

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

**September 20, 2022
8:50 a.m. – 1:59 p.m. EDT
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201**

Attendance

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

Paul N. Casale, MD, MPH, PTAC Chair (Vice President, Population Health, NewYork-Presbyterian, Weill Cornell Medicine and Columbia University)

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

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

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

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

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

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

Angelo Sinopoli, MD (Chief Network Officer, UpStream)

Bruce Steinwald, MBA (President, Bruce Steinwald Consulting)

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

PTAC Members in Partial Attendance

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

Department of Health and Human Services (HHS) Guest Speakers

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

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

Lisa Shats, PTAC Designated Federal Officer*

Audrey McDowell

Steven Sheingold, PhD

****Via Webex Webinar***

List of Speakers and Handouts

1. Listening Session 3: Financial Incentives and Performance Metrics Related to Primary Care and Specialty Integration

Amol Navathe, MD, PhD, Co-Director, Healthcare Transformation Institute, Director, Payment Insights Team, and Associate Director, Center for Health Incentives and Behavioral Economics, University of Pennsylvania; Physician and Core Investigator, Philadelphia Veterans Affairs Medical Center; and Commissioner, Medicare Payment Advisory Commission, U.S. Congress*

Mark Friedberg, MD, MPP, Senior Vice President, Performance Measurement and Improvement, Blue Cross Blue Shield of Massachusetts*

Eric C. Schneider MD, MSc, Executive Vice President, National Committee for Quality Assurance (NCQA)*

Brian Bourbeau, MBA, Division Director, Practice Health Initiatives, American Society of Clinical Oncology; (*The Patient-Centered Oncology Payment Model proposal*)*

Handouts

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

2. Listening Session 4: Payment Considerations and Financial Incentives Related to Population-Based TCOC Models

Mark McClellan, MD, PhD, Robert J. Margolis Professor of Business, Medicine, and Policy, and Founding Director, Duke-Margolis Center for Health Policy, Duke University*

Joseph Francis, MD, MPH, Executive Director, Analytics and Performance Integration, Office of Quality and Patient Safety, Veterans Health Administration*

Kate Freeman, MPH, Manager, Market Transformation, American Academy of Family Physicians*

Nancy L. Keating, MD, MPH, Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School; Professor of Medicine and Practicing General Internist, Brigham and Women's Hospital*

Robert E. Mechanic, MBA, Executive Director, Institute for Accountable Care; and Senior Fellow, Heller School of Social Policy and Management, Brandeis University*

Handouts

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

3. Public Commenters

Anne Hubbard (The American Society for Radiation Oncology [ASTRO])*

Alyssa Newman (National Association of ACOs [NAACOS])

**Via Webex Webinar*

[NOTE: A transcript of all statements made by PTAC members and public commenters at this meeting is available on the ASPE PTAC website located at: <https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>].

The [ASPE PTAC website](#) includes copies of the presentation slides, handouts, and a video recording of the September 20 PTAC public meeting.

Welcome and Overview: Discussion on Payment Considerations and Financial Incentives Related to Population-Based Total Cost of Care (TCOC) Models Day 2

Lauran Hardin, PTAC Vice Chair, welcomed members of the public to day two of the September public meeting on population-based total cost of care (TCOC) models and introduced Elizabeth (Liz) Fowler, Deputy Administrator of the Centers for Medicare & Medicaid Services (CMS) and the Director of the Center for Medicare and Medicaid Innovation (CMMI; the Innovation Center).

Dr. Fowler indicated that population-based TCOC models are central to CMMI's strategy, and noted that as with previous PTAC public meetings, the September agenda is relevant to CMS's strategy and the CMS Administrator's priorities related to value-based care. Dr. Fowler stated that CMMI is committed to pursuing new care delivery and payment innovation models, while thinking about how these models can inform future Medicare and Medicaid policy to improve these programs for beneficiaries. She thanked the Committee for including a mix of policy expert, practitioner, state policy and payer perspectives, noting that PTAC's public meeting discussions will help to inform CMMI's pipeline of models.

Dr. Fowler noted that CMMI is focused on improving data transparency for better insight into model performance; incorporating social determinants of health (SDOH) screening and referrals into models; collecting health equity data; and ongoing initiatives focused on risk adjustment and improving approaches for setting benchmarks. She indicated that the Innovation Center anticipates engaging with stakeholders, including PTAC, on new models and crosscutting initiatives as they are available. She continued by highlighting some of CMMI's most recent work:

- Dr. Fowler stated that the CMS team focused on specialty care models recently published a [blog post](#) describing how Innovation Center models have demonstrated success in lowering expenditures and enhancing quality for specialty care. She indicated that lessons learned from episode-based models such as the Bundled Payments for Care Improvement [BPCI] and the Comprehensive Care for Joint Replacement [CJR] models will inform a comprehensive specialty care strategy that will be released later this year.
- Dr. Fowler announced that CMMI has released a list of provisionally accepted organizations who could participate in the Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) model beginning on January 1, 2023. She indicated that ACO REACH is a redesign of the Global and Professional Direct Contracting (GPDC) model that incorporates factors that are intended to advance health equity, including a new health equity benchmark adjustment and requirements for organizations to develop and implement a health equity plan.
- Dr. Fowler noted that CMMI recently announced a new voluntary Enhancing Oncology Model (EOM) that will launch on July 1, 2023. She indicated that the EOM model will test how to best place cancer patients at the center of their care team that provides high-value, equitable, evidence-based care; and improves care coordination, quality, and health outcomes for patients. She also

stated that the EOM model also holds oncology providers accountable for TCOC to make cancer care more affordable and accessible for beneficiaries; and requires practices to screen for health-related social needs (HRSNs).

- Additionally, Dr. Fowler stated that CMMI recently made identifiable data files available for six CMMI models to improve data sharing.

Dr. Fowler emphasized that CMMI is incorporating beneficiary perspectives into its models by implementing more patient-reported outcome measures and evaluating beneficiary experience to ensure that models are accomplishing patients' goals. She stated that CMMI believes that success should be measured by how a model improves health, affordability, and experience of care; and how it supports partnerships between providers and stakeholders across the system to drive transformation.

Vice Chair Hardin thanked Dr. Fowler for her remarks. She provided an overview of the agenda for the second day of the public meeting, including two subject matter expert (SME) listening sessions, a public comment period, and a Committee discussion to shape the Committee's comments for the report to the Secretary of Health and Human Services (HHS). Vice Chair Hardin invited Committee members to introduce themselves and describe their experience with population-based TCOC models.

Listening Session 3: Financial Incentives and Performance Metrics Related to Primary Care and Specialty Integration

SMEs

- Amol Navathe, MD, PhD, Co-Director, Healthcare Transformation Institute, Director, Payment Insights Team, and Associate Director, Center for Health Incentives and Behavioral Economics, University of Pennsylvania; Physician and Core Investigator, Philadelphia Veterans Affairs Medical Center; and Commissioner, Medicare Payment Advisory Commission, U.S. Congress
- Mark Friedberg, MD, MPP, Senior Vice President, Performance Measurement and Improvement, Blue Cross Blue Shield of Massachusetts
- Eric C. Schneider MD, MSc, Executive Vice President, National Committee for Quality Assurance (NCQA)

Previous Submitter

- Brian Bourbeau, MBA, Division Director, Practice Health Initiatives, American Society of Clinical Oncology; (*The Patient-Centered Oncology Payment Model* proposal)

Vice Chair Hardin moderated the listening session on financial incentives and performance metrics related to primary care and specialty integration, which included three SMEs and one previous submitter. She noted that full biographies and presentations can be found on the [ASPE PTAC website](#).

Amol Navathe gave a presentation titled "Coordinating Specialty and Population-Based Payment Models."

- Dr. Navathe explained that population-based models have produced quality improvements and decreased TCOC, specifically for Medicare spending.
- Dr. Navathe stated that specialty-based models are heavily focused on specialist physicians, hospitals, and other institutions that care for patients being treated for specific conditions. He noted that these models have been somewhat successful at achieving their goals of reducing costs and variability of practice patterns. He pointed out that these models have focused largely on

institutional post-acute care. Dr. Navathe further noted there have been some quality improvements related to utilization, such as reduction in readmissions.

- Dr. Navathe emphasized the advantages that specialty-based models bring. For example, they are more focused than a population-based approach; and to some extent, they are more practical for hospitals, physician organizations, and other organizations such as post-acute care providers. He noted that an advantage relative to population-based models is that specialty-based models provide more options for policy makers to incentivize participation, noting that specialty-based models have been tested in a mandatory fashion (e.g., the Comprehensive Care for Joint Replacement [CJR] Model), as well as through voluntary programs. Conversely, he suggested that it is harder to mandate participation in population-based models.
- Dr. Navathe raised a variety of policy questions related to value-based payments and Alternative Payment Models (APMs), such as the models' impact on cost and quality. He expressed interest in understanding where the savings in these models may be located (e.g., who is generating the savings, and from what kinds of practice pattern changes). He also noted there have been concerns and questions regarding whether clinicians and health care organizations may be trying to increase the volume of episodes in specialty-focused and episode-based models. He also noted that there are concerns about potential case-mix effects in both specialty-focused and episode-based models – such as whether there may be patient selection, particularly on a dimension that would be unobservable to a payer.
- Dr. Navathe indicated that there is interest in identifying how to standardize care and whether models generate any spillover effects in which other patients benefit from practice-wide transformation generated by a Medicare model. He also indicated that there may be debate over the advantages and disadvantages of voluntary versus mandatory participation.
- Dr. Navathe emphasized the importance of understanding how population-based models overlap with episode-based or specialty-based models, and whether empirical evidence exists about the impact of these overlaps.
- Dr. Navathe mentioned CMS's goal of having near-universal participation in value-based payment models, and indicated that this may require a comprehensive strategy that includes both population-based and episode-based payment models. He noted there has been much testing of both population-based and specialty-based APMs, but it has been difficult to coordinate overlapping models. He explained that in order to transform care and reduce costs, there is a need for more efforts to harmonize models across the continuum of care.
- Dr. Navathe indicated that population-based models are heavily focused on the continuum of care; as well as acute phases of utilization that may be related to specific diseases or events (such as heart attacks or strokes) or sites of care (such as chemotherapy in the context of a physician's office or hospital outpatient department). He noted that while population-based models have been successful at reducing hospitalizations, specialty-based models have focused on reducing institutional post-acute care. He indicated that while there could be synergies between models, there could also be redundancies in care infrastructure across models. Additionally, he shared his perspective that it would take some time to develop a financially coordinated program that reduces situations where providers are being paid twice for the same care.
- Dr. Navathe highlighted a study that he did with colleagues which examined patient outcomes when there is overlap between ACOs and bundled payments, and explored how outcomes may vary for different medical conditions and surgical episodes. Dr. Navathe explained that the study focused on ACOs participating in the Medicare Shared Savings Program (MSSP) and bundled payment episodes under the Bundled Payments for Care Improvement (BPCI) initiative. He noted

the study focused on how the effects of bundled payment programs vary for beneficiaries aligned to an ACO versus those that were not associated with an ACO.

- Dr. Navathe indicated that the study found that overlap between an ACO and bundled payments decreases spending (gross savings relative to usual care) for some medical conditions. He stated that the post-discharge institutional spending, such as spending on readmissions, skilled nursing facilities (SNFs) and long-term care hospitals (LTCHs), decreases for both ACO and non-ACO patients; however, the spending for ACO patients decreases by approximately \$300 more per episode.
- Dr. Navathe emphasized that the savings came primarily from relative reductions in readmissions for ACO versus non-ACO patients. He noted that there is a statistically significant difference in the reduction in readmission rates between patients who are attributed to an ACO and end up with an episode for a medical condition at a hospital participating in BPCI when compared with non-ACO patients. Additionally, he stated that the study also found a smaller but statistically significant reduction in readmission rates when patients attributed to ACOs receive surgical procedures at a hospital participating in BPCI.
- In summary, Dr. Navathe indicated that the study suggests that bundled payment models work well with other value-based payment models, at least when in the context of ACOs or population-based payment models – resulting in lower spending and fewer readmissions relative to usual care for patients admitted with certain medical conditions, and fewer readmissions (but no evidence of lower spending) for patients having surgical procedures. He also stated that the benefits of model overlap seem to be larger when clinical complexity is larger, and suggested that these findings are important as policy makers consider how to fairly distribute savings.
- Dr. Navathe also discussed a potential approach for harmonizing APMs and developing hierarchical payment models that he developed with two colleagues.
 - Dr. Navathe explained that they focused on a global budget population-based model as the “umbrella of accountability” under which episode-based payments are applied. He stated that within this framework, ACOs would serve as a coordinating entity with a population-level and total spending level view. and the episode-based payment system for specific conditions and procedures would be implemented in organizations while falling under that umbrella of accountability. Within this context, he also discussed the importance of understanding the dynamics between organizations accountable for episode-based models versus organizations accountable under population-based models.
 - Dr. Navathe highlighted some of the benefits from this kind of hierarchical coordination, including:
 - The potential for stimulating closer collaboration between primary care clinicians, specialists and facilities.
 - The ability to create a blueprint that includes flexibility in how specialists and facilities are reimbursed, which could lead to a system in which organizations in population-based models earn savings by directing referrals for episode-based care to more efficient providers, and clinicians providing care would earn savings under the episodes.
 - Preserve the episode-based payment model and supporting continued innovation across the continuum of care.
- Finally, Dr. Navathe discussed the importance of making equity an explicit goal in designing value-based payment models. He noted that in the past, greater financial accountability has not led to more equitable outcomes – citing concerns about risk adjustment tending to be more incomplete

for marginalized groups, and evidence that clinicians working under value-based models may avoid caring for patients from marginalized groups. Specifically, Dr. Navathe suggested including building equity into quality metrics and financial incentives, as well as measuring the disparate impact on access and quality for disadvantaged populations through expedited reporting and data collection.

Mark Friedberg gave a presentation titled “Future Directions for Quality Measurement in Population-Based Total Cost of Care Contracts.”

- Dr. Friedberg indicated that his presentation would address how his organization, Blue Cross Blue Shield (BCBS) of Massachusetts is thinking about evolving and expanding quality measures within its Alternative Quality Contract (AQC), which is a population-based ACO-type contract. Dr. Friedberg noted that BCBS views payment is a high-stakes measure that has direct economic consequences for provider systems and individual clinicians. He indicated that for BCBS of Massachusetts to use a quality measure, it must be valid, important, and reliable; and noted that because the AQC organizations vary in size, the larger organizations have a wider range of measures than the smaller organizations due to reliability concerns.
- Dr. Friedberg noted that one approach for improving measure validity involves explicitly measuring the performance of shared decision-making – the degree to which decisions are made in a way that is consistent with medical science and individual patient values and preferences. He mentioned that many of the United States Preventive Services Task Force (USTFPPF) recommendations mention using shared decision-making as the optimal way to proceed in making care decisions; however, if shared decision-making is not feasible, the second-best approach is to follow the clinical guidelines.
- Dr. Friedberg indicated that BCBS would like to see shared decision-making measures replace legacy measures for primary care (e.g., cancer screening, chronic condition management) over time – noting that there are trade-offs associated with all of these services, and patients vary in their values and preferences. He shared the view that applying a single set of values and preferences set by a committee’s guidelines will likely be suboptimal for patients. He suggested that the best way to measure patient satisfaction with shared decision-making is through patient surveys. He noted that BCBS of Massachusetts is also interested in using patient-reported outcomes performance measures.
- Dr. Friedberg noted that Massachusetts General Hospital has generated National Quality Forum (NQF)-endorsed survey measures of shared decision-making. He emphasized that a key challenge relates to developing uniform methods for fielding the patient surveys (which can be expensive) while minimizing burden and variation across providers. He suggested that this could include developing a data collection method that is similar to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) in which there is little variation due to the use of approved vendors.
- Dr. Friedberg indicated that BCBS of Massachusetts is increasing its support of mental health services, starting with measuring patient-reported access to mental health services. He indicated that this is probably a preferable approach for more meaningfully understanding member experience when compared with administrative measures of network adequacy and out-of-network service use.
- Next, Dr. Friedberg discussed BCBS’s efforts on equity measurement, which they define as differences between groups of patients for which no systematic differences are ethically tolerable. He noted that BCBS of Massachusetts has published an equity report, which is intended to provide transparency about inequities in its commercially insured population, signal the importance of this issue to provider network, and enable stakeholders to hold the organization accountable for improving equity, and.

- Dr. Friedberg stated that there are no NQF-endorsed measures focused on measuring clinical decision-making rationale. However, he stated that an older quality measurement method may be useful. This approach employs structured implicit review, which involves peer clinicians reviewing each other's decision-making rationale. He noted that this approach can be universally applied, including for specialty care where many important quality measures are lacking. He noted that effective deployment of implicit review-based measures would require setting up structures and incentives for providers to do this within the context of value-based payment models. This is an approach that BCBS of Massachusetts is piloting for AQC.
- Dr. Friedberg stated that payment incentives and data are crucial to fully incorporating equity into the AQC. He noted that BCBS of Massachusetts provided its AQC providers with an equity report on their own AQC measures. He highlighted that most providers had not seen this type of data before as they did not have the capability to track it, and those who had seen this approach before had never seen comparisons to other AQC provider groups. He noted that the reports were confidential; however, seeing blinded results allowed each provider organization to compare its metrics and inequities with other AQC groups. This could help to motivate them to make investments in equity-focused activities.
- Dr. Friedberg also highlighted how BCBS of Massachusetts invests in providing tailored guidance, explanation of data, and ideas for quality improvement to each AQC group. He shared that BCBS of Massachusetts has contracted with the Institute for Healthcare Improvement (IHI) and created an Equity Action Community. He explained that this community gathers all the AQC groups to share best practices and lessons learned on how to approach improving equity.
- Dr. Friedberg noted that the quality of race and ethnicity data available within any given provider varies; for example, some providers may use multiple electronic health records (EHRs), but have not evaluated the accuracy of their race and ethnicity data. He stated that it is not uncommon for data standards to be inconsistently implemented even within the same organization. He also noted that organizations sometimes collect data in ways that are not consistent with the Office of the National Coordinator for Health Information Technology (ONC) or Fast Healthcare Interoperability Resources (FHIR) standards. He indicated that this presents an investment opportunity to help these organizations to better track their performance on equity.
- Dr. Friedberg concluded by discussing how his organization's equity report demonstrates the large inequities in chronic disease management among AQC groups.

Eric Schneider gave a presentation titled "Health Care Quality and Total Cost of Care Payment Models."

- Dr. Schneider stated that studies have shown that U.S. health professionals have the capability to deliver high-quality clinical care; however, there are challenges with care access, coordination, and equity. He noted that these challenges have an adverse impact on health outcomes and should be a primary focus of TCOC models. He indicated that his presentation focuses on addressing the necessary quality accountability infrastructure to support TCOC payment models.
- Dr. Schneider highlighted that the association between unmet social needs and poor health outcomes has been well documented. He noted that 40 to 55 percent of health outcomes are attributed to SDOH. He emphasized that this does not imply that the health care system does not play a role in patient health, but there is a need to focus on SDOH issues and find ways that the system can respond. He also noted the potential for savings given that health inequities lead to substantially higher health care costs.
- Dr. Schneider noted that although they are not often discussed, unmet social needs are broadly felt across the population. He further noted that half of respondents in a recent survey reported at least one unmet social need, with around one-quarter reporting at least two. He highlighted that

unmet social needs are reflected in the different types of insured populations; however, Medicaid beneficiaries have more unmet needs compared to other populations. He stated that there are profound unmet social needs throughout the insured and uninsured populations in the U.S., and physicians will see unmet social needs among patients treated in any physician-based payment model, regardless of the payer.

- Dr. Schneider indicated that the National Committee for Quality Assurance (NCQA) structures its accountability initiative within three programs:
 - HEDIS (Healthcare Effectiveness Data and Information Set), a performance measurement system focused on facilitating comparisons of performance and used for adjusting payments under payment-based incentive programs.
 - NCQA's Health Plan Accreditation program, focused on ensuring health plans have the structure, capabilities, and processes to serve their enrolled members.
 - NCQA's Recognition Programs, such as the Patient-Centered Medical Home (PCMH) Recognition Program, as well as recognition programs for diabetes and stroke, which focus on evaluating the structures, capabilities, and processes in place for clinicians and practices to deliver high-quality care.
- Dr. Schneider emphasized that equity measurements need to include fair comparisons, noting that there will always be challenges with sufficient sample size needed to make these comparisons accurately and reliably. He noted that comparing organizations on quality and equity measurements requires having data on a large population. He also noted that it is challenging to develop comparison groups for quality of care for chronic conditions by patient race and ethnicity. However, if this is done successfully, it will help practices better understand equity.
- Dr. Schneider mentioned that health systems that can deliver high-quality, reliable care often have strong foundational capabilities, such as a quality improvement strategy that they can build upon to add new capabilities. He noted that the PCMH is only as effective as its medical neighborhood, especially in terms of integrated specialty and primary care models of TCOC; thus, it is imperative to consider the medical neighborhood's challenges and the foundational elements needed to achieve high levels of coordination and access. He noted many of the functions of an effective PCMH rely on digital data capabilities, such as the ability to collect, analyze, exchange, and interpret data. These requirements make it challenging to compare across PCMHs.
- Dr. Schneider emphasized that the digital performance measurement system has enabled the creation of health data standards thanks to the Office of National Coordinator for Health Information Technology. He mentioned that this progress on standards facilitates use of practice guidelines, implementation of performance measurement activities, and adoption of processes connecting for collecting, transferring, aggregating, and exchanging data. He stated that a future goal is fully integrating each of these activities with each other. This can occur when guidelines and clinical decision supports are digitally enabled and linked to measures in a digital format.
- Dr. Schneider noted that EHR interoperability has been a priority for the past decade. He indicated that the current approach to certifying EHRs together with data exchange mandates will make interoperability possible. He noted that digital quality measures should focus on effectively measuring access, coordination, and equity of care, and said that the Medicare program is advancing toward these measures. Dr. Schneider emphasized that there are ongoing activities to achieve health data standardization and build technical infrastructure, and that these activities will make it possible to map the attribution and allocation of resources across teams and providers.
- Dr. Schneider emphasized that the quality infrastructure needed to support TCOC models involves consensus-based evaluation standards; methods for evaluating and documenting capabilities;

better approaches to measuring and evaluating unmet social needs; barriers to access, coordination, and equity; and standardizing health data exchange.

Brian Bourbeau gave a presentation titled “Considerations for Nested vs. Carve-Out Specialty Care Episodes.”

- Mr. Bourbeau discussed a study by the American Society of Clinical Oncology (ASCO) of 25,000 oncologists across different specialties which showed that 11,000 oncologists were participating in at least one track of the Medicare Shared Savings Program (MSSP) in 2022. By comparison, he stated that 3,100 oncologists were participating in the Oncology Care Model (OCM) during the same year. He emphasized the importance of considering specialist participation in population-based models, noting that not including providers would exclude a significant number of patients.
- Mr. Bourbeau indicated that oncology is an example of a specialty that highlights the complexity in determining whether to carve out, nest, or otherwise coordinate primary and specialty care. He stated it is possible to look at surgery and radiation within a defined time period and consider what could be included in a nested episode while overall coordination of care occurs at the primary care level.
- By comparison, Mr. Bourbeau indicated that medical oncology care has an indefinite duration in which patients may receive care over months or potentially years. Within this context, he indicated that it is important to consider if primary coordination would rest with the primary care physician (PCP), or if it would shift to the oncologist (in which case it might be appropriate to consider a carve-out episode). However, Mr. Bourbeau indicated that survivorship in cancer care as a chronic condition requires ongoing coordination between the specialist and the PCP. He noted that this is different than nested episodes, which are limited to a defined duration in which it's clear when a patient is entering or exiting the episode.
- Mr. Bourbeau indicated that medical oncology care is not well suited to defining episodes since the duration of this care is unknown, and there is not a specific time frame in which a patient enters into an episode. The financial impact of oncology care at different points of treatment may vary from patient to patient. For example, a patient may be receiving high-cost services in the first six months after starting treatment, and then their treatment intensity and cost of care may decrease over time. Alternatively, the patient may progress in their disease, making treatment more expensive over time.
- Mr. Bourbeau stated that radiation oncologists handle care management for radiation treatment; however, there continue to be some aspects of care that are managed by a primary care provider as radiation treatment is typically only provided during a defined duration. He indicated that medical oncologists employ their own patient and financial navigators, as well as social workers; thus, medical oncology could potentially be considered a carve-out episode area because a broader set of care management duties are shifted to the specialist.
- Mr. Bourbeau emphasized that employing nested episodes may reduce potential overlap in data collection and reduce administrative costs compared to carve-outs. He indicated that including nested episodes for oncology services within a population-based TCOC model may present a problem if relevant providers are also participating in a program like OCM or are providing care through an MSSP carve-out. He discussed the impact of having duplicate discounts applied, which can require a considerable amount of financial reconciliation.
- Mr. Bourbeau stated that his former practice participated in both MSSP and OCM, which made it challenging to account for how payment to the ACO under MSSP impacted payment made under OCM. He also noted that there are sometimes duplicative and conflicting quality measures where a

patient is tracked multiple times, such as feedback for Consumer Assessment of Healthcare Providers and Systems (CAHPS), resulting in patients receiving multiple surveys.

- Mr. Bourbeau indicated that in the model that ASCO proposed to PTAC, the medical oncologist was responsible for patient engagement and education; patient navigation, including financial navigation; data collection; and quality performance. Mr. Bourbeau noted that some of the model's care delivery requirements and measurements focused primarily on the handoff between primary and specialty care, which can be improved through patient navigation and communication with the patient's PCP. He noted that patients' treatments and referrals may change, and it is important to consider their survivorship care plan and the necessary follow-up between primary and specialty care for their treatment plan.
- Mr. Bourbeau emphasized the importance of phasing in different payment models depending on the treatment phases in the payment model and considering what is a carve-out episode versus active monitoring. He also discussed the need to understand an ACO's share in care management and how that should be reflected in care coordination fees after a patient's primary episode ends.
- Mr. Bourbeau highlighted that when discussing ACO-based versus specialty care models, it is important to consider that participants may not all be in the same health system. Within this context, he cautioned about the leakage that could occur when PCPs participate in an ACO while specialists participate in a separate accountable care model.

Vice Chair Hardin invited Committee members to ask the presenters questions.

- Paul Casale, PTAC Chair, asked about how to best incentivize coordination between primary care and specialty care providers within population-based TCOC models.
 - Dr. Navathe responded that so far, models have not produced sufficient coordination between specialists and PCPs. He noted that most ACOs have difficulty embracing this approach as they are focused on investing in primary care infrastructure. However, he noted that some organizations that are more experienced taking on financial risk have had success improving certain specialty-related areas, such as reducing hospitalizations. He indicated that more sophisticated ACOs may be better at managing complex patients. Dr. Navathe suggested that explicit, concrete incentives directed at specialists may be needed, because generalized ACO incentives depend on the organizational structure of the ACO to create provider-level incentives. He explained that the majority of ACO incentives are not focused on specific service lines. Additionally, he said there may be synergistic effects and improvements in care coordination when specialist-focused models operate in tandem with population-based models.
 - He suggested that there may be some overlap in infrastructure when two models are operating at the same time. However, he noted that ACOs that invest in ambulatory infrastructure perform well on post-discharge follow-up visit outcome measures. Dr. Navathe reiterated that the most effective way to incentivize care coordination between specialists and primary care is to apply incentives directly to specialist providers. He emphasized that models cannot rely on "umbrella" incentives to translate down to the provider level.
 - Dr. Schneider suggested that joint accountability for patient-focused measures and outcomes can produce the cultural change needed for a care team to provide high-quality care. However, he cautioned that measuring cost or quality of care for patients with multiple comorbidities and complex conditions can be challenging, and additional work is needed on incentivizing data collection and exchange.
 - Mr. Bourbeau stated that ACOs' financials are not always tracked in a way that allows for appropriate risk adjustment of care management payments.

- Dr. Friedberg noted that it is not always clear how specialists are paid in provider organizations. Individual providers may not be paid in a way that encourages value because either the incentives at the organizational level are not strong enough or the payment model does not give the organization up-front financial support needed to fully shift their operations. For example, in situations where the organization’s financial incentive comes in the form of shared savings payments that are delayed by several years, organizations do not have sufficient cash flow to build incentives into how their providers are paid, and thus maintain fee-for-service (FFS) payments to their providers. Finally, Dr. Friedberg noted that it is possible that some organizations do not understand the incentives offered to them and may benefit from additional education on the model.
- Lawrence Kosinski asked Dr. Friedberg if BCBS of Massachusetts is prescriptive on what participating organizations attempt to accomplish through their ACO-like model or if it emphasizes flexibility for participating organizations to design their own approach.
 - Dr. Friedberg responded that his organization does not have set structures for the ACQ groups or ACOs to follow, but it clearly encourages specific activities and requires a focus on outcomes that will result in financial gains. It does not delineate how ACOs or ACQ groups should pay their physicians or what they should invest in. The exception is that there are specific requirements for ACQ groups that apply for start-up grants (which are not connected with outcomes). Overall, he noted that the fiscal incentives of outcome measures may result in better decision-making on the part of ACOs and ACQ groups on which investments to pursue. Additionally Dr. Friedberg stated that his organization shares its approach regarding how to pay for equity with other payers in the hope that it will help other organizations establish their own pay-for-equity programs.
- Soujanya Pulluru asked Dr. Schneider and Dr. Friedberg how they approach data variability and how they ensure consistency in data collection, particularly around equity initiatives.
 - Dr. Schneider responded that his organization (NCQA) and Dr. Friedberg’s organization (BCBS of Massachusetts) are collaborating on approaches to improve race, ethnicity, and language data. He suggested that advancing social needs screenings and interventions could result in better standardization of the collection of SDOH data.
 - Dr. Friedberg emphasized the importance of collecting sufficient data on race and ethnicity. He discussed how his organization’s small sample sizes and inaccurate data on race and ethnicity complicate the reliability of its calculations. He noted that one-fifth of his organization’s members share self-reported race/ethnicity data, which provide more accurate estimates than other data sources (i.e., imputed data, vendor data, provider source data, and data from accounts and state databases). He indicated that his organization combines data from various sources in a way that measurement error is taken into account when designing payment incentives.
- Bruce Steinwald asked if decisions to pursue nested or carve-out models are constrained by clinical considerations, as opposed to economic factors or other considerations. He was interested in knowing if the clinical considerations limited opportunities to pursue nested models or carve-outs.
 - Dr. Navathe stated that the models that provide the most cost-efficient population health management are not fragmented (i.e., they are not carved into various episodes and segments). He emphasized that they have a population health model that has direct incentives for providing high-quality care within that budget and mechanisms to engage specialists more effectively. He mentioned that integrated delivery systems such as Geisinger, Intermountain Health, Kaiser Permanente, and certain Medicare Advantage (MA) plans have demonstrated better outcomes. He stated that some models that are

heavy on carve-outs may work as a transitional step. However, he suggested that moving to a population-based model is the best approach.

- Mr. Bourbeau stated that 70 percent of oncologists who qualified as an advanced APM participant and received the APM bonus did so because they were part of an ACO. He emphasized that it is not clear if this means the ACO focused on improving oncology care. This may mean that patients are not actually seeing improved quality of care. He suggested the need for nesting, carve-outs, or other ways to create incentives to improve care for patients with specific conditions, and noted that it is important to design these in a way that will benefit patients who need it most.
- Joshua Liao asked if the Committee should consider the differences between condition-based, episode-based, and procedure-based payment models, and how organization type impacts specialist integration.
 - o Mr. Bourbeau responded that it is difficult to implement condition-based episodes because patients may go to different specialists at different times. He mentioned that, in his experience, it was difficult to implement patient navigation at a specialist level that captures all possible patient scenarios; thus, it is important to start the patient navigation process at the time of diagnosis.
 - o Dr. Navathe responded that his organization and CMS's contractors have classified episodes as medical versus surgical or condition versus procedural. He indicated that there is some value in this approach, given that patients with conditions like congestive heart failure tend to be sicker than patients who are going through elective orthopedic procedures. Conversely, he mentioned that model designers may overlook the need to understand if the care is episodic or if it is part of a chronic disease. For example, in the case of patients with congestive heart failure who may also be admitted for pneumonia, it is difficult to delineate whether the admission is part of a congestive heart failure episode versus a pneumonia episode.
 - o Dr. Navathe noted that it may be beneficial to categorize patients into conditions or episodes based on patterns in their cost of care. For example, in the case of some procedures, patients may have an episodic pattern of utilization that shows a baseline level of utilization, and then a spike in utilization, after which it returns to baseline. He stated that there may be other procedures provided as part of care for conditions that require ongoing care at a high level, and these procedures might fit into a condition-based model rather than an episodic one.
 - o Dr. Navathe also indicated that organizations' approaches to practice transformation and change management differ; for example, approaches used by accountable hospital-based groups center around the hospital as the focus of activity, while an ambulatory-based physician multispecialty group's approach will be less facility-centric. He suggested that accountability for TCOC in the context of a population-based model requires large datasets that can produce reliable measures, such as those from larger organizations with bigger patient populations. He highlighted the possibility of using more targeted financial incentives and quality measurement strategies that can provide reliable measures even when patient populations are smaller.

Listening Session 4: Payment Considerations and Financial Incentives Related to Population-Based TCOC Models

- Mark McClellan, MD, PhD, Robert J. Margolis Professor of Business, Medicine, and Policy, and Founding Director, Duke-Margolis Center for Health Policy, Duke University

- Joseph Francis, MD, MPH, Executive Director, Analytics and Performance Integration, Office of Quality and Patient Safety, Veterans Health Administration
- Kate Freeman, MPH, Manager, Market Transformation, American Academy of Family Physicians
- Nancy L. Keating, MD, MPH, Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School; Professor of Medicine and Practicing General Internist, Brigham and Women's Hospital
- Robert E. Mechanic, MBA, Executive Director, Institute for Accountable Care; and Senior Fellow, Heller School of Social Policy and Management, Brandeis University

Chair Casale moderated the listening session with five SMEs on payment considerations and financial incentives related to population-based TCOC models. He noted that full biographies and presentations can be found on the [ASPE PTAC website](#).

Mark McClellan gave a presentation titled “Specialty Care Engagement and the Future of Comprehensive Care and Payment Reforms.”

- Dr. McClellan mentioned CMS’s vision to move the entire health care system toward comprehensive care relationships built on a coordinated and accountable primary care foundation. He noted that many payment reform efforts aim to allow these comprehensive models to work.
- Dr. McClellan discussed three areas relating to comprehensive care relationships and payment reform that the Margolis Center for Health Policy at Duke University has focused on:
 - First, Dr. McClellan indicated that increasing alignment across multiple payers toward common goals can reduce the burden of adopting APMs. He also noted that multi-payer alignment can increase broader support for these models. Additionally, he indicated that the Health Care Payment Learning & Action Network (HCP-LAN), a collaboration between CMS and other health care organizations, is working to advance efforts surrounding APMs and multi-payer alignment.
 - Next, Dr. McClellan emphasized the importance of ensuring that APMs address equity and underserved populations. He noted that funding to provide health care access for these populations comes not from Medicare, but from Medicaid, the Health Resources & Services Administration (HRSA), and other organizations, meaning that comprehensive care goals and their financing require alignment across a range of payers.
 - Lastly, Dr. McClellan highlighted the need to more effectively and comprehensively engage specialty providers in APMs, which he indicated would be the focus of his presentation.
- Dr. McClellan outlined several limitations to specialty provider participation in APMs. He noted that while ACOs include over 30 percent of the traditional Medicare population (and likely provide care to a sizable share of the MA population), ACOs have had limited impact on specialty care even when specialists are part of an ACO. Dr. McClellan indicated that many specialists either do not know that they are participating in a comprehensive care model or are not well supported by the ACO. Dr. McClellan stated that many physicians in ACOs take it upon themselves to engage specialists through their own care coordination efforts. However, he noted, that because this is not a comprehensive, coordinated effort, there has been a misperception that ACOs focus mainly on primary care. He also indicated that there are exceptions to this perception in the context of models such as the Oncology Care Model and other longitudinal care models.
- Dr. McClellan explained that the majority of health care expenditures and the care that patients receive involve specialists. He noted that CMS’s comprehensive care goals will be achieved more quickly if APMs directly engage specialists and align their models with the financial interests of specialists.

- Dr. McClellan noted that CMS has acknowledged the importance of specialists in delivering patient-centered care. He stated that this is exemplified by CMMI’s specialty care integration strategy, in which the Innovation Center highlighted the importance of specialists in supporting comprehensive care coordination aimed at advancing health equity.
- Dr. McClellan indicated that as a patient moves through their care journey, especially if they experience more advanced conditions, their care involves more specialty engagement—in both providing specialty care services and care coordination. Dr. McClellan noted that while many payment models focus on acute episodes, a substantial amount of a specialist’s involvement pertains to collaboration with primary care and other providers outside of those specific episode.
- Dr. McClellan discussed opportunities for early triage engagement using musculoskeletal conditions from a longitudinal patient journey perspective as an example. These care models involve using a specialty-trained physical therapist and emphasize coordination with orthopedic specialists to evaluate the best path forward for patients. He indicated that these types of care models have been able to substantially reduce admissions for major procedures, improve functional outcomes, and lower costs; however, implementation of these models requires engagement by specialists and primary care providers, as well as a significant redirection of resources. He noted that this is difficult to achieve with shared savings or primary care-focused ACO models alone.
- Dr. McClellan also outlined the longitudinal care journey for cancer patients, including identifying pathways to diagnose a patient, providing timely initial treatment, and engaging and coordinating oncologists following the initial treatment. He explained that today, many more cancer patients survive initial treatment and require care coordination and management to prevent recurrences.
- Dr. McClellan explained how improved care coordination could reduce spending by avoiding medical complications and unnecessary procedures. Both potentially avoidable situations are more likely without effective disease intervention and ongoing patient management.
- Dr. McClellan outlined proposals for nesting condition-based payment models within ACO programs that would incorporate a specialty per member per month (PMPM) payment. He noted that some MA plans are already doing this through PMPM condition-based payments to specialists; however, this strategy only works well in TCOC models with engaged primary care health groups. He also noted that instead of PMPM payments, some models use a flat population-based payment, which offers flexibility and introduces more accountability, an approach that engages specialists more than a model designed only for primary care providers.
- Dr. McClellan concluded by discussing some potential next steps for comprehensive specialty payment reform:
 - First, he noted that CMS and other payers now have data capable of describing patients’ longitudinal care experiences. These data can be used to improve care processes, utilization, and outcomes.
 - Second, he suggested developing condition-based models, and offering a few options.
 - Third, Dr. McClellan highlighted the bundled payment program and suggested introducing a path toward more mandatory adoption of those acute episode payments nested within condition-based models.
 - Lastly, he stressed the importance of making specialty engagement an integral part of ACOs.
 - For the physician-led ACOs, he suggested that condition-based payments be made voluntary. CMS could provide a model for implementation, and primary care and specialty care groups can renegotiate payments and determine the roles that they will each play in longitudinal patient management.

- For hospital-led ACOs, he indicated that condition-based payment approaches should be mandatory. He explained that, for many hospitals, the margins for the procedure-based elective admissions are higher than they are for medical admissions, meaning that hospital-based ACOs could be successful if they were to reduce medical and increase specialty procedures. He stated that a mandatory shift of some of these resources into specialty population management could alter the financial dynamics for hospital-based ACOs in a way that would make it more sustainable to implement team-based approaches to longitudinal management of specialty care.

Joseph Francis gave a presentation titled “Population-Based Total Cost of Care Models: Insights from the VHA.”

- Dr. Francis noted that the specific type of delivery system matters when exploring questions related to APM implementation. He provided an overview of the Veterans Health Administration (VHA) and its health care system:
 - The VHA operates on a global budget set by Congress, and providers are salaried but may also receive market pay based on specialty and a small performance-based payment.
 - The VHA system is centered around primary care. Every patient is attributed to a primary care team.
 - The VHA acts as both a payer and a provider capable of coordinating care across practitioner types.
- Dr. Francis outlined the VHA’s global budget system, which is based on a risk-adjusted capitation model, 90 percent of which is driven by clinical diagnosis and care practices. He explained that it also adjusts for geographic variation in pay, patient education, and research—similar to Medicare’s adjustments for teaching and research. Dr. Francis also noted that its system accounts for high-cost outlier patients. Each year, the payment model is adjusted to account for evolving trends and ensure a fair payment system.
- Dr. Francis stated that the VHA delivers near real-time performance feedback to its provider teams. He emphasized that in addition to updating providers on their current performance, these reports also offer predictive analytics for identifying opportunities for interventions and addressing care gaps. Dr. Francis highlighted the importance of providing individual-level data, and that failing to do so has contributed to physician burnout.
- Dr. Francis explained the VHA’s method for monitoring efficiency, which relies on a multivariate regression model. He noted that there is regional variation in efficiency and that this is linked to veterans moving between regions. He explained that these shifts introduce challenges with respect to resource allocation and establishing risk-adjusted capitation, the latter of which is determined by performance from prior years and therefore may not match the current landscape.
- Dr. Francis indicated that care veterans receive from outside the Veterans Administration (VA) also influences practice patterns. VHA physicians come from different backgrounds than non-VA providers. Furthermore, many VA physicians also work in other practices, which makes capturing provider performance challenging.
- Dr. Francis presented data on VHA facilities illustrating the relationship between efficiency, quality, and patient experience. He noted that the more efficient sites are also performing better on quality and patient experience, suggesting that there does not need to be a trade-off between efficiency and providing high-quality care.
- Dr. Francis presented a diagram illustrating the effect of different care components on cost efficiency. He highlighted potentially unnecessary days spent in the hospital and ambulatory care

sensitive conditions (ACSCs) as areas where there are opportunities to improve efficiency. He explained that excess days of care are often related to challenges with post-acute care, which is an area that neither the VHA nor the private sector have sufficient capacity to address. Dr. Francis also highlighted community care as an opportunity for improvement. He explained that patients can get lost in the referral process, resulting in fragmentation.

- Dr. Francis described challenges associated with low-value care, such as over-testing. Dr. Francis noted that although the VHA system would not appear to incentivize over-testing, and although there may be slightly less over-testing compared to Medicare, the VHA still has an opportunity to reduce unnecessary testing. He indicated that there is ongoing work to develop performance metrics that could provide real-time feedback on low-value care practices, which he identified as one of the key frontiers for quality measurement.

Kate Freeman gave a presentation titled “Incentives for Primary Care in Moving Across the Risk Continuum.”

- Ms. Freeman provided an overview of the American Academy of Family Physicians (AAFP).
- Ms. Freeman stated that primary care is a common good, and the public interest is best served when primary care operates as the foundation of the health care system. She suggested that the payment approach to primary care should reflect this, and that episode- or time-limited care-based payment approaches are not appropriate for the continuous, comprehensive, coordinated care that primary care provides. She suggested that the National Academies of Sciences, Engineering, and Medicine (NASEM) report supports the AAFP’s position regarding the need for a sufficiently funded prospective primary care system rather than an undervalued, overburdened FFS system.
- Ms. Freeman discussed the AAFP’s set of principles for primary care payment that contribute to a well-functioning health care system. Ms. Freeman indicated that the goal should be to move away from pilots, tests, and demonstrations and focus on supporting primary care payment in a more sustainable manner.
- Ms. Freeman also highlighted the challenges of risk and accountability. She explained that, on average, AAFP members contract with seven to 10 payers, and at least one-quarter are working with 14 or more payers—each with their own payment program, reporting requirements, and prior authorization requirements. Ms. Freeman noted that given the segmentation of the payer market, few primary care practices have a large enough patient pool to assume significant risk on their own. She added that many of the providers in independent practices do not have the margins to take on significant downside risk. Ms. Freeman explained that in addition to practice size, a practice’s ability to take on significant downside risk also requires a deep knowledge of the patient population for which the practice assumes risk, which is further complicated in a multi-payer system. She emphasized the importance of provider participation in multi-payer models that aggregate data and provide centralized support for information sharing and performance feedback. Ms. Freeman stated that even if the Comprehensive Primary Care Plus (CPC+) Model did not achieve the overall results it intended, it offers some real-world examples of successes related to efficient multi-payer models.
- Ms. Freeman indicated that most compensation arrangements for value-based primary care do include performance-based incentives; however, these incentive payments average less than 10 percent of total compensation. She suggested that when creating these value-based payment arrangements, it is unfair for PCPs to take on downside risk when they do not benefit from upside gains.

- Ms. Freeman also noted that the current risk-based payment methodologies inadvertently penalize practices serving low-income and other vulnerable populations with more health-related social needs (HRSNs); and indicated that these populations often have higher TCOC and lower Medicaid payment rates, making it harder to generate savings. To address this issue, Ms. Freeman suggested that equity be understood as a fundamental component of a model's value proposition and therefore be purposefully incorporated into payment design. She also suggested that the primary goal for these patient populations should be improving patient outcomes, and there should be less focus on reducing TCOC. Lastly, she highlighted the importance of robust risk adjustment methodologies that incorporate demographic, clinical, and social determinants of health.
- Ms. Freeman discussed integration, care coordination, and accountability. She suggested that certain specialties should be integrated in primary care (e.g., behavioral health, pharmacy, social work, and nutrition) whereas others (e.g., oncology, cardiology) should be coordinated with primary care, such as in the form of nested models. She also suggested that payment structures and incentives need to be structured to reflect this distinction.
- Ms. Freeman provided an analogy comparing family physicians with quarterbacks. She explained that just like a good quarterback, an effective family physician uses a well-planned playbook with delineated responsibilities for each member of the care team, and receives real-time feedback on their performance. Ms. Freeman stated that to be successful, PCPs need the same things; however, this becomes challenging when physicians serve as the quarterback for patients who come with their own playbook, team, or network, and different feedback mechanisms determined by their payer. Ms. Freeman indicated that it is crucial to develop a multi-payer strategy with a common payment and evaluation approach, including guidelines for which services are integrated versus those that are coordinated.
- Ms. Freeman also discussed the importance of incentivizing screening and referral for HRSNs and suggested that the current payment and incentive system is fragmented. She noted that AAFP supports reducing health inequities and believes that risk factors should account for social drivers of health. She also highlighted the need for care teams to screen for HRSNs and connect their patients with the appropriate social and community-based resources. Ms. Freeman explained that often these services are not billable under FFS, so physicians are not incentivized to provide or refer for them. She added that health-related inequities are often tied to community-level factors; however, many of these underserved communities lack the resources needed to address these challenges.
- Ms. Freeman stated that if the dual intentions of the health care system are to move to value-based payment and to advance health equity, there is a need for prospective payments and increased investment to support activities that may not be covered under FFS (e.g., screening and referrals for HRSNs). She also noted the importance of using community care hubs that offer centralized referral systems and capabilities for addressing patients' social needs, including the community-based organizations that are best equipped to address those needs.
- Finally, Ms. Freeman reiterated that primary care is a common good that is best resourced through predictable prospective payments. She suggested that beyond altering payment structures, there is a need for health care system to reevaluate physician employment contracts to better reflect the payment environment, and for payers to understand primary care physicians' role as the quarterback for their patients' care. Ms. Freeman also emphasized the importance of adequately funding health and social care systems.

Nancy Keating gave a presentation titled “Population-Based TCOC Models and Specialty Care: Lessons from Oncology Care.”

- Dr. Keating indicated that with respect to oncology APMs, there have been several studies demonstrating little to no effect of ACOs on overall spending and quality of care.
- Dr. Keating presented a graphic depicting cancer care across the disease spectrum, which showed the different types of physicians responsible for providing care at each phase. However, Dr. noted that this care is rarely provided by physicians billing from the same practice or with the same tax ID number. She cited a study that found that among Medicare beneficiaries newly diagnosed with cancer who received more than one type of treatment, the proportion receiving all the modalities from the same practice tax ID ranged from six percent for colorectal cancer to 17 percent for lung cancer.
- Dr. Keating discussed the challenges ACOs face when seeking to refer cancer patients to high-value practices, noting that several hospital referral regions (HRRs) have a limited number of oncology practices, which means that providers are left with few options when referring their patients.
- Dr. Keating presented some of the findings from the OCM evaluation. She explained that OCM is a voluntary, episode-based model for FFS Medicare patients with cancer undergoing chemotherapy, immunotherapy, or hormonal therapy. She added that at the start of the model, there were 201 participating practices; through 2019, these practices had treated over 700,000 chemotherapy episodes. In addition to the FFS payments, participating practices also receive a \$160 per patient per month payment during the six-month episode, which is intended to fund practice transformation. Dr. Keating also noted that OCM offers performance-based payments and shared savings (or losses for those in the two-sided risk track) if quality and spending goals are met.
- Dr. Keating indicated that total episode payments (six-month chemotherapy episodes) increased in both the treatment and control groups from about \$28,000 during the baseline period to about \$33,000 in 2016 post-intervention. She added that Part A Medicare payments did not change over time, while Part B and Part D payments (chemotherapy infused drugs and oral chemotherapy drugs, respectively) increased substantially over time. She noted that by the end of 2019, these drug payments accounted for 57 percent of total spending per episode.
- Dr. Keating discussed the results of the difference-in-differences analysis from the OCM evaluation. She explained that the evaluation found a relative payment reduction of \$279 for all episodes combined. She noted that for the higher-risk episodes, total episode payments decreased by \$503, whereas payments for lower-risk episodes increased by \$151. She clarified that these estimates do not account for the \$160 per patient per month enhanced oncology service payments that last for the duration of the six-month episode. Dr. Keating added that the observed savings were largely associated with four high-volume cancer types: high-risk breast cancer, lung cancer, lymphoma, and colorectal cancer.
- Dr. Keating described OCM’s quality measures, which included emergency department visits, hospice use, patient-reported pain intensity, whether patients had an established care plan, screening for depression and follow-up, and patient experience data.
- Dr. Keating noted that CMS has recently announced the Enhancing Oncology Model, the follow-up model to the OCM. She stated that this will also be a voluntary model and that it will focus on seven higher risk cancer types: breast cancer, chronic leukemia, colorectal, lung, multiple myeloma, prostate cancer, and lymphoma. She noted that this new model will not focus on the lower-risk cancer types included in the OCM. She indicated that similar to the OCM, the new model will also address quality of care through an emphasis on provider engagement and quality measurement and reporting, and participants will be rewarded for maintaining and improving

quality and patient experience. She added that the new model also intends to incorporate activities to advance health equity.

- Dr. Keating highlighted several challenges for oncology APMs:
 - First, she noted that cancer care is heterogeneous, meaning that the appropriate care plan varies depending on cancer type, stage, tumor characteristics, and phase of illness. She explained that current risk-adjustment methods are limited in their ability to account for these variations.
 - Second, Dr. Keating noted that patients receive treatment from many providers—surgeons, radiation oncologists, medical oncologists, and others—and they are often in different practices billing under different tax ID numbers.
 - Lastly, she noted that quality of care measurement in oncology care is still in its early development.
- Dr. Keating described how oncology care could be integrated into ACOs or other TCOC models. She noted that it will be important to assist ACOs in identifying high-quality, low-cost practices with whom to contract. She added that the appropriate practice to contract with will likely vary based on cancer type, stage, and treatment, as well as geographic limitations related to availability. She reiterated the challenges of operationalizing quality measurement, highlighting the fact that at smaller practices, small patient populations for a particular cancer type can bias quality measurement.
- Dr. Keating pointed to challenges associated with episodic models more generally based on findings from the OCM. She stated that episode-based models require a focus on a specific phase of a disease and type of care; however, there is often substantial heterogeneity within each of these diseases and phases. She highlighted the variation in savings based on cancer type that they observed in the OCM. Dr. Keating explained that an increasingly narrower focus can lead to models failing to include certain patients and treatments. She added that some care adjacent to an oncology model—such as survivorship or end of life care—may be best delivered by primary care providers.
- Dr. Keating discussed potential areas for improvement, which included:
 - Better data on quality and spending at the practice level. Very few practices have data from outside their own practices, and some even lack internal data.
 - More testing of different strategies for episodic and carve-out models, including mandatory models to avoid selection issues (even if unpopular among some physicians).
 - More testing of models for care that is provided by multiple providers.
- Dr. Keating concluded by sharing data from a large national survey of oncologists, which illustrated the portion of oncologists reporting that they took responsibility themselves for surveillance care for patients following primary cancer treatment, the portion of who shared the responsibility with the primary care provider, and the portion of oncologists associated with patients for whom the primary care provider or another provider managed the post-treatment care. She highlighted the substantial size of the third group (e.g., primary care provider or other provider leading post-treatment care). She also noted that post-treatment care management depends on the particular case and that these different care management arrangements are further complicated when a patient’s various providers are not in the same office.

Robert Mechanic gave a presentation titled “Strategies for Improving Alignment Between PCPs and Specialists in ACOs.”

- Mr. Mechanic outlined his observations regarding ACOs and specialty care, indicating that:

- Specialists account for a large portion of overall care, and therefore specialist alignment is a high priority for ACOs today; however, specialist alignment with ACOs remains low.
- The complexity of ACOs makes specialty alignment challenging. This is related to poor interoperability and therefore limited communication and collaboration.
- The prevailing FFS incentives and specialty culture characterized by volume introduce additional challenges for specialty alignment with ACOs.
- There is a lack of performance data and good quality measurement approaches for specialists. He added that although ACOs have claims data for their patients, these are only some of the data. He suggested implementing an episode grouper when evaluating specialist care.
- Financial incentives may not ultimately be the most important drivers of change within specialty care; other factors such as referral volume may be more important. He pointed to Dr. Keating's comments on assisting ACOs in identifying high-quality low-cost practices and indicated that he would support policy to advance this idea.
- Mr. Mechanic provided a brief overview of the Institute for Accountable Care. He explained that the Institute is a nonprofit organization that was formed with the aim of carrying out research on policy and best practices related to accountable care. The organization works with Medicare data and is involved in the modeling and data analytic work associated with MSSP, performance, and benchmarks. He noted that in their work, they use several episode groupers, particularly the Medicare grouper developed under a contract with CMMI and the BPCI model. Mr. Mechanic added that the Institute also leads evaluations for individual organizations to help them assess their various programs. He also highlighted some of the Institute's learning collaboratives, such as with the National Association of ACOs (NAACOS).
- Mr. Mechanic explained that ACOs are complicated and often unique; for example, MSSP ACOs range in size from about 30 providers to over 11,000 providers and are comprised of different physician groups. He noted that ACOs often include multiple independent provider groups that may vary in size and capabilities and may not operate on the same technology platforms. Mr. Mechanic presented a study looking at 160 ACOs that found that only 9 percent of the ACOs have all providers on a single EHR, and 77 percent of them have six or more EHRs across the provider groups. He explained that this makes it difficult to aggregate data and to communicate across care teams, particularly between primary care and specialty care providers that are in different practice groups.
- Mr. Mechanic noted that many ACO patients receive specialty care from providers outside of their ACO. He discussed a study in which ACOs were divided into four groups, each representing a different ACO type: 1) primary care provider focused; 2) primary care provider oriented; 3) specialty provider focused; and 4) specialty provider oriented. For each ACO, they looked at their respective patient populations to determine the percentage of care that patients attributed to each ACO type received from providers aligned to their respective ACOs. Mr. Mechanic noted that it is difficult to assess the percentage of primary care received within the ACO given that patients are assigned to ACOs based on where they receive evaluation and management (E&M) services. He noted, however, that many of the primary care focused ACOs have only a few, if any, specialists, meaning that patients in these ACOs receive essentially all of their specialty care outside of the ACO. He also noted that in the specialty care oriented ACOs, on average, patients receive only about 30 percent of their care within the ACO; however, some of the out of network care may be from specialists who are in the same organization as ACO-aligned practitioners, but who do not participate in the ACO themselves. He added that even among the ACOs that provide the highest proportion of specialty care within their ACO physician network, patients are still receiving only about 50 to 60 percent of their specialty care within the ACO.

- Mr. Mechanic described a survey on specialist engagement across ACOs. He noted that only 64 ACOs responded; however, the respondents tended to represent larger, hospital-affiliated ACOs that employed their specialists. Mr. Mechanic explained that although the convenience sampling design of the survey limits its generalizability, the results provide some insight into ACO relationships with their specialist. He highlighted key findings, including:
 - One-third of respondents said they work with specialists to develop care pathways as a major activity.
 - Twelve percent of ACOs said they provide specialists with unblinded performance reports as a major activity.
 - Less than 10 percent of ACOs said they direct referrals to a high-performing specialist as a major activity.
 - Seventeen percent of ACOs said they use bundled payments, whereas 58 percent noted that they are not involved in episode-based payments.
 - When asked about their use of financial incentives, 42 percent of ACOs said they did not use this approach to reward specialists; one-third of the ACOs indicated that they provide some incentives to specialists based on cost and utilization; one-third reported offering other incentives to specialists, such as participation in committees; and finally, about 20 percent of the ACOs indicated that they provide specialists incentives tied to clinical outcomes and patient satisfaction.
- Mr. Mechanic discussed barriers and challenges to engaging specialists in value-based care:
 - A lack of data and quality metrics is the most commonly cited barrier. This is tied to questions surrounding financial incentives—determining which practices are high-performing (and therefore deserve payment rewards) is challenging when there is a lack of good performance and quality data. He added that primary care providers may be concerned that specialists will dilute their shared savings.
 - The dominance of FFS incentives drives specialist behavior and compensation models, which are based on relative value units (RVUs), meaning their profits are driven by volume.
 - Many ACOs have a lean staff, including a dearth of specialists, relative to their patient volume, which makes it difficult for providers to break from their care delivery duties to engage with questions related to ACO structure and operations.
- Mr. Mechanic concluded by saying that he believes ACOs are commonly focused on connecting with specialists to understand their goals, foster collaboration, and then explain the goals of the ACO to the specialist. He noted that ACOs are also commonly using episode groupers to evaluate specialists. He indicated that ACOs are reaching out to their primary care physicians to gather feedback on specialist performance, such as whether the specialist communicates effectively and provides accurate documentation.
- Mr. Mechanic added that referral loops, in which primary care providers are required to engage with specialists about a patient before the referral can be made, aim to ensure the appropriateness of a referral. They seek to direct referrals to a preferred specialist, and even establish a specialist tiering model. Mr. Mechanic noted, however, that to achieve the benefits of efforts to improve use of specialists will require better data, and reiterated points made by prior presenters on the importance of advancing policy to address these data-related issues.

Chair Casale invited Committee members to ask questions of the presenters.

- Dr. Pulluru asked about the administrative burden that ACOs often place on primary care providers and how this could be addressed by the increasing number of specialty-centric ACOs.
 - Mr. Mechanic explained that many of the administrative burdens placed on primary care providers are requirements introduced by payers and the government; however, ACOs are

trying to give primary care providers more tools and resources so that they can focus more on delivering care and less on administrative tasks. He also highlighted the importance of encouraging primary care and specialty care providers to have more conversations about their clinical work and care coordination.

- Dr. Francis added that VHA primary care providers have also raised the issue of administrative burden. He suggested that addressing this challenge requires site-level interventions, such as introducing service-level agreements for certain specialties, which outline their specific responsibilities up-front. He also highlighted teleconsultation services as a method for supporting practitioners and mimicking the “curb-side consultations” that occur more naturally between physicians at a larger medical center but that may be harder to conduct in smaller, more rural settings. Dr. Francis noted that it is also important to give credit to those engaging in these activities, but that it is hard to determine which activities deserve credit. He noted that capturing necessary data on these activities presents additional challenges.
- Dr. McClellan added to Dr. Francis’ comment about workload credit. He explained that some ACOs are working on ways to provide physicians with the resources needed to carry out activities not currently supported under FFS, such as communicating with specialists and providing selective referrals. He noted that it is difficult to ask primary care providers to engage in these additional activities if they are rewarded based only on the FFS incentives that are tied to volume and efficiency. He explained that he supports nested models for specialists who want to engage in these activities, and he noted that there are examples of this working successfully, such as in musculoskeletal care models that are coordinated with primary care physicians. He added that certain arrangements for specialists, such as per-person payments, could help facilitate these care delivery transformations.
- Dr. Keating explained that the current model over-incentivizes procedure-based care, making it challenging to engage a specialist about a patient they performed surgery on in the past who is now facing complications. Dr. Keating noted that as a primary care provider, she is willing to seeing these types of patients, but to provide the proper care, it is important for the specialist to be available to answer questions when needed.
- Terry Mills asked about the current landscape of multiple overlapping population-based and specialty- or episode-based models, and if there is a consensus about whether nested models or carve-outs are considered to be the best approach. Dr. Mills asked about potential approaches for structuring overlapping incentives and policy goals for shifting more resources to primary care (i.e., more than the current five incentive).
 - Dr. Francis acknowledged that there have been challenges associated with the overlap between bundled models and ACOs, and he recognized that there has not been a satisfactory approach to addressing this overlap. He added that it is difficult to establish the exact value-add of the specialist or the provider being reimbursed through a bundled payment model versus the ACO. Dr. Francis indicated that he supports nesting models within an ACO, but that not all ACOs have this capability; larger organizations may be better positioned for this arrangement. He noted that many organizations lack the data to implement nested models effectively. Dr. Francis concluded by highlighting the need to compensate specialists for the additional time they spend coordinating care.
 - Dr. McClellan suggested that the appropriate path forward will vary based on ACO type. He noted that there are advantages to having specialists and hospital care within the ACO, but that most of the financial incentives for specialists and hospitals prioritize efficiency and do not emphasize longitudinal care. He added that there are gaps in the way initial treatment

and follow-up care are delivered, and explained that ACOs that have specialty care or hospitals within the organization should be capable of shifting to a condition-level payment model. He noted that these changes can happen incrementally, but by initiating these changes, it sends a clear message to specialists about the value of care coordination and collaboration with primary care. He explained that for smaller, physician-led ACOs, these transformations should be at the discretion of the organization, rather than mandated as a top-down policy such as what he suggested for larger, integrated ACOs. Dr. McClellan explained that it may not make sense for all ACOs to be fully integrated, but rather work collaboratively, which is made possible, in part, by PMPM payments. He suggested that CMS provide a template for smaller, non-integrated ACOs to follow when attempting to collaborate with specialists.

- Ms. Freeman identified two features crucial for both primary care and specialty care-focused ACOs:
 - First, the availability of data and information. She agreed with Dr. McClellan that it may not be necessary for smaller ACOs to be fully integrated, but they do need actionable data.
 - Second, the need for alignment across payers, including alignment in how they assess quality and set payment, which is particularly important for smaller organizations with less margin for error when engaging in care transformation.
- Dr. Kosinski asked Dr. McClellan to elaborate on the model he presented that included baseline payments combined with bundled payments for procedural services. Dr. Kosinski emphasized the need to develop an on-ramp for specialist participation in value-based models, an ongoing theme he has identified throughout the theme-based meetings. Dr. Kosinski asked if Dr. McClellan had examined specific characteristics of a disease that would be appropriate for a specialty-focused models. Dr. Kosinski provided the example of higher-cost diseases where patients might have a higher percentage of their overall cost of care coming from disease-specific services and therefore might require more specialist attention.
 - Dr. McClellan explained that outside of the hospital-based episode, there are not many specialties where the care is only, or even mainly, provided by the specialist, which leads to issues of fragmented, FFS-driven care. He emphasized that there is significant heterogeneity across providers; certain providers, such as those that lack the individual-level financial arrangements, are really set up only to perform procedures, whereas other provider groups are well positioned to engage in care management and coordination. He explained that this heterogeneity is why he supports nesting models and allowing physician-led ACOs to partner with specialty groups. Dr. McClellan noted that most specialty organizations are not able to participate in a patient-focused, longitudinal care model, which is why it is important to develop an on-ramp for them.
- Jennifer Wiler observed that over the course of the public meeting, there has been a common set of priorities, specifically with respect to accessible, actionable data and opportunities for process and outcome measurement. Dr. Wiler explained that some experts participating in the theme-based meetings have also suggested that there should be significant disincentives for participation in FFS, and potentially even mandatory participation in alternative payment arrangements. She asked the presenters whether they agree with these recommendations, and if so, what these disincentives would look like.
 - Mr. Mechanic noted that ACOs are currently advocating for the advancement of the APM bonus under the Medicare and CHIP Reauthorization Act of 2015 (MACRA), which ends in 2024. He noted that some presenters from the September 19 public meeting discussed enhanced primary care payments of around 10 percent. Mr. Mechanic explained that APMs

could refocus payments for patients who are attributed to TCOC models. He added that physician fees have been relatively flat since 2015, so there is a need for added incentives.

- Ms. Freeman explained that disincentivizing FFS, especially for practices with already slim margins and those caring for underserved or vulnerable populations, may risk exacerbating disparities. She noted that the question should be about how to incentivize transitioning away from FFS and explained that the more attractive APMs are, the less attractive FFS will be.
- Dr. Keating agreed with Ms. Freeman and acknowledged that CMS is engaged in innovative models, such as the Enhancing Oncology Model's use of a \$70 PMPM payments, which increases to \$100 for dual eligible patients. She noted that these types of features make APM participation more attractive to providers caring for underserved patients. She added that stable Medicare payment rates have made FFS less attractive, but that procedure-oriented specialists are still making large profits under the current FFS system, so there is work to be done on making APMs attractive for specialists.
- Dr. McClellan agreed that APMs should be made more attractive and noted that it is difficult for voluntary models to generate savings. He noted that it will take significant investments to encourage safety-net and other under-resourced organizations who fare well under the FFS system to engage in APMs. He suggested designing models that begin as voluntary and progress toward mandatory participation. Dr. McClellan suggested that it will be difficult to achieve CMMI's goal of having all Medicare beneficiaries with Parts A and B coverage in an accountable care relationship by 2030 through only voluntary models. He noted that multi-payer alignment and reducing administrative burdens are important steps toward engaging more providers in APMs.

Public Comments

Chair Casale opened the floor for public comments. The following individuals made comments:

1. Anne Hubbard (The American Society for Radiation Oncology [ASTRO])
2. Alyssa Newman (National Association of ACOs [NAACOS])

Committee Discussion

Chair Casale opened the Committee discussion and noted that PTAC will issue a report to the Secretary of Health and Human Services (HHS) that includes the Committee's findings from all three public meetings covering population-based TCOC models. He opened the conversation to the PTAC members to discuss areas they think should be highlighted in the report.

- Mr. Steinwald recalled Ms. Freeman's discussion of the incentives facing providers when considering their participation in accountable care models. He noted that while the Committee agreed that FFS should be made unattractive to encourage provider participation in value-based care, there must be support for providers who do not have an alternative to FFS. He added that reforms to FFS and value-based care incentives should not be punitive and should be designed with a glide path that eases providers' transition from FFS to value-based care.
- Dr. Wiler summarized the major themes she heard from the discussions. She observed an emphasis on data, noting that many SMEs discussed data sharing, data access, definitions, and making data more actionable. Dr. Wiler noted that these issues ultimately inform models' benchmarking and risk adjustment. In addition, Dr. Wiler observed that not all ACOs have the same business model

and that model designs should consider the distinctions between hospital-based and provider-led ACOs, and between primary care-focused ACOs and those that include specialists; such distinctions have implications for care models. Dr. Wiler added that the SMEs emphasized the importance of multi-payer engagement to improve alignment across payers and reduce the administrative burden of redundant or conflicting data collection and quality measures across payers. Dr. Wiler stated that providers cannot manage their risk if they cannot predict their revenue. As a result, she recommended further exploring how prospective payments can incentivize provider participation in TCOC models. Finally, Dr. Wiler appreciated Dr. McClellan's comment about creating a landscape that promotes innovation and flexibility.

- Dr. Mills suggested that the data available support an overlap of population-based TCOC models and an imbedded base nested model. He stated that the CMMI policy to structure value-based models separately makes it challenging to assess their effectiveness. He added that the ubiquity of APMs was making evaluation more difficult due to challenges in identifying a comparison group. As a result, Dr. Mills recommended moving toward overlapping models with episodes of care nested within a population-based TCOC model. He recalled Dr. Schneider's comment that the health care system needs to move toward a quality accountability infrastructure. Dr. Mills suggested that would be possible only when there is a united health data infrastructure platform. He noted that there was ongoing tension between a federal disconnected "pull" system where data access is provided through operations at the EHR vendor level and a national health information exchange (HIE) "push" system or utility model where health data are made more accessible under the appropriate controls. Dr. Mills added that Dr. Schneider also made clear that measuring health equity requires a very large sample size and that developing quality measures related to health equity will need to consider sample size when assessing the performance of individual provider groups. He warned that health equity measures may be measurable only at the payer level. Dr. Mills stated that he heard from multiple SMEs that the best approach for episode-based care models is to nest them within a population-based TCOC model. He observed that there were no discussions about carve-out models, although he commented that the CMMI approach to end-stage renal disease (ESRD) currently acts as a large carve-out model. Finally, Dr. Mills suggested that the easiest improvements to support transition from FFS to value-based care are enhancing primary care and creating the needed data infrastructure, but that in the current system most health care spending is directed toward specialty care. He noted that reducing costs for specialty care is more difficult and involves overlapping incentives.
- Dr. Kosinski discussed Dr. Friedberg's presentation where he observed that health plans try to influence the infrastructure of the ACO by incentivizing collecting and reporting outcomes related to SDOH and health equity. He noted that while this was carried out through a grant, the effort represents a trend that he anticipates will continue. Dr. Kosinski added that he enjoyed Dr. McClellan's presentation and discussion about implementing specialty care models nested within an ACO. He supported the idea of creating patient-specific base payments based on their conditions, complemented by adjustable bundled payments for some services to promote specialist integration into the model. Finally, Dr. Kosinski noted that the SMEs consistently expressed the need to disincentivize participation in FFS. He suggested that this would require more than freezing the FFS payment schedule.
- Dr. Liao summarized the spectrum of payment methodologies with FFS on one end, a pure capitation model (such as MA) on the other end, and APMs somewhere in the middle. He agreed

with comments about the limitations of FFS but recalled presenters' suggestions of ways to mitigate its shortcomings, such as global budgets. He also noted that it would be difficult to transition away from FFS in areas where providers do not have APMs available to them. Dr. Liao added that current policies are subsidizing MA to the point where MA organizations are achieving high market penetration that may leave less room for APMs to operate. Dr. Liao observed several opportunities to improve FFS-based APMs, including extending a five percent rate increase or using an external benchmark to reduce ratcheting. He added that these models could improve participation and viability with greater policy certainty around model changes in the future. Finally, Dr. Liao noted that several SMEs made the distinction between short-term and long-term visions for health care payment systems. He emphasized the importance of not letting short-term goals dictate the long-term vision.

- Walter Lin recalled from the June public meeting the discussion of the outsized impact investment in primary care can make for achieving a sustainable and successful value-based care model. He commented that the today's presentations, in contrast, focused on the importance of engaging specialists. He cited Dr. McClellan's comments that many specialists appear to be unaware that they are participating in an ACO and that there is a perception that ACOs are designed only for primary care providers. He appreciated CMMI's comments regarding specialist engagement. He added that many presenters discussed nesting bundles of specialty care within a broader population-based TCOC model. Dr. Lin felt there were details about this approach that need to be refined, citing the public comment regarding radiation oncology where it would be challenging to design an episode of care across multiple provider types with a single entity assuming risk. He added that it would be helpful to learn more about how those episode-based models address these complexities. He requested that the PTAC March 2023 Preliminary Comments Development Team (PCDT) consider this issue for the next theme-based public meeting. Finally, Dr. Lin suggested that it would be helpful to better understand how value-based models could address specialist involvement in chronic care.
- Dr. Sinopoli highlighted how Dr. McClellan's presentation offered a potential solution for integrating specialty services within an ACO, but that it would be a substantial operational effort. He observed that most ACOs produce minimal savings, and that when those savings are spread around to participating providers, the resulting payment does not cover the efforts to participate in the ACO. Dr. Sinopoli recalled Ms. Freeman's illustration of the multiple Medicare, Medicaid, and private payer contracts in which providers participate and noted that providers do not have the bandwidth to participate in different APMs for different payers. Dr. Sinopoli stated that this conversation made clear that providers must move into global risk arrangements with the upside potential to cover the investments to participate in such an arrangement. He added that not all providers would be able to engage in this model, but that the Committee should continue to investigate how to encourage providers to move toward a global risk arrangement. Dr. Sinopoli added that multi-payer models would be needed to produce enough volume for specialists to want to nest their services within an ACO.
- Dr. Pulluru observed that several presenters mentioned using telehealth consultations as a way of bringing specialty care into rural areas. She recommended embedding telehealth consultations within compensation mechanisms at parity with in-person consultations. Dr. Pulluru noted Dr. McClellan's presentation was a useful illustration of how prospective payments can function for specialists. She added that the health care system has finite funding and therefore prospective

payments would need to be designed in a way that does not disincentivize procedures. Finally, Dr. Pulluru found Dr. Keating's methodology insightful for making a health equity infrastructure payment that was not tied to TCOC or benchmarking.

- Dr. Mills agreed with Dr. Pulluru that there is finite funding for the incentives discussed across population-based TCOC models. He suggested that both incentives to participate in value-based models and disincentives to continue participating in FFS would be required to transition to value-based care over a predicted and transparent time frame. He appreciated Ms. Freeman's comment regarding rural providers without an option to participate in value-based care, but that without disincentivizing FFS, there would not be enough motivation to establish value-based care options in those areas. Dr. Mills added that there are multiple successful ACOs operating in rural areas.
- Mr. Steinwald stated that the health care system is well funded and that the shift to value-based care should ultimately reduce the rate of increase or the total amount of health care spending while continuing to provide quality care to patients. He recommended focusing on improving patient care as opposed to funding.
- Chair Casale noted that he heard multiple SMEs discuss mandatory participation. He added that the growth of MA has made it difficult to evaluate voluntary value-based programs. He observed that the analysis of voluntary programs has identified some successful models, but that to move beyond the testing and pilot phase of value-based care, these models must transition to mandatory programs to evaluate them more expeditiously.
- Jay Feldstein shared two themes that he heard during the day's presentations. Dr. Feldstein noted that the Committee frequently discusses physician behavior, which ultimately translates to patient behavior. He suggested that benefit design changes and patient education would be necessary to alter patient behavior, as most patients do not know they are in an ACO. In addition, Dr. Feldstein recalled that Dr. McClellan indicated that 60 percent of health care costs are delivered through specialists. He observed that is due to the large ratio of specialists to primary care physicians in the country, which is the inverse of many European countries. As a result, he suggested that specialty compensation will play a large role in reducing costs and improving quality.

Review of Draft Comments for the Report to the Secretary (Part 2)

Ms. McDowell confirmed with the Committee that ASPE would update the draft comments for the report to the Secretary based on the discussions from the public meeting and send a revised copy for the Committee's review.

Closing Remarks

Chair Casale closed the public meeting by thanking participants and attendees. He indicated that the Committee will submit a report to the Secretary based on what the Committee has learned over the past year of meetings focused on population-based TCOC models.

Chair Casale acknowledged that this was his last public meeting serving as PTAC Chair and noted that this was also Mr. Steinwald's last public meeting as a Committee member. He appreciated being a part of PTAC as it undertook the important work of researching population-based TCOC models.

The public meeting adjourned at 1:59 p.m. EDT.

Approved and certified by:

//Lisa Shats//

12/2/2022

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

Date