imaging Studies for Low Back Pain | Y | Y | | | 1 | |

| Abbr. | Measure Name |
|-------|---------------------------------------|
| WCV* | Child and Adolescent Well-Care Visits |
| PPC* | Prenatal Care Timeliness of care |
| PPC* | Postpartum Care |
| CBP | Controlling Blood Pressure |
| GSD | Glycemic status <8.0% |
| BCS-E | Breast Cancer Screening |
| COL** | Colorectal Cancer Screening |

MAC QRS is the Medicaid and CHIP Quality Reporting System

Uniform Data System (UDS) is HRSA's Community Health Center measure set

Appendix

California’s Marketplace Innovations: Driving Health Plan Accountability For Quality And Equity

Alice Hm Chen, Peter V. Lee

SEPTEMBER 30, 2022 10.1377/forefront.20220928.429170



<https://www.healthaffairs.org/content/forefront/california-s-marketplace-innovations-driving-health-plan-accountability-quality-and>

eReferral — A New Model for Integrated Care

Alice Hm Chen, M.D., M.P.H., Elizabeth J. Murphy, M.D., D.Phil., and Hal F. Yee, Jr., M.D., Ph.D.

Health care reform has generated new pressures for the U.S. health care system to take better care of more patients at lower cost. Whereas these challenges are relatively new in the fee-for-service private sector, safety-net systems have perennially had to “do more with less”; innovations in this arena have generally been prompted by clinical exigencies rather than the need to gain market share or maximize revenues.¹ We believe that one such innovation — eReferral — can serve as a new model for integrating primary and specialty care.

In 2005, San Francisco General Hospital (SFGH) was grappling with a challenge familiar to safety-net organizations: providing access to specialty care.² Because of a tremendous mismatch between supply and demand for specialty services, patients were waiting 11 months for a routine clinic appointment for gastroenterology, 10 months for nephrology, and 7 months for endocrinology. If a patient needed to be seen sooner, the referring clinician had to plead with a specialist to overschedule into already overflowing clinics. Patients would sometimes wait for months only to discover that they were in the wrong subspecialty clinic or needed further diagnostic testing, which added to delays in care.

The dual imperatives of timely access and rational triage drove the creation, implementation, and spread of our homegrown, Web-based, integrated specialty referral and consultation system, called eReferral. It uses health information technology to streamline primary care and specialists, with increasing access to specialists, improving dialogue between them, and the efficient use of resources, and enhancing care capacity.

Originally pilot used for more than 10 years at SFGH, eReferral is now used for more than 100 specialties. The eReferral system automatically populates the referral information into the PCP’s electronic medical record (EMR) as free text, along with history and examination findings. Every service history and examination findings are reviewed by a specialist reviewer to ensure quality and efficiency.

2450

N ENGL J MED 368:26 NEJM.ORG JUNE 27, 2013

<https://www.nejm.org/doi/full/10.1056/NEJMp1215594>