# PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

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PUBLIC MEETING

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The Great Hall
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

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WEDNESDAY, JUNE 8, 2022

PTAC MEMBERS PRESENT

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

PTAC MEMBERS NOT IN ATTENDANCE

SOUJANYA R. PULLURU, MD

STAFF PRESENT

LISA SHATS, Designated Federal Officer (DFO), Office of the Assistant Secretary for Planning and Evaluation (ASPE)
VICTORIA AYSOLA, ASPE
AUDREY MCDOWELL, ASPE
STEVEN SHEINGOLD, PhD, ASPE

*Present via Webex

A-G-E-N-D-A

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

9:30 a.m.

* VICE CHAIR HARDIN: Good morning and welcome to Day 2 of this public meeting of the Physician-Focused Payment Model Technical Advisory Committee, known as PTAC.

I am Lauran Hardin, the Vice Chair of PTAC. Thank you for tuning in. I would like to welcome Dr. Liz Fowler, who is the Deputy Administrator of the Centers for Medicare & Medicaid Services and Director of the Center for Medicare and Medicaid Innovation.

Dr. Fowler previously served as Executive Vice President of Programs at the Commonwealth Fund and Vice President for Global Health Policy at Johnson & Johnson.

She was Special Assistant to President Obama on health care and economic policy at the National Economic Council.

From 2008 to 2010, she also served as Chief Health Counsel to the Senate Finance Committee Chair where she played a critical role in developing the Senate version of the Affordable Care Act.

Welcome, Liz.

*** Elizabeth Fowler, JD, PhD, Deputy Administrator, CMS[1], and Director, Center for Medicare and Medicaid Innovation (CMMI) Remarks**

DR. FOWLER: Thank you so much, Ms. Hardin, and good morning, everyone.

I'm really delighted to be here with members of the PTAC and everyone participating in this Day 2 of the PTAC June 2022 public meeting. I'm so glad to be here in person today and to be able to join you.

The CMS Innovation Center's vision is a health system that achieves equitable outcomes through high-quality, affordable, patient-centered care.

We very much appreciate the partnership and collaboration of PTAC as we strive to meet the ambitious goals embedded in this vision.

I think many of you are already familiar with the strategy that CMMI issued last fall; but as you continue the discussion

1 Centers for Medicare & Medicaid Services

today on population-based total cost of care models, I thought it might be helpful to reiterate the five strategic objectives that guide and prioritize our work and tell you what we've been doing to try to reach our goals.

So, if you'll indulge me for a little, as our first objective as part of the strategy, it's -- we've put an emphasis on driving accountable care.

And that means focusing on payment and performance incentives and models, and especially in total cost of care models, for specialty and primary care providers, to coordinate delivery of high-value care, and reduce duplicative and low-value care.

We set an ambitious goal to have all Medicare beneficiaries, and a vast majority of Medicaid beneficiaries, in a care relationship with accountability and quality -- for quality and total cost by 2030. This means an ACO[2], advanced primary care or Medicare Advantage.

Although, I think we don't automatically assume that MA[3] plans are paying

2 Accountable Care Organization
3 Medicare Advantage

based on value. As we understand it, many of them may receive capitation, but still pay providers based on fee-for-service.

In February, we announced changes to the CMS Innovation Center's Global and Professional Direct Contracting model and the transition to a new ACO REACH[4] model.

And the design of REACH has laid a lot of the groundwork for our thinking in terms of how to advance equity. And the model can also be critical to reaching our accountable care goals.

Medicare Shared Savings Program and our ACO programs at the Innovation Center need to work together.

And with our colleagues at the Center for Medicare, we published a piece in the *New England Journal of Medicine* last month that speaks to our shared vision of testing certain aspects of new Innovation Center ACO models that will inform the MSSP[5] program.

We're working to design our models to provide higher-quality, better-coordinated

4 Realizing Equity, Access, and Community Health
5 Medicare Shared Savings Program

care at the same or lower cost to Medicare beneficiaries, and we aim to put the patient at the center of the care team that provides high-value, equitable, evidence-based care while holding providers accountable.

We look forward to learning more from PTAC and the speakers from the June public meeting to help inform our work on this objective.

I was fortunate to be able to meet with the PTAC members in an executive session to learn more about what happened yesterday and a lot of the lessons from the speakers. I unfortunately had to miss yesterday's meeting due to another conflict.

Our second objective is advancing health equity. We're committed to embedding health equity into all aspects of our payment and service delivery models.

And central to this work, if you look at our models launched to date, we have not necessarily been representative of patients in low-income, Hispanic, and rural communities, and we want to use all available levers to ensure equitable access to the innovations

worth testing.

Is that my microphone? No? Alright. We're working to design models to increase participation among providers that care for underserved populations and close disparities in care and outcomes.

In December, we held a roundtable on our health equity strategy. And in March of this year, Dr. Dora Hughes, who is our Chief Medical Officer, published a paper in *Health Affairs* that talked about our strategy in a little bit more detail regarding health equity.

And then in March, we held a roundtable focused on safety net provider participation in CMS Innovation models.

I'm interested to hear from your speakers what more we can do to attract these safety net providers in total cost of care models.

Objective three is related to supporting innovation. What more can we do to support model participants? Looking for ways to innovate care delivery approaches.

That includes actionable data, learning collaboratives, payment flexibilities

available to model participants.

I heard today from members about the need for really timely data, too, to make sure that it actually is influencing decisions.

Our fourth objective is affordability -- addressing affordability. We have been very laser-focused on expenditures in Medicare and Medicaid, but we also want to make sure that our models have an impact on lowering patients' out-of-pocket costs. And we're looking for strategies that target health care prices, affordability, and reducing low-value and duplicative care.

Going forward, we're focusing on payment and performance incentives in models, and especially in total cost of care models, for specialty and primary care providers to coordinate delivery of high-quality care and, as I said, reduce duplicative or low-value care.

And then the final is, partner to achieve health system transformation. And this is part of -- as I think about this goal, it's really around multi-payer alignment, and I have heard very loud and clear the need to find ways

of engaging commercial payers, working closely with states on Medicaid and other purchasers and others to make sure that we're all aligned and heading in the same direction.

It might not need to be as part of a single model, but maybe there are aspects of care where alignment makes the most sense, for example, on quality metrics.

We're working towards our 2030 goal for multi-payer payment alignment and all new models, and asking stakeholders like you how we can better align with private payers, purchasers, and states.

We're actively engaging stakeholders, leveraging existing and new mechanisms to enhance engagement with patients, providers, and payers, and we want to try to improve transparency in our model design and implementation.

We're holding listening sessions with beneficiaries, health equity experts, primary care, I mentioned safety net, specialty providers, states, and payers.

And last month, Administrator Chiquita Brooks-LaSure hosted a listening

session on dementia care, which is an area of growing interest for the Innovation Center.

The Innovation Center will continue to communicate and share our strategy through conferences, podcasts, learning events, and opportunities like the PTAC public meetings.

We're excited that the meeting here, the presentations and discussions about population-based total cost of care plan for yesterday and today focusing on addressing some of the same challenges that we're facing.

So maybe, in closing, I just want to thank PTAC for their valued work and continued support for health care transformation.

And also to thank the Committee for putting together such a vigorous agenda and an amazing panel of experts.

Again, just like the March meeting and the meetings before, I'm consistently impressed with the folks that you have presenting and sharing their perspective.

So, thanks for your attention and best wishes for a great second day.

VICE CHAIR HARDIN: Thank you so much, Liz, for the time this morning and also

these very valuable comments.

We look forward to continuing to collaborate with you and your team, and you're welcome to stay.

There's some really interesting speakers that really connect to the themes that you raised, and I hope you get an opportunity to hear them today.

So, you can move to the seating area, if you'd like, but we also understand if you have a busy schedule and have to go. We'll definitely be sending you the notes and --

DR. FOWLER: I'll be dialing in.

VICE CHAIR HARDIN: -- you can access the video.

DR. FOWLER: I will be listening. Thank you.

VICE CHAIR HARDIN: Thank you so much, Liz. I really appreciate your time.

*** Welcome and Population-Based Total Cost of Care (PB-TCOC) Models Session Day 2 Overview**

So, yesterday we had a variety of experts present from academics and payers to our very own Angelo Sinopoli.

They generously offered their experience with care delivery in population-based models.

Today, we have multiple presenters and panelists ready to share their expertise followed by a panel discussion. Then, we will have a public comment period.

Public comments will be limited to three minutes each. If you have not registered in advance to give an oral public comment tomorrow, but would like to, please email PTAC registration at NORC, N-O-R-C dot org. Again, that's ptacregistsration@norc.org.

Finally, the Committee will have a discussion to shape our comments for the report to the Secretary of HHS[6] that we will issue later after the series concludes.

*** PTAC Member Introductions**

Because we might have some new folks who weren't able to join yesterday, I'd like the Committee Members to please introduce themselves.

Share your name and your

6 Health and Human Services

organization. And if you would like, you can share a brief word about experience you may have with population-based payment or total cost of care models.

I'll start. I'm Lauran Hardin, Senior Advisor for National Healthcare and Housing Advisors, and have spent the past 20 years either directly delivering value-based payment models and now partnering with states, communities, health systems, and payers to design models for population total cost of care.

Paul?

CHAIR CASALE: Paul Casale. I'm a cardiologist. I lead Population Health at NewYork-Presbyterian, Weill Cornell and Columbia. And also oversee NewYork Quality Care, which is the MSSP ACO for NewYork-Presbyterian, Weill Cornell and Columbia.

DR. FELDSTEIN: Hi. I'm Jay Feldstein. I'm the President and CEO of Philadelphia College of Osteopathic Medicine, trained in emergency medicine, and I spent 15 years in the health insurance industry in both commercial and government programs.

I have a lot of experience in capitated products and group sharing relationships.

DR. MILLS: Good morning. I'm Lee Mills. I'm a family physician. I'm Senior Vice President and Chief Medical Officer at CommunityCare Managed Healthcare Plans of Oklahoma.

Involved in both commercial Medicare Advantage and individual exchange space. Experienced in medical group leadership. Operating in MSSP and multiple CMMI value-based models over the years.

DR. LIN: Good morning. I'm Walter Lin, founder of Generation Clinical Partners. We are a medical group focused on delivering care to the frail, elderly, and senior living, particularly nursing homes and assisted living facilities.

DR. SINOPOLI: Good morning. I'm Angelo Sinopoli. I'm a pulmonary critical care physician by training. I've spent the last 20 years in population health. I've run large integrated networks, and I've built enablement companies.

Presently, I'm the Chief Network Officer for UpStream, which is a company that partners with primary care physicians to enable them to participate in value-based arrangements.

DR. LIAO: Good morning. Josh Liao. I am an internal medicine physician on faculty at the University of Washington.

There, I'm also the Enterprise Medical Director for Payment Strategy, as well as I lead a group that does research and evaluation on payment and delivery models, including total cost of care models.

And so, in those ways think about how do we translate design and policy evaluation into practice.

DR. WILER: Good morning. I'm Jennifer Wiler. I'm the Chief Quality Officer at UCHealth's metro area.

I'm a tenured professor of emergency medicine at the University of Colorado School of Medicine, and I'm a cofounder of UCHealth's CARE Innovation Center, where we partner with digital health companies to grow and scale their solutions to improve the value and

outcomes of care for patients.

I was an original co-author of an Alternative Payment Model.

DR. KOSINSKI: I'm Larry Kosinski. I am a gastroenterologist and am the founder and Chief Medical Officer of SonarMD, a company that I founded back in 2016.

I've spent the last 10 years of my career focused on value-based care, and I'm happy to report that Sonar was the first PTAC-recommended physician-focused payment model back in 2016.

VICE CHAIR HARDIN: And, Bruce, we'd like to ask you to introduce yourself from Zoom.

MR. STEINWALD: I'm Bruce Steinwald. I'm a health economist in Washington, D.C., although right now I'm in Massachusetts. And this is my seventh year as a member of PTAC.

*** Listening Session on Assessing Best Practices in Care Delivery for PB-TCOC Models (Part 3)**

VICE CHAIR HARDIN: Thank you so much, Committee members. As you can see, we have a tremendous wealth of experience and

expertise on the panel.

So, at this time I'm very excited to welcome our third listening session for this two-day public meeting.

Paul, would you please come forward and join the table.

(Pause.)

VICE CHAIR HARDIN: We've invited three outside experts to give short presentations based on their experience, and then our Committee members will be able to ask questions.

You can find our speakers' full biographies on the ASPE PTAC website. Their slides will be posted there after the public meeting as well.

Presenting first we have Dr. Christopher Chen, who is the Chief Executive Officer of ChenMed.

Welcome and please begin, Chris.

DR. CHEN: Thank you very much. Sorry I couldn't be there in person.

Well, my name is Chris Chen. I'm a primary care doc and cardiologist. I'm also the CEO of ChenMed. We're family-owned and

unlike any other type of practice that's out there, but I believe that our model should be much more universal, much more global.

ChenMed began in the 1980s, and we had this mission that we wanted to serve. We weren't trying to chase investor returns, but by having mastered and standardized what we do, we've actually surprisingly self-funded all of our growth.

We now, by the end of the year, should be operating about 130 medical centers across three brand names hitting roughly 40 cities and about 14 states.

As of this week, I believe we're going to break 5,000 employees and, on average, we've been growing about close to 40 percent per year.

You know, our background is risk. We believe that we are, like many people in the room, a pioneer in risk in that we work 100 percent in a global risk model and, you know, we're fully accountable for the total cost of care.

That means on the spectrum of risk there's, you know, fee-for-service, then

there's that small proportional jump into value, and then you start to move down that sort of, you know, slope towards the very far end of that risk spectrum, and that's where we are, where we hold full upside and full downside, even stop loss A, B, and D. All costs.

And historically, we have operated in Medicare Advantage because it was really well-suited and structured for, you know, the type of care that we give in a risk-adjusted global capitation model, especially in the populations that we serve, which I'll talk about shortly; however, we, too, have recently applied to participate in the ACO REACH demonstration model. Just saw Liz there. So, excited that she had an opportunity to speak.

And so, we can now take this model that is able to achieve the kind of outcomes that I'm going to be sharing with you to not just Medicare Advantage patients, but also Medicare patients.

ChenMed has a focus. We serve lower-income seniors with multiple chronic conditions, and we have a mission-driven model

of love, accountability, and passion that compels us to serve those whom a health care system has essentially overlooked, forgotten, and ignored.

By focusing on this target population, we've become experts in their needs, and we've actually designed a care team, or care system, for them.

Let me just give you some demographic numbers. Our patients are about 40 percent dual eligibles; 70 percent of our patients are racially or ethnically diverse.

I have heard most recently that over 70 percent of our team, our care team, are women of color.

Our patients typically have five or more major chronic conditions, and our senior medical centers are actually located in the most underserved neighborhoods where our patients live. So, we have boots on the ground.

And these are often the patients that make up a large share of the total cost in the overall Medicare population.

We're very familiar with that 5

percent that accounts for 45 to 50 percent of the cost or 15 percent that may account for 70 to 80 percent of the cost.

Those are our patients, but I'm starting to believe that the method that we call "transformative primary care" can translate beyond our target population and can benefit the broader American population.

So, let me just share with you what we consider our model and what we consider what transformative primary care is.

So, how does ChenMed work, and what does it imply about our policies that can spur others to work similarly?

We need more people joining us in the way that we do things. So, here are some differences.

We believe this, what we call “Type 1 traditional primary care.” In short, this is a narrow and reactive primary care model where primary care doctors do not have accountability, and they are rushed to do some wellness visits and mostly churn through their sicknesses trying to triage patients downstream to the right specialists, which are typically

pills, procedures, and referrals, and they're used as a tool within large health systems to actually help to generate those downstream -- that downstream volume.

The problem is it doesn't solve health. If you have more of that primary care, you're not going to solve health, and it will not lower cost. Evidence has demonstrated that. And it doesn't address the whole person, the physical, the mental, the social.

Then there's type 2 primary care. We call that "advanced primary care." This is worlds better.

Now, the financial accountability through taking capitation is there to varying degrees, but the strategies employed are -- sort of wrap-around to the PCPs[7] that are going after the finances.

So, let me tell you what I mean. These are sort of like financial measures. These are, you know, advanced primary care groups out there that their primary goal is to chase after risk-adjustment squeezing the

7 Primary care providers

downstream providers, you know, whipping them for cost and for pricing, using third-party vendors a lot.

And in that environment, you know, actually results do improve. You get better outcomes, and you do get some lower costs, but the issue is there are complaints and -- from patients, there's potential for malalignment between patient and provider, and then there's also incomplete realization of true goals.

What I'd like to introduce you to today is what we call "type 3 transformative primary care," which we believe we are helping to create and pioneer and lead in the U.S. today, and this is where there's this true proactive, holistic, clinical model.

See, it's the same, you know, economic structure as the previous advanced primary care type 2 model, but the solutions come through the PCP. The accurate risk picture comes through the PCP's deep patient engagement.

Our PCPs, believe it or not, spend about nine to 12 months training and learning to lead teams, influence patients, master

customer service, understand medical economics, differentiate documentation and care for outcomes versus for billing, and more.

And we actually train our doctors differently. We don't joke anymore. We actually tell them seriously, doctor, when you join, it's a one-year fellowship. Do not think of this as you're an attending. You are a well-paid fellowship, right?

And we put them through this training, and let me tell you the three things that we focus very deeply on in which we think we are helping to forward the field of medicine and training in. So, three areas.

Number 1, we train doctors to think holistically. Historically, PCPs have solved problems through pills, procedures, and referrals.

We have learned that about 20 percent of a true patient's health is really -- involves pills, procedures, and referrals, what we learned in training.

The other 80 percent of the equation is moving, you know, most of these patients upstream to focus on things that, for example,

are lifestyles and behavior, social determinants of care.

And, of course, we have not yet figured out a way to modify genetics yet, but maybe one day.

And so, as doctors, as we think holistically and are training doctors to think holistically, there's something that we must sort of develop in our physicians.

Second of all, we train our doctors to focus on prevention. Now, Paul, I know you're at Presbyterian, you know.

I'm a doc. I finished my training at a Harvard hospital, and then I went to Cornell and felt very good about myself.

Came to South Florida with the equivalent of five board certifications, you can ask Bruce Lerman if he thought I did a good job. I think he still thinks very highly of me.

But what was crazy was my very first patient was a heart failure patient, and I said, well, "I got this," and that patient got readmitted and died.

And so, I discovered very quickly that I did not know that doctors do not know --

they are not trained in prevention.

For something as simple as heart failure in which I'm probably, at the time, was one of the highest trained, you know, cardiologists in the state at the time who did not know how to prevent what, quite frankly, is one of the most preventable and leading causes of admission in America today. We believe today that 90 percent of heart failure admissions are preventable.

Talk to any emergency room doctor. They'll give you a similar number: 80 to 90 percent. And we demonstrated that particularly in patients with multiple chronic conditions.

So, we are training doctors to move upstream. We are creating workflows that do not exist.

We have evidence, we have data that surpasses many of the academic institutions that I've worked at because we are so broadly distributed and because we have access to the full source of all the datasets to create these workflows in prevention.

And third, we're training doctors how to win.

What I've discovered is that doctors, during our training process, were not taught to be accountable for outcomes.

We are altruistic people that are mission-driven. It's a calling, but yet we aren't taught how to win.

We are taught, and we come in wanting to win, but not taught how to win. And the only way that you know if you're winning or not is you have to measure it.

So, we actually make our PCPs accountable for an outcome. We expect our PCPs to reduce hospitalizations by 50 percent.

It is not enough to try. We do not give out trophies for trying. We are unique in that we give trophies for winning, and, therefore, we believe that we, our doctors, are accountable for improving the patient's health outcome across the spectrum because you cannot improve what you do not measure. And so, we measure everything.

We have folks with -- several analytics people. In our organization, we have well over 300 -- it would be close to 400 data scientists and software engineers in our

organization that's partnered with us. And so, we take our tech and we take our analytics very, very seriously.

So, what is our care model? It's very simple. If you just take concierge medicine and put it on steroids, you got it.

So, our PCPs have very small patient panels. Typically about 400 to 1. Concierge is typically 600 to 1. In our neighborhoods, it's typically 3,000 to 1 because they are deeply underserved, right? High depravation indexes.

And this allows the PCP to have a deep relationship when we see our patients monthly, at a minimum, to manage their complex diseases.

And our doctors, they are surrounded with a care team, and they give their patients their cell phone numbers.

And then we give them a whole host of capabilities in terms of case managers, care coordinators, care promoters, pharmacy services, and we wrap around that PCP, but the PCP leads the team. We believe that we are the largest physician leadership organization in

the country.

And so, we believe that the most important element to our PCP success is to learn to get patient trust. You cannot modify behavior and move upstream without earning patient trust.

So, the way we do this is with these frequent visits, with the cell phone, you know, giving away your cell phone number, with meeting with the families, wrapping around in the home.

And it's not just the PCP and their care team, but their care team reports to the PCP. PCP is ultimately accountable.

And so, we are focused and in line with the patient in creating a plan, a very customized plan with that patient, with all these resources, to improve health and ultimately reduce hospitalization rates.

Another highlight is a deep investment in overcoming social determinants of health. We offer door-to-doctor transportation through our MA benefits. We plan to do that so our doctors can come to us immediately any time during office hours.

And then in the off hours, we have different resources depending on the markets that we're in given that we're in so many cities.

We, you know, we provide on-site lab draws. We do on-site medication dispensing for 85 to 90 percent of our medications. We have all tier 1 specialties on site. We have diabetic resources. We do cooking classes, social classes, Zumba classes, tai chi classes to reduce hip fractures and falls, you name it.

And we do that in addition, and we marry that -- those resources with end-to-end, purpose-built technology developed specifically for outcomes, not to increase revenues and billing. That is not the goal.

We have our own EMR[8] -- so, that's very unique -- and then we develop our workflows in that EMR.

ChenMed is a primary care company, but we're responsible for everything. Therefore, if a ChenMed patient needs care beyond what we can offer within our employed

8 Electronic medical record

primary care staff and our tier 1 specialists, then the PCP remains the quarterback no matter where they go.

And, again, we have these central analytics teams that they partner with our patients to focus people through more high-value, better-outcome specialists.

We are tracking this data, and we are tracking who follows evidence-based medicine, because we even have central specialty centers of expertise within our organization, but the key point is the patient remains our patient regardless of where they go.

We are fully accountable for everything that happens no matter where the patient goes, and the financial model supports that. ChenMed brings light to the darkness.

Just want to wrap up with this final point here. What we do matters in our communities at large because when we treat our senior patients and their health outcomes, it benefits their families because so often our patients are the caregivers, the grandmas or the grandpas that are watching grandchildren so

their children, who are 75 percent of the time single moms, can go and work their one or, many times, two jobs.

So, if we can uphold the senior population in these neighborhoods that we serve, we actually don't just serve the health of the patient, but we transform the health of the community because these are the individuals that are the pillars of the health of the community.

So, let me just talk some data because we like that. We talked about a 30 to 50 percent lower hospitalization rate. We do the same for ER[9] visits.

Our screening rates are much higher than national averages, and that's where the average is much higher.

We have care programs that have -- and we've published that we can reduce stroke rates by 22 percent. We have reduced heart failure admissions by over 70 percent.

We believe that our -- not believe, we have data that supports that our patients

9 Emergency room

when they develop cancer, have a 50 percent six-month mortality compared to patients who are not ours prior to joining us with cancer.

So, pretty cool numbers, we believe, and we're going through data right now, but not only do our patients and -- many times we are equalizing their outcomes between our Black and our white patients and our duals and nondual patients. We believe we're equalizing that.

And in many cases we are even eclipsing the average Medicare recipient, and even in higher-income outcomes, because they are patient-focused and outcomes-focused.

Our patient satisfaction numbers are in the 90s, as you can imagine, concierge medicine for the lowest-income people, and the upper income scoring in the 80s.

So, here are some simple suggestions. Number 1, I believe we must push global risk that's two-sided.

Partial cap does not work. People will not change their behaviors. They will wrap around things to get their outcomes.

Number 2, we must protect and enhance risk-adjustment, not kill it. You have

to -- you got to take away the incentive to pick a perfect population, and doctors can do that. We've seen that in the past.

So, you need risk-adjustment. Otherwise, people will not go and take care of the sickest population, but how do you prevent a gaining?

You have to rely on people who are closest and most accountable for the care. So, we believe that PCPs should be the ones who are risk adjusting.

We do not believe that you can, you know, hire third parties and wraparound services and go to the home to just diagnose people and not participate in actually transforming their care, and we must put that risk with primary care.

And we must come up with solutions that can fundamentally change tech and how we do tech, and we believe that health equity is best solved locally, not across the board.

And that's it. Thank you very much for your time.

VICE CHAIR HARDIN: Thank you so much, Dr. Chen, for that very interesting

presentation. We are saving all questions from the Committee until the end of all presentations.

Next, I'm honored to announce we'll be having a joint presentation from Dr. Palav Babaria, Chief Quality Officer and Deputy Director of Quality and Population Health Management at the California Department of Health Care Services; and Mr. Paul Leon, Founder, CEO and President of the Illumination Foundation.

Please go ahead.

DR. BABARIA: Thank you so much.

Hi, everyone. It's a pleasure to be here with you today and to share some of what we are doing in our California State Medicaid Program, also known as Medi-Cal.

I am an internist by training and have spent most of my career working in value-based payments and clinical operations on the health care delivery system side mostly in California's safety net, and joined the department a year ago to really lead our work around value-based payment, quality, health equity, and population health management,

especially given the tremendous changes happening across our program right now through the CalAIM[10] initiative.

You can go to the next slide. So, to provide a little bit of context, we're going to kick off with what we are doing right now to really think about whole-person care for our members that really touches upon a lot of the same themes that Dr. Chen touched upon thinking about how do we provide integrated upstream care that really gets at the root drivers of our members' needs.

You can go to the next slide. So, for those of you who are not enmeshed in the California Medi-Cal landscape, we, the California Department of Health Care Services, launched CalAIM, which is really a multi-year transformational initiative to fundamentally change how our state Medicaid program operates and achieve a few really critical goals.

We are a very large state. We have 58 different counties, very different populations and regions across those counties,

10 California Advancing and Innovating Medi-Cal

and we have significant social drivers of health that day in and day out impact the outcomes of all of our members in the Medi-Cal program.

CalAIM really seeks to identify and manage member risk through this whole-person care approach and really addressing the social drivers of health as a key part of our Medi-Cal program.

We also have a lot of variation across the state. So, a lot of the initiatives in CalAIM seek to provide a consistent and seamless experience and standardize many of our fundamental program components across the state of California.

And then most importantly, all of the initiatives in CalAIM are geared towards improving quality outcomes, reducing health disparities, and driving delivery system transformation through value-based payments.

We can go to the next slide. So, a little bit of background and context. The two initiatives that I wanted to highlight that are part of a much broader suite of initiatives that comprise CalAIM are Enhanced Care

Management and Community Supports.

The issues that Enhanced Care Management and Community Supports are designed to address is that we know over half of all of our Medi-Cal spending is attributable to 5 percent of enrollees with the highest-cost needs.

We also know that our Medi-Cal enrollees have often multiple complex health and behavioral health conditions.

And we also know that across the state, these enrollees have to engage in multiple different delivery systems.

They access most of their physical health through our managed care delivery system. Our behavioral health system is carved out and operated at the county level.

So, for anyone with severe mental illness or substance use disorder needs, it is an entirely different delivery system that may or may not be effectively integrated and coordinating with their physical health needs.

Dental is similarly a carve-out, and then there are numerous local county-based programs that provide care management and

county coordination -- care coordination as well.

Go to the next slide. So, both Enhanced Care Management and Community Supports, which we are currently in the process of scaling statewide, were really informed by previous tests of change under, largely, our previous Section 1115 waiver programs.

The Whole Person Care pilots and the Health Homes Program pilots really looked at, you know, how do we take these very complicated high-utilizer individuals and create an effective suite of wraparound services that will change their health outcomes?

The initial evaluation, which is not finalized yet, showed really remarkable results in this domain.

So, from the beginning point of the Whole Person Care pilot to our mid-year evaluation, enrollees who reported being in excellent or very good overall health increased from eight percent to 22 percent. There were more modest improvements in emotional health.

The number of enrollees ages 18 to 59 with controlled blood pressure went from 36

percent at baseline to 65 percent after enrollment in this program. And there were also modest increases in the number of enrollees with controlled blood pressure rates.

The changes on total cost of care and especially readmissions, ED[11] visits, and hospitalizations were a little bit more mixed.

Not surprisingly, a lot of those changes were delayed in seeing those outcomes after enrollees were established in their care management programs.

So, the experience from those pilots that occurred in numerous different geographies and populations across the state led to the creation of Enhanced Care Management.

Enhanced Care Management is a new Medi-Cal benefit and a contract -- or, sorry, it is a new managed care contract requirement that is available to all of our enrollees in managed care who meet certain criteria.

And the care management is provided through community providers, and they essentially become the lead care manager who

11 Emergency department

will coordinate that member's needs across delivery systems, across local social services entities, housing entities, to really provide the whole-person care not just for their health care needs, but also linkage to addressing all of their social drivers of health.

In addition, Community Supports are currently optional services, but they are strongly encouraged, and Medi-Cal plans have been slowly scaling up the number of Community Supports that they provide.

They are really focused on, you know, providing, in lieu of services that we know, can reduce the hospital length of stay, prevent avoidable readmissions and hospitalizations.

You can go to the next slide. So, to just provide a little bit more detail, so for ECM[12], this is really, as I mentioned, designed to provide comprehensive wraparound care management for any enrollees that have complex needs and really navigate those enrollees across all of the different delivery

12 Enhanced Care Management

systems that could be fragmented and very challenging for our members to navigate, and they are designed to address both the clinical and nonclinical needs of these high-need enrollees.

We can go to the next slide. Community Supports are really services, as mentioned, that are designed to be in lieu of other types of health care utilization that is often higher-cost with lower-value when we look at the quality outcomes.

So, I'm not going to read all of these, but these are the suite of Community Supports that, in current state, are not offered statewide, but each managed care plan based off of local needs and capacity is starting with a few of these and then looking to scale over time.

We can go to the next slide. I think I'm turning it over to Paul. So, hopefully that brief overview of what the state is doing around Enhanced Care Management and Community Supports will provide the context that is needed to understand what Paul and his team have been doing at the local level, and

the impact that these programs have for our Medi-Cal beneficiaries on the ground.

MR. LEON: Thank you, Palav.

I'm happy to be here. My name is Paul Leon. I am a public health nurse by trade and CEO of Illumination Foundation.

We are a grassroots nonprofit that --we're a provider in Southern California, Los Angeles, Orange County, and Inland Empire.

So, back in 2007, straight out of MBA school, we walked into -- actually it was a class project -- walked into this shelter in Orange County and realized that -- at this shelter, there were about 200 children, families, individuals with mental health, substance abuse, and realized that we had to take care of this population.

At that time, there were about six to 7,000 rough sleepers, people that were staying in the streets of Orange County.

As you know, Los Angeles now is the epicenter for homeless and unstably housed. So, we migrated up into LA.

We currently are the largest medical respite recuperative care in the nation. We

have 408 beds. We get discharges directly from the hospital, police, county, and we can settle for it for now.

The Fullerton site up in the left is our flagship site. It actually has a shelter on the bottom, a medical respite. And on top, services, primary care, dental, psychiatric, housing navigation, and workforce.

All the services are on the top, and on the bottom it's a navigation center and a shelter. It also has -- it's a full-service area that individuals could stay there.

Our newest site is UCLA. You'll see on the bottom that it's actually a medical respite that is within the hospital.

So, that is kind of the trend now for medical respites to partner with a hospital and place them either adjacent to the hospital or in a facility near the hospital.

So, what we realized early on, we started 15 years ago, is that not only did you need a central location, which we call a hub, and that's a medical respite, but also you needed to discharge individuals from that facility.

They're not quite ready to go to another facility, so we actually transfer them to micro-communities.

You can see there we have, I think, about 241 different micro-communities. Some that are mental health, substance abuse. A lot more for seniors now and couples.

These are the micro-communities. Again, 241 doors. They're in the community adjacent to the medical respite.

So, this is our model, and it's basically Street2Home. We have individuals that are homeless, and now we're seeing a lot more individuals that are just unstably housed.

They lost their housing and it -- from month to month, they're staying at different places, couch surfing, going back with their parents, going back with their kids, either way.

So, this is the model that we developed early on. It's the ability to take somebody from the street to either a navigation center, a family emergency center, and you'll see medical respite, recuperative care is in the center, and then into a micro-community and

permanent housing.

Prior to CalAIM, we figured out how to fund this through city grants, through different organizations and hospitals that would pay for medical respite with charity dollars.

And then, of course, when we're able to get individuals into housing, HUD[13] would pick up, and we'd pay with it for vouchers.

So, that was our continuum of payment until CalAIM came. And when CalAIM was initiated, it now funds pretty much all this process.

A little bit about the data and some of the clients that we see. We do both predictive and prescriptive analytics, but you can see that the population, like Dr. Chen was talking about, that we see are high-risk, high-score risks that we use the HCC[14] predictive model from CMS.

And you can see that we have 245 of these clients that we got the information from our CalOptima, or CMO, that have 10 more -- 10

13 Housing and Urban Development
14 Hierarchical Condition Category

or more distinctive diagnoses. Most of our clients have mental health plus medical health that we're taking care of.

This is just another breakdown of the scores that we're seeing. More of a visual of clients that you can see run the whole gamut of risk.

So, one of the things that we started to really realize, and we did this early on, but we didn't call them social determinants of health.

We realized that it was not just the medical things that they were coming to us for. A lot of them was, you know, somebody would come to us with a broken leg or a wound; however, they had no transportation, they couldn't pick up their medication, they couldn't do follow-up with the hospital.

So, we really started to focus on and do a lot of the AI[15] work and really drilled down so we could do prescriptive analytics and really drill down on social determinants of health, you know.

15 Artificial intelligence

And you'll see, I believe -- no, it's the next slide, but one of the really incredible benefits from medical respite, you could see how many individuals weren't connected to a primary care physician.

And now, you know, then they came into our program, and we were able to connect them to their primary care physician.

Obviously, the savings are immediate when you can curb the, you know, the ED utilization and hospitalization.

You can see right from the start we were able to enter these patients into medical respite and then provide most of the care on site or by one of our local FQHCs[16].

One of the things that we found out when we started really analyzing the data -- we have years of data, but we never really scrubbed it -- is that we actually were taking care of SPMI[17] patients.

We had no idea that there was that big a percentage of clients that were in medical respite.

16 Federally Qualified Health Centers
17 Severe and persistent mental illness

Normally Beacon, our local provider, was admitting the mental health diagnosis for bipolar and schizophrenic, but within recuperative care.

When we are with our clients and really could get -- speak to them, they started to trust us, we realized that they were really multi-focal patients with mental health and their medical diagnosis.

One of the things, again, that data really showed us is the cost savings and especially first year compared to the second year.

And you can see that the obvious things that you can do when we bring our clients in, just basic teaching is going to save money right away.

Things that -- transportation, basic needs, and especially housing, which is a component that CalAIM is starting to address, but you can see that if you stick with the social determinants of health, that the savings sometimes will come the year after.

And, again, this is just one of the graphics that we realized early on. This is

data from our CMO clients -- 1,266 clients.

Their actual cost to CalOptima is almost $26 million. It went down when they became a medical respite.

And then afterwards went up quite a bit because that's housing in there, but also medications were increased. We were really happy to see that. So, overall savings for one year on 1,266 clients were $17 million.

VICE CHAIR HARDIN: And, Dr. Babaria, we need to wrap up in about two more minutes.

MR. LEON: Okay. So -- and, again, this is just some of the early projections for CalAIM.

You can see that we've already implemented a lot of the parts of CalAIM, and it so far is really working well.

We're able to see and now be able to get reimbursements for some of the things that we're doing that we really couldn't do prior to that. And again, these are monthly projections for CalAIM.

And I'll just leave you with one last item is that, you know, we had -- our last

client that came in had actually lived in a cave for 12 years above LA. Was working, living in a cave.

And we entered her into our medical respite, and she has been there about six weeks and is doing really well, but that's the kind of clients that we're seeing with, you know, a lot of unstable housing. So, thank you.

DR. BABARIA: Thanks, Paul.

And I would just say, you know, the local trends and complexity that Paul's describing is something that we've seen across the state in numerous of these Community Supports and Enhanced Care Management programs that are serving our members.

So, hopefully that local context provides a little glimpse into what we're trying to accomplish.

The one thing I did want to plant a seed with all of you is, as we've been doing this work and really focusing on our complex, high-utilizer individuals, it has become abundantly clear that we also need to step back and take a long view of health and wellness.

We can skip to the third slide.

There is information in here about how we're contextualizing our value-based payment work and all of these initiatives within our larger population health management strategy, but I'm going to pause us on this slide for a second.

So, as we've been looking at our programs, I think, you know, as Dr. Chen mentioned, prevention and upstream intervention are not things that we naturally do well across the health care delivery system or that, you know, we physicians are particularly trained in addressing.

I think one of our unique roles, as a government payer, is that we really can step back and take a longer view than sometimes our health care delivery system or managed care partners can.

So, when you think about our Medi-Cal program, we cover over 14 million individuals right now, or one in three Californians.

But when you look at the younger populations, we cover about half of all births in the state of California and more than half of the children residing in the state.

Then when we take our health equity lens, almost three-quarters of all Latino and Black children in the entire state of California are covered by the Medi-Cal program.

And we know through extensive literature, research, trends in our own programs and our work on adverse childhood experiences, screening, that what happens to these children and pregnant individuals really determines what their long-term health outcomes are decades later.

(Interruption.)

DR. BABARIA: Sorry, is anyone else hearing that background noise?

VICE CHAIR HARDIN: You may want to mute, whoever just joined.

DR. BABARIA: So, I think, you know, just want to underscore that when we think about these complex populations and individuals, if we really want to address the number of high-utilizers and individuals with poor health outcomes and multiple conditions that are in our nation, we really have to look upstream by decades, and government payers are really in a unique position to take this long

view.

You can go to the next slide. This just shows our Bold Goals initiative that we're launching to really think about this upstream intervention.

And we are, you know, rolling this out through all of the levers that we have across the Medi-Cal program, including in our value-based payment programs.

We can go to the next slide. And I think where we're really trying to double down is, you know, like many of the folks have talked about, how do we recenter primary care and not just investing in primary care as it exists today, but really integrating it with upstream public health and social services programs that we know work and have a return on investment over the long run, you know, especially home visiting.

First 5 Association have a number of models that are really working in the state of California.

In addition to that, we are supporting investments in primary care transformation and, with our managed care re-

procurement with new contracts going into effect in 2024, are also mandating reporting on the percent of spending on primary care as a percentage of total spend at the health plan level with the plan to set targets for that spending in the future, as well as the percentage of Alternative Payment Model arrangements for our health plans.

So, I just encourage us to really, you know, think about where can we put in that long-term thinking and the long-term view so that at some point in the future, we really are curbing the number of individuals that we need to enroll into programs like Paul's, as effective as they are.

VICE CHAIR HARDIN: Thank you so much, Dr. Babaria.

DR. BABARIA: Thank you. I'll turn it over to questions.

VICE CHAIR HARDIN: And now at this point, we have a few moments to open up the floor for the Committee Members for discussion and questions.

So, Dr. Chen, if you can also join, and I see Bruce has his hand raised. Bruce.

MR. STEINWALD: My question is for Dr. Chen.

Doctor, what proportion of the entrance into that one-year fellowship that you mentioned actually make it through to the end?

And would you say that there's a selection process that limits the number of primary care physicians who would thrive in your kind of system, or do you think there is a real upside to that?

DR. CHEN: What a fantastic question.

It's only the number one thing that we focus on as an organization. So, you know, if our job is to take primary care doctors and sort of de-program fee-for-service from them and then re-train them in the ways that we just discussed, you know, holistic care, preventative care, learning how to win and lead, not everybody can do that necessarily, right?

So, we spend an enormous amount of time, data, interviewing, to figure out who are the primary care doctors that we believe can do this kind of care.

Now, the good news is it's over 50 percent, we've discovered. The number of -- I would say, in our population, over 95, 97 percent of doctors get through the training program and do alright.

But then you're saying that's because, Chris, you're doing a great job selecting, and we think we can do a better job.

So, I'll give you an example. I was on a panel once with a very prestigious organization, leader of one of those, and they were talking about their brand of the doctors that they're looking for, you know, these amazing pedigrees and all the things that we talked about. And he's like, you know, we don't hire these type of doctors.

And I said, can you do me a favor? When you say "none of those doctors," can you send them over to me? Because those actually happen to be the profile of the doctor that I'm looking for, and it's outrageously counterintuitive.

So, doctors that can lead, doctors that can think holistically and move upstream, who can build relationships with their

patients, are very different than what typically medical schools and residency programs are looking for and even prestigious organizations. It's just a very different profile.

We actually psychologically profiled our doctors. We spent five hours doing that. We capture all this data as we're interviewing them and determined what are the types of doctors that can do this care.

I'll give you a couple pearls of things that we look for that trump your pedigree, that trump your, you know, your scores and everything else.

Learning agility is absolutely critical. The speed at which they can learn because, remember, we're telling them all the stuff that you've learned in the past may not help you as much in this model in the future. So, learning agility is one thing.

Second thing that has to go with learning agility is humility. Humility in different ways. Humility in, A, to learn quickly, but humility also with the patient.

So, if there is this attitude that

some doctors have, right, where -- with patients where they are, you know, I am the authority and you are not, and you don't have to listen to me and that's your problem, that, unfortunately, doesn't work well when you're building relationships with a patient, and you're trying to get them to change their lifestyle behaviors and trying to get you to tell them the, you know, you have to convince them to tell you when their son is stealing their Social Security check so you can deal with that, right? These are fundamental, real issues, and so you can only do that with trust.

So, you're right on. I believe that fee-for-service will be here to stay because I do think there is some proportion of the primary care work staff that is primarily designed for that volume-based type of care and not -- shouldn't be accountable for outcomes, but the majority of primary care doctors out there, I believe, can make that switch and should make that switch. It's far more validating.

We don't have a problem recruiting docs, by the way. There's a huge shortage, and

we don't have that huge problem.

MR. STEINWALD: Thank you.

VICE CHAIR HARDIN: And then Lee next, and I'd just like to give everyone -- we've got about five more minutes.

So, if you can make your question succinct and answer succinct, there's a line of people who'd like to ask.

Lee?

DR. MILLS: Thanks so much.

Dr. Chen, can you tell us more about your model's involvement with specialists, how you select them, how you contract with them, how you work with them inside your total cost of care-type arrangements --

DR. CHEN: Sure.

DR. MILLS: -- and philosophy.

DR. CHEN: You know, also, first of all, we are not based in California. So, we do not have the ability to create our own delegated network.

So -- and we're in so many cities. We're in 40 cities right now. So, we can't hire specialists everywhere.

However, I can tell you there are

certain Tier 1 specialists -- obviously, cardiology is one of them, endocrinology -- there's certain ones that are in our population that are very common, and we will do our best to hire Tier 1 specialists to come on site either through a contract arrangement or through direct employment.

We prefer direct employment so we can go through that training process that we discussed before and the selection process, but then no matter what you do, you're going to have to work downstream with the local sort of ecosystem there.

And you go to the health plan provider network, and then we start with that, and we start looking at data.

We have Blue Button claims data, we have health plan data, they can share some of that with us, and we can look at some of their patterns, and we've developed algorithms across the board.

We have these central specialists that sit in a corporate center that actually develop algorithms that say, do our doctors following evidence-based care? And you can

study that through claims data, believe it or not.

That triangulates it, and then you got to sit there, and then you got to go visit those specialists and say, okay, are you the kind of doctors that want to collaborate on care, or do you just want us to send patients to you, but you never want to have a conversation, you don't want to collaborate, you don't want to coordinate?

And if you're in the latter, sorry, we don't want to work with you. If you're in the former, and you want to be a partner with us, and you're okay with us being the quarterback of that care, then you're a great partner, and we found the outcomes are the best, and that's essentially what we're looking for.

We do not beat them up for costs, by the way. That's a unique thing. We do not beat them up for their rates.

We prefer collaboration over rates every day. You get better outcomes at a lower cost.

VICE CHAIR HARDIN: And, Walter --

thank you.

Walter?

DR. LIN: Again, thank you for -- all the panelists for great presentations. Very informative.

Question for Dr. Chen, and you've kind of answered part of this with your answers to Bruce and Lee's questions, but it sounds like you have really engaged primary care doctors that you select through a very rigorous selection process.

They give out their cell phones, they have small patient panels, but I'm wondering what kind of levers that ChenMed has post-training to really continue to engage and influence the PCPs to produce such great outcomes, 30 to 50 percent decrease in the ER and hospitalization rates.

I suspect some are financial, but -- both financial and nonfinancial.

DR. CHEN: So, let me just handle the financial piece because usually that's a big part of people's questions. Yeah, absolutely we compensate for outcomes and -- so, that's number one.

We do -- we give them, you know, good compensation to begin with, and then we give them tremendous upside based on their outcomes.

Number two, we are an overly transparent organization when it comes to those outcomes. Everybody knows how everybody else is doing.

So, you can imagine during the selection process, humility is very important because if you're not comfortable working together and sharing data together and all talking about it together, this is not the place for you. So, we're outrageously transparent across even markets and outcomes.

The doctor sitting next to you, you know exactly how they're doing, you know how you're doing, and you're learning from each other.

So, it's not a shaming concept. It's about -- it is a team type of aspect from love, accountability, and passion.

Last, but not least, we allow doctors to grow. Doctors, they get into their job, and they're like this is -- I've reached

my ceiling. This is what I'm going to be doing. I'm going to sit in a room and see patients for the rest of my life. And we're saying, maybe, but there's a tremendous opportunity to grow and lead.

And so, we will -- we've developed a development path for doctors to grow in our organization in dramatic ways, and it's not unusual for doctors to get promoted every one, two years into new roles and new leadership roles, either clinical leadership roles, administrative leadership roles, teaching, selections.

Remember, physicians are such a fabric of our operating model, and we pair them with business leaders. So, we need doctors to get promoted. And so, they get that opportunity.

And then they get recognized by their peers and by other folks and, you know, testify at Congress and whatnot. So, that becomes exciting, too.

VICE CHAIR HARDIN: And, Angelo, I saw you had your tent up.

DR. SINOPOLI: Yeah. Lee asked the

question I was going to ask, so --

VICE CHAIR HARDIN: Excellent.

DR. SINOPOLI: Good.

VICE CHAIR HARDIN: So, for Dr. Babaria and Mr. Leon, can you speak to the criteria for determining which patients are appropriate for Community Supports and Enhanced Care Management?

And also, what kind of crossover you see with the senior populations when you think about Medicare. If you could speak to those two things?

DR. BABARIA: I'm happy to start us off at the state level and then, Paul, you probably have more details at the local level.

So, for Enhanced Care Management, we have specific populations of focus that were really informed by those Whole Person Care and Health Homes pilots targeting individuals who are homeless, have severe mental illness, substance use disorders, you know, usually with other criteria such as ED visits, hospitalizations, or chronic conditions.

We are still working on our policy and rolling out that benefit for justice-

involved populations, as well as children and youth, and still finalizing the criteria, as well as for long-term care and individuals residing in the community, but who meet long-term criteria of care. So, more to come in that space in the year to come.

And then for Community Supports, it's really, you know, anywhere -- based off the recommendation of their provider, anywhere where that benefit would thought to be beneficial.

So, there's a broader application, and we will be doing a thorough evaluation to really assess the efficacy of that approach and, you know, what the impact is on both health outcomes and total cost of care.

MR. LEON: Yeah. And for us, medical respite, they're referred to -- usually by the hospitals now because with CalAIM, we can self-refer, but many of the plans and providers aren't really sure where their clients are. And they give us a list each month, and we go through and find their clients with outreach.

And as far as seniors, it's the

fastest growing population of homeless and unstably housed.

So, many of the plans, for example, Kaiser, they want us to find, you know, maybe a grandmother who's staying with two different daughters and will just pop up in the ER.

And they won't really know where their client is at or their patient, so we will enroll them in ECM, and then make sure that we can navigate their primary care physician.

DR. BABARIA: And I should just add --

VICE CHAIR HARDIN: Go ahead. Go ahead.

DR. BABARIA: I was just going to say on the seniors' front, I definitely underscore everything that Paul said that in almost all of these categories, you know, we are seeing the impact of all of these chronic conditions, the housing crisis in California on seniors.

And so, we have a separate workstream specifically focused on duals in our program, and that is absolutely where we see a large burden of all of these issues.

VICE CHAIR HARDIN: Jennifer?

DR. WILER: Thank you for the wonderful presentations. My question is for Dr. Chen.

We heard yesterday about participation in incentivizing providers, physicians in particular, in programs and outcomes.

What percentage of your physician's total compensation is incentive comp?

DR. CHEN: So, you know, I mentioned that we had multiple layers, right? So -- and doctors have tremendous opportunity to grow.

So, we bring them in with a base that is essentially highly competitive with, you know, their market. That's usually the starting point.

And then we usually put about an additional 20 to 30 percent opportunity on top of that. That's at the base PCP level.

As you start to, you know, if you will, move up the ranks and demonstrate that you are successful in this model, and you continue to teach or even develop workflows that -- or do research that helps us drive

towards, you know, better outcomes, what we mostly flex in that environment is usually based on outcomes, and it's going to be the variable component.

So, you could have a doctor at one point getting an additional, you know, 50 percent of their compensation could be entirely variable and all the way to the very top, where you have folks where perhaps even two-thirds of their compensation is based on outcomes.

So, I hope that helps.

VICE CHAIR HARDIN: Thank you. One final question for Dr. Babaria.

Can you speak very briefly to multi-payer alignment that's happening with AHCP[18] in the state?

There's a lot of interest in the group, but a brief answer, and then we'll go to break.

DR. BABARIA: Absolutely.

So, at the state level, we have a collaboration between Medi-Cal, which covers about a third of our population; Covered

18 America's Health Care Plan

California, which is our incredibly robust state health care exchange; and CalPERS[19], which is our sort of state employee and retirees system -- benefits system.

So, collectively between us, we cover upwards of 42 percent of the entire population of the state.

So, us three state purchasers have an ongoing strong relationship and collaborative to align all of our measures where possible, really, you know, support that downstream Alternative Payment Model in a coordinated fashion and are participating in the HCP-LAN[20] state transformation collaborative so that we can really scale some of those efforts statewide with primary care practices.

VICE CHAIR HARDIN: Wonderful. We want to thank you all very much for joining. At this time we're going to take a short break until 10:45 Eastern.

Please join us then. We have a great lineup for our roundtable panel discussion. Thank you so much.

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19 California Public Employees' Retirement System
20 Health Care Payment Learning & Action Network

(Whereupon, the above-entitled matter went off the record at 10:41 a.m. and resumed at 10:49 a.m.)

*** Panel Discussion on Assessing Best Practices in Care Delivery for PB-TCOC Models**

CHAIR CASALE: I am excited to kick off our panel. I ask our panelists to go ahead and turn on video if you haven't already.

To further inform us about best practices related to population-based total cost of care models, we've invited esteemed experts to represent several perspectives. PTAC members, you'll have an opportunity to ask our guests questions as well.

The full biographies of our panelists can be found on the ASPE PTAC website. So, I'll briefly introduce our guests and their current organizations.

First, we have Lee McGrath who is the Executive Vice President of Healthcare Services for Premera Blue Cross.

Dr. Gary Puckrein joins us from the National Minority Quality Forum, where he is the President and Chief Medical Officer.

We also have Dr. Robert Saunders. He is the Senior Research Director of Health Care Transformation at the Duke-Margolis Center for Health Policy. So, welcome and thank you for joining us.

To start off, the Innovation Center at CMS has set the goal of having every Medicare fee-for-service beneficiary in a care relationship with accountability for quality and total cost of care by 2030.

What do you see as the potential for accountable care relationships and models to improve quality of care and health outcomes while reducing total cost of care?

What changes are needed to maximize how these models can achieve these objectives?

First, I'll turn to Rob.

DR. SAUNDERS: Thanks, Paul, and I appreciate the opportunity to be here today.

As Paul mentioned, I'm Rob Saunders with the Margolis Center of Health Policy at Duke, and we do a fair bit of research looking at the facts of various payment and delivery reforms.

You know, there's a couple of places

here where we've been focused on opportunities to improve total cost of care models.

You know, there's clearly been some movement over the last several years since we've expanded the number of population-based or total cost of care models, and we're starting to see positive results in various cases.

Although, I think the evidence is not quite where we hope it will be yet, but, you know, one of the big challenges that we're seeing is really where do you engage specialists in a number of these APMs[21], you know.

A lot of the total cost of care models to date have really focused on primary care, which is incredibly important, but there's been less focus on the specialty physicians or specialized care, which is at least, you know, 90, 92, maybe a little bit more percent, of total health care spending and total health care in general.

And so, one of the challenges is

21 Alternative Payment Models

what we can do to better engage specialists in these types of arrangements, you know.

Now, in research we're seeing a variety of strategies take place. There's some network referral strategies that individuals at ACOs or total cost of care organizations are using.

There's more specialized types of total cost of care arrangements like, say, your ESCOs[22],for your end-stage renal disease, there's some contracting strategies, maybe virtual bundles. And then, of course, we all want to end up in a care re-designed place as well.

So, those are some places where I think we're seeing some movement. There's not a total silver bullet here yet, but I think there's a lot of opportunity to integrate the specialist perspective a bit more in these types of total cost of care arrangements.

CHAIR CASALE: Thanks, Rob.

Next, I'll turn to Gary Puckrein.

DR. PUCKREIN: So, the National

22 ESRD (End-Stage Renal Disease) Seamless Care Organizations

Minority Quality Forum, we start from the place that the health care system should be about mitigating patient risk.

The real purpose of health care is to reduce hospitalizations, emergency room visits, disability, mortality for each patient, and we see no Medicare beneficiary who is coming in through the health care system with any expectation that the system is going to elevate their risk.

When we look at these models, these models are not patient-centric. They're financial models. They're just based on moving money around.

And there's really no evidence, actually, that over the long course of all of these patient models -- of these financial models that we see improvement in health outcomes for beneficiaries.

And, you know, the operating assumption is that if you pay a physician this way or that way, are you necessarily going to get good outcomes for patients?

I think the place we ought to begin is with patient outcomes. So, model the system

and have the system focus on improving patient outcomes.

Certainly when you're dealing with equity, you've got to be able to focus down on what's good for patients and have the system organized around that.

I think if the system becomes focused on patient outcomes, that will get the results that we're looking for.

I don't see any evidence that any of these patient models in the short run, or the long run, are going to bring the kind of quality that certainly patients expect to get in the Medicare program.

CHAIR CASALE: Thank you. Next, we'll turn to Lee McGrath.

MS. MCGRATH: Sure. Thanks so much, Paul. I'm not sure where I'm esteemed, but I appreciate the compliment early starting out with that.

So, I'm going to take a different type of approach. Although, Gary, I can't begin to tell you how much I love the sentence that the models are just about moving money around, because that actually breaks my heart,

and I think you're right.

I think what we need to be successful, because I actually really love CMS' mandate around we want every Medicare beneficiary to have a tight relationship with primary care, I think what we need to be able to do in order to make that work in a way that actually focuses on patient outcomes and not just moving the money around is access, investment in infrastructure in order to effectively move information back and forth from wherever it sits, whether, you know, lab outcomes or lab results sit in Labcorp, or whether there's claim information sitting on Premera's claim system, or whether there is information from an emergency room when grandma took their kids to Florida or Disneyland.

Wherever it sits, getting it in a really useable, manageable position for the primary care physician to then activate on that, that takes an amazing amount of investment and a different way to think about how to impact care in a meaningful way.

So, that care becomes about everything that happens in the patient's life

and not just when I'm standing and looking at the patient saying, hey, why does your back hurt, how can I help?

Then the other third piece, I think, is the definition of "primary care." I'm not sure that it's been really defined.

Are endocrinologists primary care? Are cardiologists primary care? And how do we think about that?

And then going through the things I just talked about, access, infrastructure in terms of data analytics, those are things that will have to be contemplated as we think about, I hope, broadening the definition of "primary care" to meet the patient outcomes that we all want.

So, that would be where I would start from.

CHAIR CASALE: Great. Thanks so much.

So, our fourth panelist has joined, Dr. Kristofer Smith, Chief Clinical Officer from Prospero Health.

So, Kris, if you turn your video on if you're there and --

DR. SMITH: I am here. Can you hear me?

CHAIR CASALE: Yes, we can. Yeah. I'm hoping you heard the first question. I was wondering if you had some thoughts around that question on accountable care relationships and changes needed to maximize these models.

DR. SMITH: Sure. So, you know, I think there's a number of -- is this -- are we talking -- I just want to make sure and I apologize for being late to the Webex. It's not the preferred video conferencing application for my company.

Are we on Question 1 or Question 2?

CHAIR CASALE: Question 1. So, what do you see as the potential for accountable care relationships and models to improve quality of care and health outcomes while reducing total cost of care, and what changes are needed to maximize how these models can achieve these objectives?

DR. SMITH: Yeah. So, I did hear some of the comments.

I do think that, you know, we're 10 years into this journey on models of care and

certainly, I've had the good fortune of participating in them from both the side of health care delivery systems, as well as for-profit companies such as Prospero or Navajo.

I think where I see us continuing to struggle as we think about these models is often around what population are we trying to improve quality and total cost of care.

And this is where I think we often struggle a little bit because, as we've heard, we want to put most beneficiaries into care relationships for accountability for quality and total cost of care.

I think that there are portions of the population where we should be leaning in on certain elements of quality, whether those are measured by access, whether they're some of the primary care measures that we all are held accountable to, but I think there's not as much data that we should be holding provider groups accountable for total cost of care across entire populations.

My experience working in this space is that the reward and the data that would support -- there are subpopulations of high-

cost patients that require different models of care in order for us to achieve improvements in total cost of care, and then there's a whole tail of maybe 50 to 75 percent of the patients where there's not actually a lot of cost to break out of the system if you're talking about utilization.

And so, I think we need to start to really reframe the idea that we're going to delegate total cost of care for entire populations to provider entities or to for-profit groups because I don't see that there's a whole lot of compelling data around reducing total cost of care in most of the populations, yet there is the ability to reduce total cost of care in certain, like, the frail, elderly, end-stage renal patients.

And so, I would lean in more on those for total cost of care, and I would think more broadly about quality in the remainder of the populations that aren't high-cost with a lot of below-value care.

CHAIR CASALE: Great. Thanks, Kris.

And so before we move to the next question, I want to open it up to PTAC members

for any follow-up questions.

Larry?

DR. KOSINSKI: Alright. I'd like to ask Gary a question specifically about specialist participation.

How do you have -- or have you managed to put enough income at risk on the specialist side for them to participate fully in value-based care?

And if you're not doing it through income, are you accomplishing it through management of the network and bringing a larger percentage of their workload into the value-based care arrangement?

DR. PUCKREIN: I presume you're directing that question really at Robert because I think --

DR. KOSINSKI: Oh, I'm sorry. That really went to Robert. I'm sorry.

DR. SAUNDERS: I'm happy to chat, Larry. I know given your experience in thinking through a number of Alternative Payment Models really focused that specialist participation, you understand the nuances that happen here.

What we're seeing out there in the

field is that it really varies to what extent specialists have had their compensation adjusted in terms of those total cost of care arrangements.

I was on for a little bit of the last panel where Chris Chen was talking about some of the compensation changes that they were making over at ChenMed, you know.

I think what we're seeing, writ large, is that there have been very few places that have changed compensation patterns even if they're in a large health care system that, say, has an ACO contract or some other type of total cost of care arrangement, that actually go forth and change compensation to their specialists.

If they do, it's probably in the percent range, and that's in the big systems, you know.

I think if we're talking about a smaller practice, you know, then we get into a question of what level of their book business or their level of their practice is actually affected by that total cost of care arrangement, and most of the time we're talking

about small numbers that we've seen in the field with some notable exceptions, you know.

I think where you've been able to get, say, a really focused arrangement for GI[23], for instance, you know, and I know you're familiar with this where you're able to have something like an IBD[24] Medical Home and the like that's really focused on one condition and really get a practice engaged.

But for many of the general specialists who receive a number of different conditions, usually we haven't seen a huge percentage of their compensation or the practice revenue affected by these types of total cost of care arrangements.

So, I think it's a mixed bag right now, is the short answer.

CHAIR CASALE: Lee, I wonder if you might have some comments about, again, this topic of sort of engaging specialists within total cost of care.

From your view, what are the opportunities how best to think about how to

23 Gastrointestinal
24 Inflammatory bowel disease

engage them in these models?

MS. MCGRATH: I think the opportunities are actually endless, and we have to be creative in thinking about it, but I can't keep underscoring what Gary mentioned. It can't just be about moving money around.

So, we need to really make sure that we're talking about access and quality and, you know, infrastructure and reducing transaction costs and figuring out how we can make systems and specialists, or primary care, or whomever, more efficient and make it easier to do their jobs and remove the burden that has been put on them.

So, we can keep talking about the money, but I -- it makes me sad if we just keep talking about the money. It should really be about something more than that.

And, by the way, I get that increasing access and infrastructure costs a bunch of money, but that's actually where I think our investment should lie as opposed to just, you know, continuing to, you know, just create contracts that, you know, measure something against something, and then we pay

for it because I think we haven't seen all of, you know, we've been in the value-based care world now for a while, and we need to see a greater change.

I think our customers, members, patients, however the word we want to use, expect a lot more from us.

CHAIR CASALE: Great. Thank you.

Josh?

DR. LIAO: Lee, thanks for those comments, and I wonder, kind of thinking about that and some other things that Gary and Rob have mentioned, you know, if we kind of pull on that thread of investment and that, you know, it takes something to then do something and increase access in other things we care about, bring it back to the question, do we think those are things that we might change or adjust in total cost of care models or, in your view, is that something that should be outside of that?

I think that's relevant to us as a Committee. The point is well-taken and for me, at least, it's how would we incorporate that into specific changes in these models or should

it be separate?

MS. MCGRATH: I don't know if it should be separate or not. There's not a conversation that I have with a provider today as the person who's in charge of the provider network here in Washington and Alaska that doesn't involve how can I help with access, how can I help, you know, reduce transaction costs, you know, how can I help staff your facilities, right, since there's a labor shortage.

So, I'm not sure, you know, whether it's separate or not, but I will just say, for example, at Premera, we are literally standing up primary care.

There is not enough access in Spokane, and it's a fantastic community. We love Spokane. We can't let there not be enough access.

And so, we just -- I mean, it was exhausting and expensive, but we stood up primary care, right? And we did that because we love our communities, and we're standing up primary care now throughout the state.

And, again, we're doing that because, I mean, we just -- we love them. How

can we not just be yelling at other providers, like, what are you -- like, that's -- no, let's jointly figure out how to do this, and we put our money where our mouth is, and we invested in primary care.

DR. SAUNDERS: And I think just building on what Lee says and underscoring Lee's point and Gary's that, you know, it's relatively easy to change the way we pay. It's much, much harder to redesign care.

You know, our research also shows that it takes several years. I mean, you know, Step 1 in many of these arrangements is you're just figuring out what are the details. Like, in giving me a claims feed, how do I open this file, you know?

Year 2, maybe you're trying to do a thing. Year 3, hopefully you're seeing a result, and that's, you know, folks who are pretty well-resourced and have a good sense of what to do.

I think to your question on up-front capital, I think that's a big issue here, you know.

We had early on, say, like, the ACO

investment model, like, which included some level of up-front capital, you know, maybe a hospital system or a health system may be able to tap into capital reserves.

But to start an ACO, you know, depends on which type of ACO, you know. We're talking probably three-quarters of a mill, a mill, to get the data infrastructure, to get the people, to get the care coordinators, and all of that is up-front.

And then on the Medicare side, you do that, you then improve care, and then 18 months later you get the check that is your reward.

You may or may not have the cash flow to survive, especially if we're talking about a petitioner to practice and still working on cash accounting and trying to work that way.

You know, I think we've seen actors in the market help fill that gap a little bit, your ACO enablers, your Elevates, your Privias, your Agilons, who have been able to tap in and provide some of that up-front capital, but I think to Lee's point, there's still a big need

here.

And it's different, you know, the up-front capital and that infrastructure investment is different than the ongoing incentive structure that we put in place.

And, you know, many practices don't have the access to capital that allows them to start putting those investments down and then waiting, you know, two years, three, to see if that investment pays off. They need, you know, help up front.

So, I think we'll struggle having a payment model that doesn't include something that's thinking about where does that up-front capital come from.

DR. SMITH: Yeah. Robert, if I could follow up on that, you know, my career started out in, you know, health systems.

And that was exactly our challenge, was we had so many different models. Each of them required -- I wish it was only half a million to three-quarters of a million dollars in start-up costs, right?

They often required enormous both start-up costs, as well as subject matter

expertise that we didn't have.

And then we built that over time, but each new model, you know, almost started over with new capital requirements to meet the needs of the model.

And so, what you're seeing now, I think, is almost the privatization of fee-for-service innovation in the marketplace right now with most of the interesting investments coming out of private equity and venture capital. I don't know that we want that to be that way.

I think what's also not happening is you're not seeing delivery systems really transform themselves because they simply don't have the working capital.

I mean, Lee, to -- I applaud you for trying to find primary care doctors to put across an entire state, but, you know, they're just -- they don't exist in many of our states.

And we don't have the dollars to invest in the salaries to pull people into primary care who might have otherwise are now going into hospital medicine or emergency medicine.

So, the up-front costs if we are

comfortable with the privatization of Medicare fee-for-service innovation, then we can continue to make -- put forward demonstrations at private equity companies like direct contracting can fund, or we have to figure out a different model for much bigger up-front capital investment.

DR. PUCKREIN: So, let me return this back to the patients for half a second.

So, if we look at Medicare fee-for-service right now, about 24 percent of Medicare beneficiaries in a fee-for-service program have diabetes.

They have a 60 percent hospitalization and ER visit, right? Sixty percent of them are going to the hospital or going to the ER every year.

If you look at the hospitalization rates and ER rates for the last five years, they're completely flatlined by -- the number of people who went to the hospital or the emergency room last year was almost the same number the year before.

And what that says to me, that's a system that's not learning. It's not learning

one doggone thing about how to take care of patients with diabetes.

We could talk about -- I mean, we could go down the list of this, right? And the point I'm making is that that's the conversation that we're not having.

We're not saying to ourselves, why is our system behaving like that? What do we need to do in order to change that?

And what I'm suggesting is you got to start with the numbers. You got to start with the numbers of patients, right?

I understand the financial investment, and I understand it costs and all that, but the purpose of health care is to mitigate patient risk, and all you're doing is talking about mitigating financials.

And so, we're putting patients at risk, and that is really a failed system because it ain't health care if that's what the system is doing.

CHAIR CASALE: Great. Thank you for all those comments. I'm actually going to move to Question 3 for our panelists.

I want to ask about addressing

health-related social needs in population-based total cost of care models.

So, in your opinion, what are some best practices for integrating screening and referring to address social needs in total cost of care models?

Gary, I'm going to start with you.

DR. PUCKREIN: That's a very tough question because we are not succeeding clinically.

And so, bringing social services into this -- and I'm assuming that we're talking about housing, transportation, food, and all those kinds of things which are obviously critical to health care, but is the health care system really built to do that right now and to add those on? Is that going to really help the situation?

There's got to be some integration obviously between social services and health care, but, for the moment, I would pay attention to what we're doing clinically to make sure that we're operating at the top of our license clinically and then obviously form those partnerships with social services in

order to improve our outcomes with patients.

But I'm not sure -- even though I deeply understand that social services are critical, but I'm not sure if this health care system is prepared to take that load on right now.

CHAIR CASALE: Thank you. Kris, I'm going to turn to you next about your opinion on best practices for integrating screening and referring to address social needs in these models.

DR. SMITH: Sure. Thank you.

So, I actually think that we've come a long way in terms of inclusion of screening for social determinants into many of our health care environments.

I think that, you know, we've also learned that a variety of different folks, when trained properly, can do it.

And you can actually use, whether we call them community health workers or even medical assistants, you can use staff that are relatively affordable to collect the information.

And I think that we also have seen

in the marketplace the proliferation of some solutions, whether they're things like NowPow or Aunt Bertha, which are providing the sort of network, so to speak, and contact information for all these social services.

So, I think we're actually pretty far along in Medicare with their standardization of the social determinants screening has really helped, but I'm with Gary.

I think that all that we've done now through building all that infrastructure and learning has created longer waiting lists in our social service agencies.

And our experience is we incorporate social determinant screening for all of our populations, and we are making referrals, but the referral isn't being acted on any faster.

And what we're -- I appreciate the refocus on social determinants and I appreciate how they do -- are determinant of patient outcomes, but, as a country, we have so underinvested in those entities that are capturing the referrals.

I don't think we're -- we are not making the progress we hoped, and I don't think

we are going to, because these social service agencies don't have the capacity to take the referrals.

CHAIR CASALE: Great. Thanks for those comments.

Lee?

MS. MCGRATH: I agree with all of that, and I think I'll just -- I'll take the approach of what we're doing at Premera. How's that?

So, in with the primary care that we're investing, and we actually created a team-based way to manage the patient -- and "manage" is such an insurance word, so I hesitate to use it, but really to provide love to the patient and create a magical moment, as we refer to it, between the patient and the physician, as well as the team that is supposed to give a big, giant hug to that patient.

So, we've employed social workers and pharmacists and case managers and behavioral health specialists, and we have, you know, invested heavily in community liaisons to understand, you know, where affordable housing might be or food banks, and trying to create

that relationship to the good people in the areas that we've invested in primary care to be able to provide that loving hug to the patient once they leave the four walls of the clinic.

So, that's how we view making sure that our patients, our members, are getting what we think they signed up for when they signed up for Premera insurance and what they've signed up for -- or what they just deserve, right?

So, that is, you know, how Premera has taken that approach and invested heavily in.

CHAIR CASALE: Great. Thank you. Appreciate that.

Rob, any comments on this?

DR. SAUNDERS: I think, you know, building on what others have said that there's been a fair bit of activity on the screening side, and I think we're getting better at encouraging screening for social drivers of health, you know.

This year, for instance, there were a few measures that were put forward in the Measure Applications Partnership review, and I

think we're already seeing at least one of those proposed for some of the Medicare hospital programs.

And the Measure Applications Partnership, you know, is probably going to -- recommended those -- some for the physician programs as well, you know.

I think as also building on others, the struggle is often linking the screening to the referral or the acting on the identified social need, and that tends to be where the challenge takes place.

Some examples of things we can work on or build on would be like North Carolina's Healthy Opportunities pilots which are doing screening, but also have funding -- in this case, Medicaid funding -- to help with the actual referred service on housing, nutrition, transportation, interpersonal violence, and also set up data tools to help with the referrals so that there's a sense of not only the referral to the community-based organization, but, you know, information and feedback back to the referring clinician to say, and here is what happened, you know, with

that case, you know.

We were able to meet that need, or we also found that there were other social needs, or we've been able to work with the patient in the following ways.

I think without that infrastructure to help with the connection between the screening clinician or the screener, whether that's a community health worker and the like, and the community-based organization, we're going to have a little bit of a struggle and may have some problems in actually making things happen.

The other thing that I think is worth flagging here is we're starting to see a little bit of cacophony happening in the social drivers of health screening space, you know.

We've done some just informal sort of surveys and, you know, finding that, you know, individual systems are finding, you know, three, four, five different variants of the screening tools, each of which have different ways of asking the question, each of which have different ways that they are, you know, looking for answers, each of which are also coding the

answers a little bit differently.

And we may be repeating the cacophony we have with quality measures and the social drivers of health, and then it's a really good thing that we're seeing so much attention paid on social drivers of health.

That is a good thing, but I would hate to repeat the challenges that we have and the burnout and burden that we have with quality measures on social drivers of health which aren't going to help with the long-time sustainability encouraging greater connections between the health care system and the social care space.

DR. SMITH: If I could just follow up your comment, I just want to -- I want to find a silver lining to the social determinants because I think, you know, the one place where, as we have, in our programs have gotten better at measuring social determinants in a way that can feed into our risk stratification models, I will say that the one area that we have, Gary, to your point about managing the medical, is we're getting better at using the social determinants to help us to identify who, you

know, which diabetic patient, to your earlier comment, is more likely to be the one hospitalized because from just a claims standpoint without the social determinants, they look rather homogenous.

And once we start to layer that in, we've had some good success in highlighting folks who need more help that we wouldn't have been able to do without attention to measurable, reportable social determinants.

CHAIR CASALE: Thank you. Appreciate all those comments. I'm going to open it now to PTAC members.

Any follow-up questions before we move to the next question?

Lauran?

VICE CHAIR HARDIN: Just a quick question.

So, universally across the country, there's an issue of screening and referral to nowhere.

And I'm curious for each of you, I've heard some innovative practices you're investing in in your systems.

What motivated you to put the

investment in actually building some of those services, and what recommendations might you make as we look at total cost of care to generate more investment and actually investing and building those resources?

DR. SMITH: Can you just clarify which resources? You mean you would like us to build the actual receivers of the referrals or --

VICE CHAIR HARDIN: Yes.

DR. SMITH: -- the infrastructure to capture the information?

VICE CHAIR HARDIN: So, when we think about health-related social needs, things like transportation and housing and food security.

Universally across the country, there is an issue with referral to nowhere, but I've heard in you describing some of your models you're building some of those things in.

You're investing in care management, social work, behavior health, pharmacy, the community liaisons.

What motivated you to do that? And then how -- what advice would you give to

others for investing in that?

DR. SMITH: I can try.

Lee, do you want to go first on that or --

MS. MCGRATH: No. Please, go ahead.

DR. SMITH: Yeah. So, I mean, much like Lee, you know, we, in our programs, are investing in other members of the care team.

Whether they're social workers, community liaisons, community health workers, you know, we're definitely trying to surround the patients with more individuals who have skills, whether it's around managing things like social isolation, depression.

But where we're not investing is we're not investing in, like, paying for transportation on the care delivery side.

And the reason we're not, in many ways, our food, you know, we're not buying food for folks, is because it's hard to build a business plan around that.

And in former life, we did that, and everybody was very excited because it makes for a good press release.

And then after about two years,

someone looks at my budget and says, why are you paying for all this food? What's the ROI[25] on that food? And it's very challenging to build a business plan around some of those services.

And so, that's why I am a little bit jaundiced that you'll get the delivery side to be able to make those investments.

On the payer side, I have definitely worked with forward-thinking payers, particularly in the Medicaid space, who will partner with us on studying what the return is for these investments, but I think it's very hard to see if providers will lean into that space and make those investments.

MS. MCGRATH: That's a really good answer. So, for Premera, I mean, it was, you know, our employer groups were like, our patients aren't getting in to see care, you know.

Our employer groups hire us, right, to help and do that. Like, a Premera ID card should get you places, right? And so, we had

25 Return on investment

to answer that.

I think the business case -- how do I say this? So, the best way to solve the business plan is if we hold -- if our patients stayed with us, if our members stayed with us for a very, very long time, the business case proved out.

If they only stayed with us for six months, it doesn't. And that is a -- that's something we have to fix and have to really think about because if someone holds onto a Premera ID card, for example, for 80 years, business case works great.

If they stay with us for six months, the business case for providing food or transportation is really tough.

And somehow, you know, I literally am -- like, it can't be about money. It really can't. And yet, you know, we have to, you know, still pay our employees. So, we have to figure that out.

We're committed to figuring that out at Premera. Truly, we've invested hundreds of millions of dollars into primary care and teams to surround that primary care.

And we've invested a ton in providers that are just not owned by Premera, to be super clear, in Seattle, in Washington and Alaska, but, you know, it's really hard.

CHAIR CASALE: Thank you.

DR. SAUNDERS: I'm sorry.

CHAIR CASALE: Go ahead, Rob.

DR. SAUNDERS: I was just going to say I would build on those two comments just to say in our surveys and talks with delivery systems and payers, I think we're hearing similar feedback across the board.

I mean, one point here would be there's a lot of technical nuance here and what you can use different dollars for.

And if you are using traditional Medicare dollars, there's a set of restrictions. If you're using traditional Medicaid dollars, here's your restrictions.

Medicare Advantage has a little bit more flexibility in certain areas, but not others, and, you know, being able to navigate that technical nuance is incredibly important and incredibly challenging.

I think the second piece here is --

and, Lee, I know you hit on this a little bit, is that there's different -- I hate to use the word "return on investment," but there's different returns depending on what services are provided and, at the end of the day, folks have to think about long-term sustainability.

And, you know, in some cases if you were targeting, say, food, to use Gary's example, to a diabetic patient who may be housing insecure and, therefore, have less access to, you know, fresh foods and probably doesn't have a refrigeration, let's say, for their insulin, you know, that -- you may see your changes in care utilization within a year, you know.

Some longer-term changes, Lee, as you mentioned, may take, you know, five, 10, 15 years until you actually see changes in health outcomes and changes in utilization patterns and just -- I think a lot of folks are still figuring out what are those specific care delivery services that can take place and show changes in a short amount of time.

That's a big issue with North Carolina's Healthy Opportunities pilots and

Medicaid, is that they're not funding every service in transportation, nutrition, housing, interpersonal violence, but have a fee schedule of here are very specific services that they are funding with the theory being that they may see returns and changes in a short period of time.

And I think the final question here, which is an existential one, is if you want to see something done in the most expensive way possible, you have the health care system be in charge of it.

And we don't want to have, you know, the health care system take over social services. We have a well-functioning -- or at least a well-defined social service system, and the question may be more a partnership as opposed to health care trying to absorb all those services and do them in-house, but there is a little bit of tension here as we think about social determinants of health screening and meeting those needs that we don't just have the health care system absorb and overtake social service systems.

DR. PUCKREIN: I would make the

argument that we've come to the point where we have to start reimagining our health care system.

It has to be fundamentally -- and I've been saying this, obviously -- focused around patients.

I think if the health care system is incentivized, if the incentive is around patient outcomes so that everyone is working competitively to improve patient outcomes, I think a lot of these issues would get addressed.

I think about it, you know, cable companies, they fight over membership tooth and nail, right? And we want health care plans to fight over membership tooth and nail.

And I think the way you get them to do that is to really focus on patient outcomes to make the system really focus in on patients.

And unless we do that, we're just talking money all the time, and in a year, you're going to find out that you can't afford to provide food and housing and all these other things and, indeed, sometimes we can't even afford to provide care, you know.

So, I think we're really at that moment particularly given the medical revolution that's around us.

The science is exploding, and the health care financing system is not competing. It's not supporting that.

And so, we have to make that shift if we're going to get the full benefit of the medical revolution that's going on because the challenge is only going to get greater because the new technologies are going to cost, and the disparities around them are going to increase.

And the only way forward, I would argue, is really to center this conversation around patients and make everybody in the system think about evidence-based patient outcomes.

CHAIR CASALE: Great. Thank you.

Angelo?

DR. SINOPOLI: Yeah. This is Angelo Sinopoli, and this question might be directed more toward Kris and Lee.

Have you explored the opportunities

in your communities to partner with EMS[26] for transportation and innovative transport models that can benefit the patients there in your communities?

MS. MCGRATH: Yes. Yes, we have explored it. We have explored it. And to tell you the truth, we do a ton in Alaska with helicopters and have invested a lot in those tiny little sea planes that make me really scared and nervous, and it makes no Alaskan scared or nervous.

And we've invested a lot into being able to provide transportation in super rural, very cold, snowy places in particular.

DR. SMITH: Yeah. So, in a number of different stops in my journey of building complex programs, we've used EMS not as much for transportation to, say, like an appointment. We've used EMS mostly for our help with unscheduled visits and acute visits.

So, patients call, we can't get a -- I've built mostly home-based models for complex patients.

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26 Emergency medical services

And so, mostly we use EMS and paramedic staff to get out to patients' homes because we can't get to them with their usual longitudinal provider.

And I will say that, you know, when we did work with this in downstate New York around some programs for the frail/elderly, we were able to partner with EMS programs.

We got a response time down to under 30 minutes for patients where we couldn't adjudicate the clinical complaint over the phone.

I will tell you when you get that response time down to 30 minutes, boy, you can really -- you can really impact total cost of care because all of a sudden everyone calls all the time looking for help because they know they'll get help in a timely manner.

So, that's where I think there's tremendous, tremendous opportunity to innovate and partnership with our EMS colleagues provided we can provide the right oversight and supervision.

CHAIR CASALE: Thank you.

Jennifer?

DR. WILER: Thank you for a very interesting discussion.

There was a comment made about the business case and the cycle time to actualize the investment in care and to see that outcome and, Gary, you made some really important comments about being -- trying to constantly focus on being patient-centered.

I'm curious. Have any of you heard of programs where retention of members or looking at recidivism rates from programs is considered a quality measure?

And if not, would you be open to that as a measure that we endorse?

DR. SMITH: One of our key performance measures is what we call "controllable discharges" from our services, because we view it as an early warning sign that we're not providing something that patients want.

And if the patients and families do not believe that we're providing something of value, they won't call us. If they don't call us, we can't help them when they're having a deterioration.

So, we use controllable discharges or unexpected discharges as a key measure of our performance. So, I would be in favor of that.

CHAIR CASALE: Any other thoughts from panel members? If not, we can move to Question 4.

So, in our discussions over the last two days, we've highlighted the trade-offs when designing total cost of care models.

One of those trade-offs potentially is between maximizing beneficiary choice of providers and providing flexibility for accountable entities in managing costs they're able to control.

So, as you -- in thinking about that trade-off, was interested in your thoughts on how to balance that particular trade-off of beneficiary or patient choice and flexibility of the accountable entity to manage costs that they can control.

Lee, I'm going to start with you.

MS. MCGRATH: Yeah. I think the question that was just previously asked about retention feeds in here, right?

And Gary actually -- what are the feedback loops? I really love that word and that concept.

So, we get retention as an insurance carrier, right, from employer groups and from individuals who buy our insurance on the exchange, and that's our feedback loop.

And I love the retention idea of incentivizing providers to hold onto patients. I think that's fantastic.

But, you know, we don't -- we also have to make sure our premiums -- our feedback loop is affordable premiums.

And when we don't standardize, we run the risk of increasing costs and increasing premiums.

And so, all of those pieces are in the mix as how we think about -- how we think about value-based care, how we think about partnering with providers, how we think about our own provider entity, and how we think about what we deliver consistently to the employer groups and to the individuals who buy our insurance on the exchange.

And I think it's important to

understand everybody's feedback loops and everybody's -- Kris was mentioning his signals that he uses of success.

Our signal is truly, does the employer stay with us? And, by the way, just to super overcomplicate this, the fact that -- I forget what it's called. What happened during COVID? The great resignation or whatever.

We saw an amazing change in -- yes, we retained the employer group, but the employees were moving so fast and, therefore, waiting for premium becomes more complicated, therefore, retention rates at the employee level become more complicated just because people were quitting or resigning or moving.

And so, all of those feedback loops are things that we spend a lot of time at an insurance carrier thinking about.

And one of my favorite things that, I think, has happened in value-based care in the last 10, 15 years, is we -- each side has learned about each other in a different way.

And so, hopefully I am providing that perspective of how we think about things

so that when an insurance carrier and a provider sit down to duke it out over what makes sense, everybody understands what -- the feedback loops that each side is using in order to be successful within their own organization, then ultimately to the patients, members, and community.

CHAIR CASALE: Great. Thanks, Lee.

Rob, I'm going to turn to you next with this question of, you know, Medicare fee-for-service, you know.

You can choose any provider, but when you're in these accountable entities, what's the trade-off in terms of maximizing that choice versus flexibility for the accountable entity to manage cost?

DR. SAUNDERS: Thanks, Paul. And you're right. The trade-off here differs depending on the type of insurance, you know.

Medicare fee-for-service, where you've got full choice, is different than Medicare Advantage, which may have some -- or likely have somewhat of a network, and then commercial insurance which would have a much tighter network.

You know, I think we've seen a few different strategies done out there in the field, you know.

If we're thinking about ACOs, they may be looking at referral strategies, or they're starting to look at who are the specialists nearby who are providing the high-value care, and how do we get that information into the hands of the referring clinician, as well as into the patient to talk those things through at the time of referral?

And that effect alone can have -- or that type of action alone can have a decent-sized effect in changing where folks are going.

You know, there are always countervailing forces if someone is trying to come up with a SNF[27] network, let's say, and only encouraging folks to be half an hour or an hour away, and folks want to stay local because that's where the kids are, that's where their caregivers are, you know, we're going to see pushback.

But being able to provide some level

27 Skilled nursing facility

of just nudges and suggestions and support at the individual clinician level and, as Gary's reminded us, to help patients as well as they're thinking about their choices, can be useful.

I think one thing we saw during COVID, which was interesting and we didn't expect, was the number of partnership strategies that were pretty effective here.

So, for instance, we saw a number of ACOs working, let's say, with local SNFs on infection control or testing or treatment paradigms, which didn't even necessarily have financial relationships, it was just a straight care delivery partnership, and that those can be pretty effective in both improving care, but also in managing patients in different settings.

And so, I think there's some opportunity here even if we're not talking about, you know, changing the way that we're structuring the total cost of care arrangement, but providing better focus on those partnerships, referrals to make a difference in how care is delivered.

DR. PUCKREIN: I would just say that I think about this as competition, and we need to have competition in the health care system.

Too much of it now is centered around, I'm sorry, CMF, but you're taking attention away from the beneficiary and not forcing the competition to be around the beneficiary so that the beneficiary is making the decision about where they're getting their health care, who's delivering it.

Competition is good here. It's a good thing, and it will force everyone to operate at the top of their license, but you're not allowing that to happen. You're interfering too much in the marketplace, to be blunt about it.

And so, my strongest recommendation is to get some competition into the system, to figure that one out, because I think everyone will operate in the patient's top interest once they are competing for their attention.

CHAIR CASALE: Thanks for those comments.

Kris, I don't know if -- do you have any particular comments around this trade-off

of sort of beneficiary choice or, you know, narrow networks versus full networks, versus flexibility for the accountable entitles to manage costs?

DR. SMITH: Yeah. I mean, I agree with many of the comments. I think the only thing that I would add is as we think about different models that are coming out of Medicare and CMMI, anchoring on -- allowing patients to choose to move out of a demonstration or out of a practice, I think, obviously has to be maintained, but the algorithms by which you attribute patients to practices and to programs needs to err on the side of stability in the population.

Because, as Lee was saying, if you have -- if you have 20 to 30 percent churn in your population, the likelihood that that's going to dampen your ability to improve quality and total cost of care, I think, is pretty well-established in literature and in our lived experience.

So, I would say that that is something that has to be top of mind as we're developing new models of care.

CHAIR CASALE: Thank you. I'm going to open it up to PTAC Committee members. Any questions? If not, I'm going to turn to Question 5.

We spend a lot of time as a Committee thinking about specialty care within total cost of care models.

And, you know, there's a lot of conversation -- I think we've talked about this a little bit about whether there is the benefit of having sort of a structure regarding the accountable entity.

So, indeed, you know, should there be sort of specialty models that are sort of clear for the specialist to then engage in the total cost of care model versus having flexibility for the accountable entity to sort of organically determine how to incentivize providers.

And, Gary, I'm sorry to be talking about money. It's part of what we're trying to think about when we think about -- we're not ignoring quality and outcomes, but we'd be interested in thoughts around this.

Kris, maybe I'll start with you on

this as you think about the role of the specialists to engage them or incentivize them.

DR. SMITH: Um-hm.

CHAIR CASALE: The trade-offs between providing sort of a structured model for them to participate in versus having them in a total cost of care model, and then the accountable entity sort of more organically incentivizes the specialist.

DR. SMITH: Sure. So, just, you know, in terms of my bias, I'm an internist, and so I believe that, you know, the data supports that we want patients to have medical homes.

And I think that a lot of the work that your group is doing, that we've been doing over the last 10 years, part of what it should be trying to do is reinvigorate primary care such that 10 years from now, we can see that these investments led to a larger primary care workforce, for example.

And so, I'm not a big fan of having sort of subspecialty ACOs. I would think that we would want ACOs that are built around primary care networks, and that those primary

care networks be allowed to determine how they want to contract and what the relationship they want to be with, whether it's the subspecialty providers, whether it's the subacute rehab facilities, even the hospitals.

And I think in my lived experiences, as some of these models have delegated the ability to negotiate financial terms with, let's say, laggards, all of a sudden these entities who are trying to stay out of total cost of care models like hospitals are all of a sudden now trying to fix readmissions because they see that the ambulatory network around them is demanding that and that the ambulatory network, unlike the insurance company, they can actually move patients.

And so, they can work to move a patient to one hospital two miles down the street compared to the other hospital who's not willing to work on these value-based incentive models.

CHAIR CASALE: Great. Thanks.

Gary, thoughts on this?

DR. PUCKREIN: I actually like the idea of leaving the power with the ACOs.

Obviously, to me, it's -- they're focused on patient outcomes, and I think of them as finding partners to help them get the best possible outcome for the patients.

I think if we're forcing everyone into various systems, you're going to lose that attention on the patient.

At the end of the day, the buck has got to stop somewhere. And so, I would leave it with the ACOs and -- but obviously they've got to report on outcomes. You've got to have that sense that they're making improvements for patients.

CHAIR CASALE: Thank you.

Lee, any thoughts on this?

MS. MCGRATH: I mean, I'd be actually really curious what the underlying piece of the conversation or the question is.

Is it we should be pushing more money to specialists?

CHAIR CASALE: No. It's more about do we need to create specialty models that need to be either nested, carved, you know, sort of nested within a total cost of care, or do you allow the total cost of care entity to sort of

work with the specialist and sort of organically develop what the incentives should be?

MS. MCGRATH: So, right now we incentivize primary cares who are thinking the insurance carrier should take the money from the primary care and move it to the specialist?

Is that what the question is?

CHAIR CASALE: It's really more about how -- collaboration between primary care and so really not so much -- I don't want to overemphasize the money piece. It's more about, in reality, it's currently the specialists have not -- even within Medicare ACOs, the specialists have not been particularly engaged within those models.

And there's a lot of conversation that CMMI has had around, you know, they have quite a few specialty models currently in the BPCI[28] program, et cetera.

And the question is, do they need to continue some of those models, is that helpful, or is it better to sort of focus on the larger

28 Bundled Payments for Care Improvement

total cost of care model?

MS. MCGRATH: You know, I think the three fundamental things that are wrong with health care that we all need to address are affordability, access, and fragmentation of care.

And I don't know if creating more models and more ways to move money around will address affordability, access, and fragmentation of care, and I'd rather talk about what can address affordability, access, and fragmentation of care.

So, you know, fragmentation of care and affordability and access, I think, can be addressed a lot by investing in sharing information and data, and I think the payer role in sharing data is gigantuum.

I think the responsibility for CMS to share additional information is gigantuum. And I think the ask for physicians, even if they're not within the same system, is sharing information.

So, Gary's point about increasing competition, well, they also need to share information back and forth because if the

competitors aren't sharing information, you have access, affordability, and fragmentation of care problems.

And so, I think those are the things that need to be discussed, and that's where I would head in terms of the conversation.

CHAIR CASALE: Great. Thanks, Lee.

DR. SMITH: Wait. Can I just follow that?

CHAIR CASALE: Oh.

DR. SMITH: Can I follow up for one quick second?

CHAIR CASALE: Sure.

MS. MCGRATH: Sure. Go for it, Kris.

DR. SMITH: You said something, Paul, you used the word "nesting."

MS. MCGRATH: Um-hm.

DR. SMITH: And I would like -- I'm curious to see what other panelists -- nesting is a disaster. And it's a disaster because it introduces such uncertainty.

And again we're getting to money, but in terms of planning, if you are a provider and you want to take population risks, but you

may have X, Y, and Z carved out, but you won't know until 18 months after you've entered, you create such uncertainty around the modeling and patient attribution that if I'm a provider who is on a 1 percent profit margin, I have no interest in figuring out whether that complexity is going to hurt me or help me.

CHAIR CASALE: Great.

DR. PUCKREIN: I just want to --

CHAIR CASALE: Go ahead, Gary.

DR. PUCKREIN: -- pick up on something Lee said about data.

CMMI could play a very big role in freeing up data because they're not going to get great health care until the data is moving around.

And so, if I was seated at CMMI and I was really thinking about innovating, I would be thinking about how to break down these data walls so that we can share information across the system, and I think it would be a dramatic change of the kind of care that patients will receive.

CHAIR CASALE: Thank you, Gary.

Rob, I know you've done a lot of

thinking around this. I know you alluded to some of this in your opening question/remarks.

Any other additional thoughts around this?

DR. SAUNDERS: Just a few thoughts building on what Kris, Gary, and Lee have said already. I mean, I think three thoughts here.

One, you know, if we look at and talk to specialists now, they don't really feel like a lot of these total cost of care models are for them. That can be just a total lack of awareness.

If you ask folks who are in an organization that is an ACO, you know, did you know that you're part of an ACO, and senior clinicians, senior attendings down to trainees will look in confusion at you if they even know what that word means, let alone feeling like that represents them and their care. So, I mean, I think there is clearly a need for more focus on engaging specialists.

It's hard to see that there will be one solution given the different types of specialists and subspecialists we have in play right now.

In some cases that may -- it may make a lot of sense to pick a particular population and have a model that is very focused for them, you know.

ESRD[29], younger inflammatory bowel disease come to mind where you've got, you know, a condition that is managed by a specialist, and that specialist is in charge of most of that person's care and would be expected to manage that.

In other cases, you could see more of a case of having a total cost of care arrangement and then thinking about where there are opportunities to pull folks in.

I think the third point here is really the technical -- and Kris noted this, you know, some of the challenges we've had to date in nesting, say, bundles within ACOs, have been challenging from a technical perspective, they're challenging from an implementation perspective.

The ACOs would note that they are taking a lot of the risk here of, you know, is

29 End-stage renal disease

the bundle doing well? Then they don't really see any advantages to that.

And so, it makes it difficult to plan. It makes it difficult for them to succeed in their role.

And so, where there may be opportunities to, say, move that nesting approach or that sort of coordination approach to, say, like CMMI or to other -- whoever the care is in this case so that they're bearing, say, some of that actuarial risk, as opposed to the ACO having to think about, alright, if I'm to stay in this type of ortho bundle, I'm going to be, you know, harmed if that goes well because I don't get to see that type of return.

So, the short story here is I think we've got to do something here more on specialty payment reform to make sure the specialists feel involved.

There will probably be some diversity, and the technical pieces are nontrivial, and we're probably going to need to see a lot more improvement there.

CHAIR CASALE: Great. So, I'm going to just move to the final question for our

panelists and appreciate all the discussion.

So, for each of you, just interested in hearing any final thoughts or insights you'd like to share as PTAC thinks further about population-based total cost of care models.

Gary, I'm going to start with you.

DR. PUCKREIN: I think we have a great moment here where we can do a lot for the future of health care.

I don't think that value assessment models have proven themselves. Actually, we've been doing this since 2005, by my recollection, and they haven't really worked.

And so, I think the moment has come now for reimagining, and I think that imagining has to be around the patient.

And I think CMMI has a great opportunity here to break down all kinds of walls and help put together a health care system that has to now take care of a diverse population.

We haven't even gotten to the issue of diversity and inequities and all that. And all of that has to be addressed, and I don't think the current system is really designed to

take on those kinds of challenges.

CHAIR CASALE: Thank you. Kris?

DR. SMITH: Thanks. You know, my final thoughts are just going back to my initial thoughts, which is I think there's a lot more evidence around certain large populations of patients who need alternate models of care and that many of the people who are insured through Medicare or Medicaid who are relatively healthy do reasonably well on the current system.

And so, I would continue to ask that you consider -- if total cost of care is the top priority versus quality, then you have to find populations where total cost of care can be -- total cost of care reductions can be achieved because we believe that there is low-value care being delivered to those cohorts.

There is not compelling evidence that for much of the cohorts that we're trying to delegate at a population level, that there's a whole lot of total cost to strip out of their medical expense.

CHAIR CASALE: Thank you. Rob?

DR. SAUNDERS: Yeah. I think I have

three thoughts. Echoing Gary, I wish we would have talked a little bit more about health equity.

There's a lot -- and we've been writing a lot about this recently. There's a lot of opportunity to leverage these types of total cost of care and accountable care arrangements to improve health equity, but they have to be thoughtfully designed, and they also need to be thoughtfully implemented.

So, I think that is one place where we can push a bit more, but related, but different, there's also a tension here in how we've been engaging the safety net in these types of total cost of care arrangements.

They've largely been left out for a wide variety of technical reasons. But if we would like these types of total cost of care arrangements to reach a large portion of the U.S. population, especially those who are living in more traditionally vulnerable areas, involving the safety net is incredibly important.

And finally just to go back on the primary care specialist collaboration point,

there is a lot of potential here, and I think at this particular moment, there's a lot of questions technically about how that can be done in a total cost of care arrangement.

But anything we can do at this particular moment to help with that type of collaboration would be welcomed.

CHAIR CASALE: Great. Thank you.

Lee?

MS. MCGRATH: Since we have about 30 seconds because I took a hard stop at 9:00, I guess I'll just leave folks with something that I tell my team all the time. We've got to lead without fear and only the bold survive.

And I think it's our time to really answer what every single person in America is screaming and yelling at us about, and we need to listen, and we need to lead without fear, and we need to be super bold here.

CHAIR CASALE: Great. Great way to end. Thank you, Lee.

So, on behalf of the Committee and our audience, I would like to thank each of our panelists for their insights today. We're grateful that you have been generous in sharing

your expertise.

So, at this time we have a break until 12:45 Eastern Time. Please join us then. We will begin with our public comment period followed by our final Committee discussion to wrap up the meeting.

(Whereupon, the above-entitled matter went off the record at 12:00 p.m. and resumed at 12:46 p.m.)

*** Public Comment Period**

CHAIR CASALE: Welcome back. We're going to move into the public comment period. We don't currently have anyone signed up to give a public comment; however, I'm going to pause -- check with the host before we move on.

Are there any folks who want to contribute?

(Pause.)

CHAIR CASALE: Okay. Great. So, hearing no public commenters, that will be the end of the public comments, and we'll move right into Committee discussion.

*** Committee Discussion**

So, the Committee Members and I are going to discuss what we've learned yesterday

and today from our guest presenters, the roundtable discussion, the background materials.

As you know, this two-day meeting is Part 2 in our three-meeting series on population-based total cost of care models.

After all three meetings in the series are complete, we will submit a report to the Secretary of HHS.

So, the report will include our findings from the March, June, and September team-based discussions.

While it's fresh in our mind, we want to discuss what we learned yesterday and today. Lots of information to sift through.

So, Committee Members, please check the pocket of your meeting binder for a document of potential topics for our deliberation.

Our goal is to begin developing comments and recommendations that will inform the portion of our report to the Secretary on care delivery, best practices, and innovations, and to pave the way for our September discussion of payment methodologies to

encourage what we've identified at this public meeting.

As you make comments or ask questions, please remember to flip your name placard up. So, I'm going to open it up now to the Committee Members, and we'll get started.

So, Jay?

DR. FELDSTEIN: Thanks, Paul.

One of the things that stood out through every session, and it generated a lot of questions by the Committee, is how do we integrate specialty care and specialty cost into a total cost of care model?

And when I struggled with this back in my insurance days, and I think we all struggle with it today, and that is if you believe that whoever is responsible for the care is responsible for the cost, then that should be the accountable party.

And, in many circumstances, for many conditions, the specialist is the best person suited to get the best patient outcome. So, somehow we've got to figure it out.

We can't just say, you know, oh – we keep putting it in the parking lot because

it’s so difficult to deal with, but we really do need to figure it out if these plans and models are going to be successful.

CHAIR CASALE: Yeah. I appreciate that comment. Other thoughts particularly on that topic?

I know we’ve asked several of the panelists around this around, you know, how to either incentivize specialists, engage specialists.

And to your point, Jay, there are certainly, you know, thinking about best outcomes and how specialists can engage in the cost of care model.

So, Larry, I'll start with you.

DR. KOSINSKI: Well, the term that you used early in the meeting on yesterday, "cascading accountability," you know, forget primary care, specialty care.

We've designated those definitions, but they're fluid in many respects because a specialist following someone with a serious chronic disease has to be providing primary care for that illness to that patient.

And likewise, the internist, who’s

managing multiple complex conditions, who may be experienced, is delving into the specialty world in multiple specialties at the same time.

So, I push back on this definition of primary and specialty care, and I keep coming back to what is total care for the patient depending on what the illness is.

And we know from what we've heard over the last couple days that the frontline work has to be proactive, and it has to have a lot -- whatever touches are necessary for that person's illness, that person's SDOH[30] status, whatever number of touches are necessary, those touches have to be made.

And whether they're made by a primary care doctor or a specialty physician or a nurse practitioner or a PA[31], whoever is performing this, or even an unlicensed person, we have to define the touches to the patient.

And then if we want to be able to pass responsibility for cost onto a population-based total cost of care model, we have to be able to envision the layers of accountability

30 Social determinants of health
31 Physician assistant

that have to be created there.

So, I heard a lot over the last two days about frontline work. I'm starting to get comfortable on what that frontline proactive primary care work should be.

I didn't hear enough on the specialty side, but what I think I gathered out is we either need to use tighter networks so that the number of patients a specific specialty group is seeing has enough critical mass for them to change their practices, and either it's the number of patients they're seeing or it's a financial driver, but in order to get into that specialty space, we're going to have to look very distinctly at what are bundled -- what type of services they provide are bundled because they're low-variability, they're high-volume, they get bundled, but that gets nested inside this total cost of care, and then what conditions they're managing, and how do we provide the care management support there.

It's obviously very complicated, but those are my takeaways from the two days.

CHAIR CASALE: Yeah, that's great.

Very helpful.

Yeah, as I think about cascading accountability and the comments you made, you know, I think it also requires sort of a culture change even amongst the specialists.

And again, I'm speaking as a specialist where even on the quality side, you know, so depression screening, I hear endlessly specialists saying, well, I'm not accountable, I don't do that, but really it's the collective accountability, and you're sort of within that cascade of accountability.

For us to move all of this forward, it can't be the bucket of this is primary care, this is specialty care. It needs to be -- we need to think how we can do this sort of more collectively.

Josh?

DR. LIAO: Yeah, I agree with those comments, and I was just going to say, you know, to me, lots of good things to noodle on for me over the last few days.

I think I returned to a few things with regards to engaging specialists. One is, do we think populations -- their care is just

ongoing in a kind of monotonic ongoing way, or are there kind of curves where there are episodes that come up and down? That's one.

The second is, in some of those episodes, the kind of patterns of care, do we think specialists play a key role in that?

And then the third is, do we want to go by who's touching versus that's the phase of care where more people are needed?

I tend to favor the latter. And the reason is even in the primary care setting, we were hearing even some of that outreach is not traditionally the primary care physician anymore, right? It's other team members. Some are licensed, some are not. So, I think the who's touching is not as important.

Thinking back to the idea of centering on patients, it's when that patient needs something to be able to define that moment and then ask the question, is a subspecialist a key player in that?

And so, listen, lots of, I think, technical work needs to go into it, but, you know, I do think about this idea of nesting, and I think about nesting in that way.

And personally, I think, you know, we want to be careful on avoiding kind of the tail wagging the proverbial dog a little bit because, you know, some of the comments about, you know, well, it takes incentive away, the margins are small, 18 months is retrospective. That's true.

I just want to call out that in total cost of care models that engage primary care docs, that's what they're dealing with already. We've been dealing with that for a long time.

And so, those are issues to address, but the main issue is should we find a way to bring primary and subspecialty care together for those parts of the care that need both.

And personally I think the answer is yes, and I think those technical things can be worked through and need to be worked through.

Things like cost accounting and who gets assigned what cost, we need to work through that, but I take the optimistic view that we should do it.

And until we do that, I think things like nesting or other ways of doing it that

acknowledge that -- those parts of the care that need those team members, not who touched them last is important to me.

CHAIR CASALE: Yeah, that's great.

Lee?

DR. MILLS: I think something that I heard throughout multiple talks, and I think many of the members around the table have commented on, we've had robust discussion on, is just about the centrality of the data that's required to impact access, affordability, and fragmentation.

And having an essentially all-source, normalized, timely, updated, you know, no one EMR is good enough, no one or even three payers is good enough, it's got to be all sources all the time, which can only be done on a big standardized national framework, which is already coming together.

So, I think this is a huge leadership opportunity for CMMI in three different parts. One would be to, you know, proceed with bold policymaking and set the standards for how that all-source data should be, you know, what the nomenclature is, how it

should be standardized, normalized, and set some bounds to that.

The other would be to change the -- essentially change CMMI's actual paradigm around data, that data is a siloed treasured resource to be protected and closeted to it's a health data utility that must be ever present and flow through everything we do, or it's never going to be effective.

And lastly, to essentially move forward and to start requiring data participation with the national framework that's established that is receiving all this data and normalizing it and then feeding the parts that need the data to make a difference.

To just an earlier point, yeah, we have to get comfortable with -- we can't have an 18-month period where that data, that lifeblood, is linking to metrics that are defining quality and utilization.

We've just got to get comfortable that we're not going to be able to act on it 18 and 24 months later when 99.9 percent of all the data is known.

Typically you've got about 94 to 96

percent of the claim run out within six months, and that's pretty much the -- in my mind, the outside of when any provider or patient group can react to data and make changes in response to it. Past that it's a dead issue, and it's too late.

CHAIR CASALE: Thank you. Walter?

DR. LIN: So, I just wanted to circle back around to the whole discussion around kind of how the specialist fits into the total cost of care.

A couple thoughts. You know, I think one of the standout lines to me from our two-day session this week was when Dr. Smith said, "nesting is a disaster," and, you know, it harkens back to kind of old business school principle.

If everyone's accountable for something, then no one is really accountable for something, right?

And so, I think as we think about total cost of care, it's crucial to assign accountability to a single organization, a single -- ideally a single provider who can make a difference at the front line, but it

can't be, in my mind, at least, multiple providers with complicated carve-outs and nesting schemes. And so, that's just one thought.

Another thought I wanted to share was I think there's good evidence in the literature that primary care is one of those few areas in health care where increasing the spend in that area actually decreased total cost, right? And so, I think that's also important to keep in mind.

And in my own practice and how I -- in my experience with others as well, who better to make the decision of how to use specialists and which specialist to use than the primary care doctor who is supposed to be coordinating the patient's care among multiple specialists?

And that -- the weight of that, those referrals and the use of those specialist will, I think, even be more important if we give more accountability, both financially and quality-wise to the primary care physician.

So, you know, I'm an internist. So, I'm clearly biased in this arena, but I do

think that sometimes we overcomplicate things, and we just need to figure out the kind of base entity or the base unit of health care in which to assign accountability and then have that person just be truly accountable for the patient's care.

CHAIR CASALE: Thanks, Walter, for those comments.

And, Bruce, I do see your hand up. I'm just going to make a comment, and then I'm going to turn to Jen before you.

Just two comments. I'm not sure when Dr. Smith was referring to nesting, it sounded like he was describing carve-outs more than nesting.

It was like you're taking money out of the total cost of care as opposed to the way I think about nesting as still within the total cost of care model, but then there's a piece of it that's sort of within specialty care.

And I think the other piece, I think, that deserves further conversation is around what is the right level of accountability?

I know I asked Dana Safran yesterday

on the quality side, you know. When you think about patient outcomes, it's very difficult to assign that to a single provider.

Similarly around all this, what is the right level for accountability as we think through this?

So, Jen, I'll turn to you.

DR. WILER: I want to agree with Lee that I think one of the biggest opportunities that we have as a nation is to recognize access to meaningful, actionable data related to health is the great equalizer to help improve what are current disparities.

And I agree with Walter that what I've heard over the last two days affirms that if we focus on the patient and patient-centered care, and we heard lots of great applications of transformation and care delivery models that are making a difference in terms of patient care outcomes, focusing on an Accountable Care Organization might be too big of a swath.

And that really getting down to the base units, as you've described, around an accountable entity, could be a provider, primary care or specialist, but that entity has

to own everything. And we heard that over and over.

So, yes, maybe in heart failure, a cardiologist is the right person to own total care for a patient who is in a certain phase of disease progression, but then they have to own all their diabetic care and when they have a stroke, their rehabilitation, and fill in the blank, fill in the blank.

I think our payment models should be agnostic to ownership, but have a principle to prioritize that there needs to be an owner. Because if not, there will be inefficiencies, and ultimately that leads to poor outcomes and higher cost.

And so, clearly by creating accountable entities, we heard strategies around by builder partner, and that's my last comment.

And that's those incentives to then partner with that accountable provider group or entity need to be compelling enough to want to create a relationship.

And so, I do think we need to go deeper and think about, you know, payment

models that recognize that that relationship is both important and needs to be valued, and there's a cost associated with paying for those relationships.

CHAIR CASALE: Yeah, that's great. Thanks, Jen.

Bruce, I'm going to turn to you.

MR. STEINWALD: Okay. Thank you.

I want to agree with both Walter and Jen. Beginning with Walter, he alluded to there's decades of research that shows that communities that have robust primary care are much better off in terms of patient outcomes and costs --

CHAIR CASALE: Sorry, Bruce. You're a little soft. If you can just get a little close -- yeah, thanks. Sorry to interrupt.

MR. STEINWALD: Okay. Decades of research have shown that communities with robust primary care are much better off in terms of outcomes and cost per capita than other communities. And that's not even transposed to primary care, of the kinds we're talking about now. Just as a footnote that's probably beyond our scope, the way that

we select for physicians in this country discourages primary care, and Medicare adds to that discouragement by the way they subsidize medical education that's both hospital- and specialty-oriented.

And if we think we need more primary care, and I agree that we do, it should be to transform to sort of Level 3 kind of primary care that Dr. Chen mentioned that makes the primary care physician the quarterback, but extends the concept of primary care to be much more than just what the primary care physician does.

And I'm in favor of that, but how we get there obviously is a problem. I do think that the organic way, I think as you called it, Paul, of dealing with the relationship between primary care and specialty care is probably the way to go.

CHAIR CASALE: Great. Thank you, Bruce. Appreciate the comments.

Josh?

DR. LIAO: I appreciate the comments that were made. I want to kind of respond to a few of them, and I think this is actually

really important for us as a Committee and probably as a collective us as a country to grapple with.

As a general internist who has also practiced primary care, I think I -- I think -- I don't want to speak for anybody else, but I think I believe in the same vision and, like, the values that we're working towards.

I also try to filter through the fact that we've heard from some very good exemplar organizations that even across them primary care has meant different things.

And then I think about how even some presenters have talked about having a hard time finding primary care clinicians in key parts of certain states.

And so, as we think about scale, right, and things that might be done through this, it -- I kind of oscillate between that, like, what it could be in the best case, but then what might be a way to engage primary care more broadly speaking.

And so, I think just to echo a few comments, I think how we get from here, given that variation is, too, where we want to be is

important.

And are we solving for the exemplar, or are we solving for the norm, and how might models look different if we did that?

And so, you know, maybe it's a semantic issue around carve-outs versus nesting, but I do think -- I think the issues that we're talking about with sample size, attribution, all the things that have been brought up, do you take too much of that financial skin out of the game, what's patient-centered?

Those are -- I think, to me, it comes back to something that was in Question 4, I think, which was do we want flexibility, or do we want more structure?

And, to me, TCOC models as we understand them now, short of bigger changes like defining new costs, feel more flexible.

So, if we believe that the changes need to happen, then I think we should grapple with things like nesting or carve-outs or dynamic ways of defining primary and subspecialty care.

All are on the table, from my view,

but to then, I think, articulate early on all the problems with that, are we then suggesting in some ways something closer to what we have today? And that's an open question.

CHAIR CASALE: Great. Thanks, Josh.

Angelo?

DR. SINOPOLI: Yeah, thank you. So, I just wanted to make the comment that I think this is one of the best meetings that I've attended since I've been on the Committee.

And so, I just want to congratulate everybody that was involved and all of our great speakers today.

I think we agreed on a lot. And I think that we agreed a lot around primary care and what primary care needs to be resourced with, how they need to function in really creating a true transformation within primary care.

I think we need to have a little more discussion in regards to the specifics of what some of those are.

I do agree -- I was a pulmonary critical care doc, and I functioned somewhat as a primary care physician for a lot of patients

with various pulmonary issues, but prefer the idea that the specialists are part of the primary care team and not necessarily the primary care doctor, because even in my practice, there were a lot of things that I didn't know about and wasn't covering.

And so, to try to function as a specialist and consider yourself as the primary care doctor and not part of the team, I think, does give a disservice to the patient.

And so, we've got to figure out what that looks like and how to incentivize the specialist to be primarily responsible for what they're responsible for, but to be part of that team.

I do agree that data is huge, and we've got to solve that problem because chiefly early entrance into this just don't have the data to be able to make the right decisions.

And then the last comment I want to make is there were some discussions about us not being ready for or not paying attention to the social issues, social determinants, accountable community-type issues that affect our patients, and I don't think we can just put

that on the back burner.

I think that, you know, the organizations that I've seen that have really addressed those see such a benefit from it that we've got to figure that out, and I think that's got to be put back on the front burner.

I don't think that the MLR[32] can cover all the cost of all the social issues. And so, we can't rely on the medical models to fix all that, so we've got to have some collaboration somehow with other agencies to help us solve those problems, but it's critical to get the outcomes we're going to need going forward. So, thank you.

CHAIR CASALE: Great. Thanks, Angelo. Great comments.

Lauran?

VICE CHAIR HARDIN: So, I agree with Angelo. I think this has been one of the most stimulating meetings and interesting in my history over the last two years.

So, I think I reflect a lot on health-related social needs in these models,

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and these are the themes that I definitely heard.

So, across the innovations utilizing data not only to understand the population, but to case find across systems and to build a comprehensive, deep patient story across EMRs is critical for integrating social needs, but also really deeply understanding what was actually happening with the patient.

And then the theme of integrated teams, so bringing in social work, nursing, case management, community health workers, pharmacists, really building an integrated team and everyone operating to the top of their license, and then people spending their time only doing what mattered most from their discipline.

So, for example, in hospice and palliative care when the model shifted, and it was no longer fee-for-service, it didn't need to be the physician that had the direction of care conversation because there's no longer payment attached to it. It wasn't a billable event.

So, then things shifted, and people

started to learn, well, what was 101-version that many people could do to a standard of care and what required the highest level of education and experience to do.

And that's how we sort out the delivery of our care, and that's how we carry it together and get more done in the visit that we have in the office and across systems as well.

I heard a theme of really starting to think about care where people live. So, definitely the primary care is the center, but outside of that office visit, how do we effectively and appropriately reach people, extend our services in the place where they spend the most time and really deeply invest in relationship and trust building, which is where many of these models talked about actually seeing movement in outcomes.

The challenge came up around -- there's been a lot of movement with health-related social needs screening, but we're navigating to nowhere.

The lack of investment in those services, we could find out a lot about what's

going on with people, but if there is no one to refer to in that community, there's really an imperative for us to look at that on a broader level and some ways of partnering and sharing to develop that. Also, seeing new payment models under Medicaid that are starting to pay for that.

So, we heard some really exciting innovation from California where there is now payment for housing, there's payment for housing navigation, really Enhanced Care Management for the most complex and vulnerable populations.

And then what's happening from that is integration of health care and social services in community-based systems.

So, we heard of a housing and health care integrated system. We're seeing community-based collaboratives take on some of these social needs, including starting to blend and braid city funds, county funds, other sources of dollars that extend the table and the opportunities for really addressing social needs.

And then finally under the

California approach, we also heard about payer collaboration that's emerging from that and how they're incentivizing that, again, to generate collective dollars to really deeply address health-related social needs.

So, a lot of rich material for future dialog.

CHAIR CASALE: Thanks, Lauran, for those comments.

Lee?

DR. MILLS: Yeah. So, I was going to pick up a thread that we heard several different times most eloquently today that just as we turn our attention, and it becomes one of the CMMI focuses on, you know, diversity, equity, inclusion, and social determinants of health and looking beyond the 20 percent that actual health care impacts, we need to take on this issue of rapidly diversifying social needs screening methods and prevent -- I love the phrase "prevent the cacophony from occurring that we've seen in the quality space," and that is very, very real. And it's going to happen unless we take proactive steps, and CMMI can lead the way to prevent that.

And I would propose that just like I am not convinced there has to be seven different standardized definitions of what a breast cancer screen quality metric looks like, there doesn't have to be five different ways and five different ways to ask the question to screen for a given social determinant. We just need a way.

If we have seven ways, it's going to distract everybody's time and attention to arguing which is the best and how to compare them, and one dataset doesn't talk to another dataset and can't be normalized.

And that is simply distracting us from receiving the information and engaging with the actual need that our patients have. And so, I think that is another opportunity for bold policy leadership that CMMI can step into.

CHAIR CASALE: Yeah. I think great comments and, you know, it's so far down, though, the quality. We're trying to come back to it, but now we're at -- as you're saying, we're just at the beginning of this whole measurement at SDOH.

It's a real opportunity to sort of

have CMMI sort of take the lead on how to move that forward in a rational way.

Josh?

DR. LIAO: Yeah. I just want to maybe take Lee's point and kind of zoom out on it a little bit and say that I think one of the things I've heard from -- over the last few days from a few of our speakers is this idea that they are the financial -- it's not about moving dollars, but the dollars are structured in such a way where they have the ability to buy an AC or to walk to the back and grab a nebulizer and give it to a patient.

And I think there's a harmony between what they're able to do and then the big dot patient-centered outcomes are being held accountable to.

Contrast that, I think, now under other payment structures where there's much more restriction, right?

I just want to raise as something for us to consider, is that holding clinicians, primary care, subspecialty care, different teams, different clusters of clinicians, accountable for those ultimate patient outcomes

when we don't have the ability to, like, affect them.

It may be 20 percent, you can quibble about the numbers, but the 100 percent outcomes when we are affecting 20 percent and not a resource to do that, I think, is not a bridge to a productive place.

And so, I just -- to me, it raises an urgency to address one of those things to get us into better alignment.

Either we begin to look more like the flexibilities, or we think about the outcomes or maybe something that's a combination of those.

CHAIR CASALE: Yeah, that's great. And I think I was thinking about, Angelo, your comment about the MLR, and, you know, so we need partners on this.

You know, to the point about just SDOH in general and where to collect the data and how to implement and -- you really need to think more broadly around, you know, who those partners should be to really help with all of this.

And I'm not sure all of those -- who

all those should be, but really I think CMMI needs to think about that now, not only just the screening, but then -- in moving -- who else in addition to this sort of health -- the traditional health care system that can help with this work.

DR. WILER: Totally agree with Josh's comments and just wanted to resurface something else that we heard in that many of these successful models have proactive outreach and actually high touch, ultimately high utilization.

And so, back to what's currently, you know, considered to be within scope and out of scope, we've created models that incentivize higher patient panels and face-to-face interactions often that are patient-driven.

And what we heard today is flipping that model -- or over the last two days, flipping that model on its head and actually having care teams direct the interactions in a way that benefits patients.

So, there's got to be ways to incent that kind of activity that ultimately improves health.

CHAIR CASALE: Yeah, I couldn't agree more. And I was thinking about that, you know, again thinking back to my own practice days as a specialist, you know, when you see the patient, you know, you know in the traditional model, you're not sure when they're going to get back to see the primary care doctor. Is the information going to get back to the primary care doctor?

And then even if I have a recommendation that they see, like, a different specialist, well, should I just make that referral myself because I'm not sure if, you know, my recommendation is going to get back?

So, to your point, all these proactive touches will, at least in my view, raise the confidence within the sort of team that, in fact, that information -- it always goes back to the information, is going to get back to primary care who can then decide, yeah, that's an appropriate referral to someone else and reduce the fragmentation, et cetera.

DR. KOSINSKI: Well, Jennifer prompted something for me to remember. And that is that there really is very little way to

pay for proactive care in the current fee-for-service model.

And we heard from multiple speakers. Fee-for-service is not going away. We're going to have to live with this some way in the future.

We also heard that payments need to be timely, that value-based payments need to be timely. They can't wait for an 18-month reconciliation period. I live in this space all the time.

We've talked about maybe not focusing on venture-backed entities. Well, the only reason I am able to provide up-front money to providers is because of the financial backing we have.

So, it begs the question that we discussed yesterday on the chronic care management codes, the principal care management codes.

Should we be recommending some adjustments to the current fee-for-service system that will allow us to bridge into the value-based care system more efficiently and effectively? Is there something we can do now

that can do that?

I realize that raises legislative issues that are beyond the purview of our Committee, but if they're listening to what we're saying, maybe we need to make some adjustments to the fee-for -- or recommend changes to the fee-for-service system that allow us to make this transmission.

CHAIR CASALE: Yeah. And along those lines, I mean, CMMI has said, you know, they have the ability to do the waivers just like they're doing for ACO REACH, to waive, you know, the copays on the patients.

So, they could think about how more broadly to do some more of these waivers if you're in, you know, some kind of total cost of care model.

Josh?

DR. LIAO: I think connected to prior comments, but another theme that we heard yesterday and then, I think, kind of indirectly said today, and we've been talking about, I think, in all the things that I've been hearing that I just want to surface is that, you know, cost doesn't equal need.

And relevant to total cost of care, I think if what we're talking about is identified need either through just our clinical encounters, through screening, through data capture, through hopefully more timely data and shared data, I think if we're thinking about that, one of the questions I posed to one of the -- to the panel was around should that be brought into TCOC models? Should it be outside? Should it be collaborative as we've seen in some states?

I don't know. But if we're talking about need mediated through higher touches and a broader aperture about how we're thinking about it, then I think pegging these models as the cost must come down, we may run into a challenge there.

On the other side, I think one of the speakers today said, you know, there are probably certain populations where there is cost to be taken out of the system. And so, I think work to be -- to look at that is very useful.

I think, in that, my suspicion is that we'll find there will be some collection

of primary and subspecialty care, which is why I think this issue of how do we engage in this is so important, so we can actually identify those areas to then take a cost come down approach to TCOC models versus a needs-based approach.

And just very quickly here, you know, Larry's comment about, you know, the financial ability to operate, to me, is a bit of a potentially pragmatic one.

We may wish for a different, you know, current state, but where we are now, that's an ability to deliver the care we believe is right.

In that same way, just going back to the point of primary care, I think we've heard visions of what primary care can be and should be, and it is in certain settings, but the pragmatism is that until we get there, I would love to see models and approaches that, again, bring primary and subspecialty care together so we can do that business of is there really total cost to remove here, or is it more of a needs thing where we need investment? And those, to me, are very different.

CHAIR CASALE: Great. Thank you. Thanks for those comments.

You know, under the topic of unintended consequences -- I always like to talk about unintended consequences, so -- but one of the topics listed under this -- and, Jay, you've brought this up a few times -- is around pharmacy, which generally is not part of, you know, total cost of care for some of the models and whether really Part D should be part of total cost of care.

We know the private payers often focus on, you know, medication adherence, et cetera, and in that world, the current model is often, you know, they include some of the Part B medication, but not the Part D.

And so, as we think about total cost of care, where does that sort of the pharmaceutical spend sit, and should it be?

And to counter that, I'll just tell you from my experience both when we bid in the Oncology Care Model and when we were in the ESRD ACO, over time there were certain medicines that became available where all of a sudden the costs went up astronomically, and

then all of a sudden our -- didn't look very good against our benchmark.

So, you know, there's not a perfect answer, but just, in general, should pharmacy be something we should be thinking about or, you know, sort of having some recommendations to CMMI as they're thinking through total cost of care?

So, any thoughts on that?

DR. KOSINSKI: We should at least be including the drugs that are in the medical cost because the shifting of cost between Part B and Part D that occurs with specialty pharma, I don't know how you wrestle with total cost of care unless you either have that totally out, which doesn't make sense since it's 40 percent of the cost of care, or you have to at least have those specialty drugs in that really blow up the cost on the Part D side and on the Part B side.

I don't know how we talk about total cost of care without at least including that.

CHAIR CASALE: Any other thoughts on that?

DR. LIAO: Yeah. I think, yeah, I

agree with that point broadly. I would just say even before we get there, in current models that look at A and B, I think many organizations that have been in these models have seen that Part B medication spending is significant.

What's interesting to me is you double click and zoom in on that a little bit, and the question is to what extent, again, not to belabor the point, do primary/subspecialty care work together?

That exemplifies the point of the engagement, right, whether, again, we're all in it together, or it's in a sequence carved out.

I don't want to get into the semantics, but even in Part B over five-plus years of ACOs, I think we can see that issue come to play.

I think the moment we then wrap D in, this issue is just only going to be magnified. So, to me, it's like a precondition to really think through this specialist piece.

CHAIR CASALE: Great. Thanks. So, again, I know I brought up the pharmacy on the unintended consequences.

Any other thoughts on any particular unintended consequences that come to mind as we think around total cost of care models?

Yeah, Jen.

DR. WILER: I know we talked about this briefly yesterday, but just to circle back to it, I don't know if it's an unintended consequence as much as don't forget to include. And that's back to what's high-quality care.

We all know value is quality to cost, and we've focused all of our conversation on cost and will do so in the fall, but being explicit about what is the definition of quality for a given patient population is really important.

And we heard today that, you know, there's not a sustainable business model to do currently nonrevenue-generating activities to actualize what we think are high-quality outcomes because it just takes that long in terms of evolution of health, maintenance of health or prevention of deterioration.

And so, we need to start thinking about process measures that accountable groups, i.e., providers, can own and be incented to do

that we know are good surrogates for achieving the outcomes that we want.

And currently what I have heard in these conversations is that they -- that those are not in place, but these innovative care models are creating them within their own space and trying to create internal incentives that we could learn from.

And I think there were quite a few that were described, including one that, you know, again I think this ratio of primary care touches to specialist touches is a surrogate marker for engagement.

And to your point, Paul, of including -- ensuring conversation essentially between the patient and the care team was an interesting idea.

So, I think focusing more on, you know, what's the definition of "quality" would be a really valuable conversation.

CHAIR CASALE: Thanks, Jennifer.

Lee?

DR. MILLS: Yeah. Just a philosophical underpinning that I've heard refrains of here that I think bear more noodle

time and us thinking about and discussing it at a future meeting, which is this question of are we going to incrementalize our way to the glorious new future? And I propose the answer is no.

And what I mean is when you think about -- first of all, if you're going to incrementalize it, we would have done it in the last 20 years of pilots and trials, right? We would have already gotten there.

But partly the science of -- the science of change and performance improvement says at some point along an S curve, further input of resources doesn't increase improvement. You have to jump to the next higher S curve, right?

We heard several good examples by ChenMed and Prospero and others earlier yesterday. They did not incrementalize their way to their current state. They just changed their model and took a leap.

I think that that's a really important concept, and I'm not sure I've made up my own mind really where we are, but it's consistent with the, you know, the path forward

where we're not going to have a pilot model for every disease state.

It looks like the future is fewer models, and they're more standardized and more broadly applied, perhaps in some areas not optional. That feels like leaping to the next S curve.

And so, I think as we keep wrestling with what this is about, I'm not sure, you know, more codes to transfer value, and a fundamental fee-for-service concept is going to get us where we need to go.

We need to try to distill what has worked and whatever models we can think of and try to say, well, here's at least the skeleton of what the future model might look like. And it's up to people with, of course, you know, the Secretary's encouragement to jump to that future in some fashion.

CHAIR CASALE: Yeah, I think that -- I appreciate those remarks. Really helps my thinking and then also begs the question, you know, to make -- do people voluntarily leap, or do they need to sort of get them pushed, you know, sort of mandatorily leaped, figuratively?

DR. MILLS: Yes, they do.

(Laughter.)

CHAIR CASALE: Walter?

DR. LIN: I wanted my last comment for this public meeting to be one of hope, you know. As one of the newest members of the Committee, I thought we were taking on a tremendous undertaking by trying to tackle the whole opportunity of population-based total cost of care, you know.

There's so much work that's been done by many, many people and institutions, but one thing that leaves me really hopeful as we end our session, is that we heard from a number of organizations over the past two days that are already doing this, and doing this well, and doing this with a financially viable model that also is hitting the quality metrics and having high net promoter scores and low patient disenrollment.

So, I think there are models out there that we can continue to learn from, and we hope to continue this conversation in September.

CHAIR CASALE: Just to be clear,

that doesn't need to be your last comment because, you know, we can still -- we have time to continue our conversation, but thank you for those comments. That's very helpful.

Josh?

DR. LIAO: Gosh, I almost wish I made my comment before that comment of hope. You know, I think I had a thought about unintended consequences, but I'll kind of loop in what I heard from Lee, which I agree with, which is that, you know, we're talking about populations.

Kind of the thing that lives on the back-end behind populations is how you select those populations.

And they keep -- the thing that keeps me up at night potentially, as someone who applies scholarship and evaluation to this and who helps lead things locally at my institution, is that issue of selection at the patient level, but also at the clinician level, at the group level.

I think probably all of us have seen at least snapshots of that happening. And so, I was trying to think through all the important

things I've heard around this table and how many could be punctured by issues of selection, and I think probably all of them.

So, I just wanted to add that to the record, but say that I think the other theme -- and I was actually counting it on our questions for our listening panel today -- was that the number of times the word "trade-offs" came into -- we brought up.

And so, I guess at some point, we need to trade and go. And monitor, yes, and be careful, yes, but I think if we keep propping up trade-offs and saying there are trade-offs, there's an inertia to that.

And so, with respect to do we -- do they jump in on their own, do we nudge them in to jumping in, these are things we'll get into, I think, at the next session, but I would love to see us, as a Committee, move to from identifying those trade-offs to actually saying, in this trade-off, here's the put, here's the take, this is our recommendation because we think this is bold, and at least that would be my hope.

CHAIR CASALE: Yeah, that's great.

You know, I think we spend a lot of time talking about data, performance metrics, and that data piece keeps coming back in the comments that many of you've made of really being foundational and really to move all of this.

And some of the models that we heard from is -- some of the presenters also emphasize that, you know, for their models to work, they really need timely data.

And for many places, this continues to be a challenge, you know, just either they don't have the financial wherewithal or don't have access to the data sources to really move this forward.

And I think again this is something -- we talked about emphasizing to CMMI to think through how they can really help support this to really -- if we're going to really continue to push, as you said, Lee, not so incrementally, but to really, you know, it's hard to sort of push or make people do things if you don't have the tools for them to be successful, and I think that data piece is just a critical underpinning.

So, again, how you sequence things, that, I think, as we communicate to the Secretary and to CMMI, I think, really needs to be emphasized.

Jen.

DR. WILER: Walter, I'm going to pick up on your theme of hope. I think over the last couple of days, and actually if I think over the last year or so as we've been doing these theme-based discussions and having the opportunity to talk to leaders across the country who are just doing phenomenal things, you know, really they're our early adopters.

Despite our current system, there is a lot of really impressive innovation that's going on, and I am encouraged by the fact that, you know, these previous models and programs have sparked innovation that has helped us to understand what an ideal care model might look like or what does it need.

And, you know, really we need to move now to uptake and then diffusion. And so, that's a jump from Curve A to Curve B that, you know, I think, Lee, that you were talking about.

And, you know, just to summarize some of those things, again, totally agree. Data infrastructure is a utility. It's got to be ubiquitous.

We've heard that over and over. It cannot be underscored how important that is. And that that's real cost, real money, and real expertise.

And so, that seems like that would be an ideal investment from a federal or a state level. Although we heard even at the state level, because of where patients seek care, that a single-state strategy is probably unlikely to be successful.

I think we've also heard that these programs cannot be voluntary because right now with how the incentives are aligned, it -- even though there's been a conscious focus to not allow cherry-picking, it still will happen.

And fortunately, right now, it seems to be the opportunity is in chronic care management of some of our most frail and elderly patients, which is a good thing, but at other times, the incentive might be for a different population.

So, the safety net -- so, these programs need to not be voluntary, and they have to include our safety net patients and program partnerships, but we cannot expect, as was described before by Josh, these programs to be implemented with all risk being put on the backs of providers.

It is unfair, and it's unrealistic, and they will balk and you -- we need them to participate in a meaningful way because when they are leading decisions and care teams, we get great outcomes. And that's actually what we want to try to achieve.

And so, I think what we heard with our last panel of really thinking about how to incent closing the gap in areas that we know are the biggest barriers, access in coordination are potentially ways for us to be thinking about how to go from these wonderful pilots of innovation that show that it can be done to creating this, you know, uptake in diffusion.

I think that's where CMMI has a real opportunity, so I agree with your optimism.

CHAIR CASALE: Thank you.

Bruce?

MR. STEINWALD: Can you hear me okay?

CHAIR CASALE: Yes.

MR. STEINWALD: For just a couple of minutes, I'd like to defend the concept of moving money around, which somehow seemed to be cast in a negative during much of the discussion.

You know, historically in Medicare, moving the money around often meant trying to move money within the fee-for-service system, which maybe had some limited success in supporting primary care, but I would say very limited.

But if we're now talking about moving money -- and someone did say, maybe it was Lee, there is an incentive to move to a different mode of practice, a transform mode where there's a team approach to care and -- that needs to be attractive.

And there certainly can be attractions other than monetary, but certainly there has to be monetary.

At the same time, there can be --

many people think there are, and there's lots of evidence, that staying within the fee-for-service system has mounting unattractive features, many of which are navigating, you know, adjudication, things like that, that can be relieved from the physician who practices in a different setting.

And so, the notion that moving money around is somehow distasteful, I think, is incorrect.

I think we need to think about how to accomplish an objective through moving money around and also through other mechanisms that go along with it.

CHAIR CASALE: Thanks, Bruce. We appreciate the perspective of the economist. You do have to think about money. It's important.

Before we close, any final comments from any of our Committee members? Great discussion, great feedback.

Audrey, I'm going to turn to you to see if you either have other questions or clarifying points you want from the Committee or -- let us know.

MS. MCDOWELL: Thank you.

So, first I would like to ask if the other ASPE staff have any points that you guys might want to make. Lisa? Steve?

Okay. So, I just had one follow-up question regarding one of the issues that I think Chinni had raised during the PCDT[33] presentation yesterday as one of the things that maybe you were trying to think about.

And I think you've touched on it a little bit, but there's still, at least from my hearing, I still had a question.

When we began the theme-based discussion yesterday, Debbie Zimmerman had kind of talked about the need for, as part of total population-based total cost of care models, looking at managing to achieve lower cost for high-risk patients, as well as making a significant increase in investment and services for lower-risk patients so that both of those needed to happen at the same time.

Today we heard one of our panelists say that if total cost of care is the top

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priority rather than quality, then there's a need to focus on the populations where we believe that we can achieve total cost of care reduction.

So, I'm wondering if you guys have come to a point of thinking about, you know, should the focus within these models be more so on the higher-cost patients, you know, chronically ill, higher-cost patients versus on kind of what was referred to as that broader tail that maybe they have lower cost right now, you know, and the prevention of that, and then how do you, I guess, in September, how do you manage the cost associated with whichever strategy?

CHAIR CASALE: Angelo?

DR. SINOPOLI: Yeah. I think we have to spend some time discussing that tail and particularly that group, the rising risk group, and identifying -- and there is some ability to identify who's going to be increased -- who's going to need increased resources going forward, you know.

As a pulmonologist, COPD[34] gets worse, and you can't change that pathophysiology. They're going to get worse, and they're going to start utilizing and needing hospitalization, et cetera. And the earlier you intervene in those things, the better.

So, you're not going to prevent everything, but I think we have to pay attention to those rising risk patients and fix what we can and mediate what we can't fix.

CHAIR CASALE: Yeah, I would agree with that. I mean, and I think – I'll get to everybody else -- , and I think maybe, Larry, you said this, you know, a patient who cost a lot last year isn't necessarily the one that's going to cost next year.

And so, you know, you really need to think about the whole population, particularly the rising risk, as you alluded to.

Larry?

DR. KOSINSKI: I jotted down that I was impressed with Dr. Zimmerman's Slide 4. I

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mean, I think that really tells the story. And if you're looking at it from a population point of view, you got to invest.

You got to invest in the early care, and those people may have low risk now, and if her curve is accurate, then you're avoiding the higher-cost, higher-risk deterioration later.

I know in our population of inflammatory bowel disease, someone could have a totally -- it can vary from year to year to year.

So, unlike illnesses like COPD that once they reach clinical significance, they're going to continue to deteriorate, there are many illnesses that have periodicity to them that -- and we heard from our actuary that, you know, like the stock market says, past performance doesn't predict future performance.

So, I think I would lean more towards Dr. Zimmerman's approach.

CHAIR CASALE: Josh?

DR. LIAO: Audrey, thanks for bringing this up. To me, there's at least two distinct issues here.

The first is in managing

populations, do you focus on the tail, or do you focus on kind of the bell, like, the middle of the distribution? I think it's a both end.

My sense is early on, maybe there are people in the tail that can help, but you're going to want to move people across the population. At least ostensibly that's the goal.

I think in recognizing that, though, because just like in the clinical context when you give them medication, often you get the biggest effect of the people who have the least well-controlled disease.

If you intervene early, how would you measure that improvement in someone before they've gotten, you know, out of that range?

I think that speaks to the importance of quality measures in that. So, I like the idea of taking a broader approach. It may be staged, I think, a focus on quality.

The second issue to me is what to do with the tail. And for the reasons that Paul and Larry have mentioned, I think it's not one group that never changes, but I go back to my comment about cost not being need.

If we think that they are in the tail of that curve because there's something that we can do less of because they don't need it, it's overuse, it's potentially unwarranted, then I think those models should push us to that.

I think if it's a need, and they actually need more services, different services, right, to move them out of that tail, which I think everybody probably wants, then I think the traditional TCOC approach of doing less is probably not the right thing.

Now, we're talking about investment within these models, adjacent to these models in a collaborative way, again, I don't know, but that's how I think about that.

CHAIR CASALE: Great. Thanks, Josh.

Audrey, any other clarification?

MS. MCDOWELL: No. Thank you.

*** Closing Remarks**

CHAIR CASALE: Okay. Great.

So, I want to thank everyone for participating today, our expert presenters and panelists, my PTAC colleagues, and those listening in. We explored many different

facets of population-based total cost of care models.

Special thanks to my colleagues on PTAC. A lot of information packed into these two days, and I appreciate your active participation and thoughtful comments.

We'll continue to gather information on our themes through a Request for Input, which is posted on the ASPE PTAC website. You can offer your input on our questions by July 20th.

Now that we have explored relevant care delivery innovations, the next step is to dive into the financial incentives to encourage these, which we will do at our September public meeting. I hope to see you all then.

*** Adjourn**

The meeting is adjourned. Thank you.

(Whereupon, at 1:50 o'clock p.m. the meeting was adjourned.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Public Meeting

Before: PTAC

Date: 06-08-22

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate complete record of the proceedings.

Neal R Gross

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Court Reporter