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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TUESDAY, SEPTEMBER 20, 2022

PTAC MEMBERS PRESENT

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

PTAC MEMBERS IN PARTIAL ATTENDANCE
LAURAN HARDIN, MSN, FAAN, Vice Chair

STAFF PRESENT

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

8:50 a.m.

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

* **Liz Fowler, JD, PhD, Deputy Administrator, Centers for Medicare & Medicaid Services, and Director, Center for Medicare and Medicaid Innovation Remarks**

VICE CHAIR HARDIN: I am Lauran Hardin, the Vice Chair of PTAC.

Yesterday, we began our day with opening remarks from the CMS[1] Administrator, Chiquita Brooks-LaSure. And she offered some context on how our work fits into her vision.

Today, we're honored to be joined by Dr. Liz Fowler, 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 of Global

1 Centers for Medicare & Medicaid Services

Health Policy at Johnson and Johnson.

She was Special Assistant to President Obama on Healthcare and Economic Policy at the National Economic Council.

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

Welcome, Liz.

DR. FOWLER: Thank you so much. And good morning, everyone. And it is definitely morning here in California where I'm traveling for meetings and site visits. So, I'm sorry I'm not there in person.

I'm really pleased to be able to join you for PTAC's quarterly public meeting, and I want to personally thank PTAC Chair Dr. Paul Casale and Bruce Steinwald for their contribution and professional dedication as three-term Committee members. Thank you so much for your service.

As Lauran said, CMS Administrator Chiquita Brooks-LaSure shared the CMS strategy yesterday and how value-based care supports her priorities related to equity and innovation.

As with previous PTAC meetings, your agenda this fall is extremely relevant to the CMS strategy and the Administrator's priorities related to value-based care.

And in particular, population-based total cost of care models are central to the CMMI[2] strategy.

The June presentations and discussions and the presentations yesterday and the ones you have planned for today will help inform our pipeline of models.

And I want to commend PTAC for including a mix of policy experts, state policy perspectives, practitioners, and payers. These are exactly the perspectives that help inform our work.

In my time here today, I'll spend a few minutes highlighting some of our most recent work and preview what's coming next. As PTAC is well aware, the CMS Innovation Center is committed to pursuing new care delivery and payment innovation models. And in doing so, we're thinking about how these models can inform future Medicare and Medicaid policy to improve these programs for beneficiaries today

2 Center for Medicare and Medicaid Innovation

and into the future.

In addition to our care delivery and payment innovation models, we're focused on increasing data transparency for better insight into model performance; incorporating social determinants of health, screening, and referrals into models; collecting health equity data; and we also have ongoing initiatives focused on risk adjustment and improving our approach to setting payment benchmarks.

We anticipate engaging with stakeholders including PTAC on new models and crosscutting initiatives as they are developed.

This summer, the CMS team focused on specialty care models led by Sarah Fogler published a blog that described how Innovation Center model tests have demonstrated improvements in lowering expenditures and enhancing quality for specialty care.

Episode-based payment models like the Bundled Payments for Care Improvement, or BPCI Model, and the BPCI Advanced Model, as well as the Comprehensive Care for Joint Replacement, or CJR Model, focused on specialties that provide an important foundation for increasing access to coordinate

and integrate specialty care.

We are using these lessons learned to inform a comprehensive specialty care strategy which we hope to announce later this fall.

And based on our request for applications received earlier this year to solicit participants for the ACO REACH[3] model, we recently announced a list of provisionally accepted organizations that will -- who could participate beginning on January 1st, 2023.

ACO REACH is a redesign of the Global and Professional Direct Contracting Model. It's intended to better align with CMS's commitment to advancing health equity and in response to stakeholder feedback and participant experience.

We're excited about the factors that incorporate into this model that are intended to advance health equity, including a new health equity benchmark adjustment and requirements for organizations to develop and implement a health equity plan. This past summer, the Innovation Center also announced a

3 Accountable Care Organization Realizing Equity, Access, and Community Health

new voluntary Enhancing Oncology Model, or EOM. The model will test how to best place cancer patients at the center of their care team that provides high-valuable -- high-value, equitable evidence-based care and improves care coordination quality and health outcomes for patients.

This model also holds oncology practices accountable for total cost of care to make cancer more affordable and accessible for beneficiaries.

And the model will require practices to screen for health-related social needs.

We're including many lessons learned from the Oncology Care Model, as well as feedback from stakeholders in this new model. It's a five-year model, and it will launch on July 1st next year.

And finally, this past August, the Innovation Center made good on our promise to improve data sharing by making available new research identifiable files, or RIFs, for six CMS Innovation Center models: the Global and Professional Direct Contracting Model; the Oncology Care Model; the BPCI Advanced Model; Comprehensive Primary Care Plus, or CPC Plus

Model; Kidney Care Choices Model; and the Primary Care First Model.

CMMI continues to build on the foundation of innovation for -- for innovation in health care, and we believe success should be measured by how well it improves health, experience, and affordability of care, and how it supports partnerships between patients and providers and stakeholders across the system to drive transformation.

As we're driving accountable care, we're incorporating beneficiary perspectives into life cycle of our models, implementing more patient-reported outcome measures to measure what matters to beneficiaries, and focusing on evaluating beneficiary experience and models to ensure that our models are accomplishing their goals.

In fact, later this afternoon, we're hosting a webinar focused on our strategy to incorporate patient perspectives into models. If you're interested, I'm sure it's not too late to sign up.

Let me close by thanking PTAC for this opportunity to share what the CMS Innovation Center has been working on and where

we're heading. And again, to send my thanks and best wishes to Dr. Casale and Bruce Steinwald for their commitment to PTAC and its mission. I hope the second day of your meeting is just as productive as it was yesterday.

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

VICE CHAIR HARDIN: Thank you so much for providing those remarks virtually, Liz. It's really exciting to hear all the developments. And we're looking forward to working with you and your team over the next year.

Yesterday, we heard from several guest presenters on their vision for how population-based payment models can help us move forward toward a more proactive, patient-centered health care system.

Today, we have two more listening sessions of experts ready to share their thoughts on payment considerations and financial incentives for total cost of care models.

We've worked hard to include a variety of perspectives throughout the two-day meeting, including the viewpoints of previous PTAC proposals submitters who addressed relevant issues in their proposed models.

We'll then have a public comment period. Public comments will be limited to three minutes each. If you have not registered to give an oral public comment, but would like to, please email ptacregistration@norc.org. Again, that's ptacregistrationatnorc.org.

Finally, the Committee will conclude the day by shaping our comments for the report to the Secretary of HHS[4] that we will issue on this topic.

*** PTAC Member Introductions**

Because we might have some folks who weren't able to join yesterday, I'd like the Committee members to please introduce themselves. Share your name and your organization. And if you would like, you can share a brief word about experience you may have had with population-based payment or total cost of care models.

I will cue each of you.

4 Health and Human Services

I'll start. I'm Lauran Hardin, Vice President and Senior Advisor for National Healthcare and Housing Advisors and have led value-based payment model implementation in multiple settings across the country.

Larry?

DR. KOSINSKI: Good morning. I'm Larry Kosinski. I am a gastroenterologist and have been involved in value-based care for the last decade.

I'm currently the Chief Medical Officer of SonarMD, a company that was formed on the heels of our presentation to PTAC back in 2017. We were the first PTAC recommended physician-focused payment model, and it spurred the formation of SonarMD, which is involved in value-based care for patients with complex chronic diseases.

DR. WILER: Good morning. I'm Dr. Jennifer Wiler. I'm the Chief Quality Officer at UC Health and co-founder of our systems at Care Innovation Center and professor of emergency medicine.

And I helped co-develop an Alternative Payment Model for acute unscheduled care.

DR. LIAO: Good morning. I'm Josh Liao, physician and faculty member at the University of Washington where I'm fortunate to help lead value-based payment and care redesign in our system, as well as contribute to evaluation and research on these topics.

DR. SINOPOLI: Good morning, Angelo Sinopoli, a pulmonary critical care physician by training, presently the Chief Network Officer for Upstream, which is a value-based risk-bearing organization.

Prior to that, I was a Chief Clinical Officer for Prisma Health, where I also developed a large clinically integrated network that was involved in downside risk, and founded and developed the Care Coordination Institute which was an enablement company for organizations going into risk arrangements.

DR. LIN: Good morning. I'm Walter Lin, founder of Integration Clinical Partners, also a member of the Public Policy Committee at Society for Post-Acute and Long-term Care.

Our medical practice cares for Medicare beneficiaries residing in senior living, especially nursing homes and assisted living facilities.

DR. PULLURU: Hi, I'm Dr. Chinni Pulluru. I'm a family medicine physician by trade. I lead clinical operations as Vice President for Walmart Health and Wellness, where all of the things that touch clinical delivery and clinicians are under my umbrella.

I also lead their value-based care strategy.

Prior to that, I was at DuPage Medical Group, now called Duly, where I led the clinical care delivery platform, as well as value-based care.

DR. MILLS: Good morning, Lee Mills. I'm a family physician. I am Senior Vice President and Chief Medical Officer at CommunityCare of Oklahoma, which is a regional provider-owned health plan operating in Medicare Advantage, individual exchange, and commercial space primarily on a total cost of care capitation payment model.

Prior experience includes helping lead two different MSSP[5] plans in two states, and then, operating and leading four different CMMI models over the last 15 years.

MR. STEINWALD: I'm Bruce Steinwald.

5 Medicare Shared Savings Program

I'm a health economist right here in Washington, D.C.

CHAIR CASALE: Paul Casale, a cardiologist. I lead population health at NewYork Presbyterian, and I lead the ACO for Columbia University, Weill Cornell Medicine and NewYork Presbyterian.

VICE CHAIR HARDIN: And Jay is joining us virtually.

Jay, please go ahead.

DR. FELDSTEIN: Good morning, everyone. My name's Jay Feldstein. I'm an emergency medicine physician by training.

Currently, I'm the President and Chief Operating Officer of Philadelphia College of Osteopathic Medicine.

And prior to this role, I spent 15 years in the health insurance industry in various roles in both commercial and government programs.

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

VICE CHAIR HARDIN: Thank you, Jay.

So, next, I'm excited to welcome the

experts for our third listening session for this two-day meeting.

We've invited four outside experts to present on financial incentives, specialty integration, and performance metrics in population-based models.

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

After all four have presented, our Committee members will have plenty of time to ask questions.

Presenting first, we have Dr. Amol Navathe, who is the Co-Director at the Healthcare Transformation Institute, Director at Payment Insights Team, and Associate Director at the Center for Health Incentives and Behavioral Health Economics at the University of Pennsylvania.

Welcome and please begin, Amol.

DR. NAVATHE: Good morning. Thank you so much for the invitation to come join and present on financial incentives and performance metrics related to primary care and specialty integration.

If we can go to the next slide,

please? Are we able to advance to the next slide? Thank you.

So, I will be discussing focus around this notion of how do we marry population-based versus specialty-based model approaches, particularly given that both have been important to have been tested in the past decade-plus post the Affordable Care Act.

In fact, both of them have a history of being tested well before that, going back to the early 1990s.

In general, if we think a little bit about what population-based models have produced for us, it's certainly relative to not using population-based models.

In this case, we've seen gains in quality. So, quality improvements, specifically focused around reductions in hospitalizations and other acute care.

We've seen some increases in efficiency in post-acute care use as well.

And we've seen overall that there's been a decrease in the total cost of care, as well as specifically around Medicare spending in models of Medicare program incentives.

On the other side of the page, if

you will, we have specialty-based models which are heavily focused around specialist physicians and hospitals and other institutions that take care of patients who are largely being cared for because of their specific conditions.

Their goals have been, and I think to some extent, the results have been, to reduce cost, and variability in practice and cost. A lot of that effort has been focused around institutional post-acute care such as skilled nursing facility use, inpatient rehab facility use, as well as home health use.

And we have seen some early successes certainly in that space. We've also seen some quality improvements focused largely in the context of utilization, again, so thinking about readmissions, for example.

Some advantages of specialty-based models is that they're, by definition, more focused in a population-based approach. And, to some extent, they are more practical for hospitals and physician organizations, as well as other organizations such as post-acute care providers in coordinating.

They're -- another advantage I would

highlight relative to population-based models is that there are more options for policy makers to incentivize participation, care cheaply, meaning that specialty-based models have been tested in a mandatory fashion with Comprehensive Care for Joint Replacement program, or CJR program, that this -- the CMS Innovation Center had put out and is currently running, as well as well as voluntary programs.

And relative, for example, population-based models which have been much harder for a variety of reasons to try to mandate participation in.

Next slide, please?

There's understandably a number of different policy questions around value-based payments and Alternative Payment Models.

I outlined here several. So, one chief example would be the impact on cost and quality relative to not having those models.

We're also very interested in where those savings may be located. In other words, who's generating those savings and from what type of practice pattern change?

There's been some concerns, more in the case of specialty-focused models, or

episode-based models around whether there may be some sort of volume response from clinicians and health care organizations to try to ramp up the volume of episodes, for example.

There's always concerns in both types of models where there may be some sort of case mix effect. In other words, is there some selection towards patients who may be preferable, particularly on an unobservable dimension, unobservable to a payer, for example?

There's a lot of interest in how can we standardize care? There's also a lot of interest in do these models actually generate some kind of practice spillover where not only does, for example, a Medicare patient benefit under a Medicare model, but do primary care patients also benefit because of a Medicare model that is generated practice-wide types of change?

I've highlighted that there are multiple mechanisms of participation, chiefly voluntary versus mandatory. And we can debate whether one of those has advantages based on the empirical literature.

But here, what I wanted to focus on

is overlap with other APMs.[6] So, how do population-based models tend to overlap with episode-based models and specialty-based models and vice versa? And is there empirical evidence, and to some extent, what is the empirical evidence that this may be good or bad when we think about it from a perspective location?

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So, one question we may ask is, why does it matter in the first place?

CMS has stated that there is a goal to try to get to near universal participation in value-based payment models in the near future.

This likely means that we need a comprehensive strategy that will require both population and episode-based payment models.

Again, if we kind of rewind back to the post-Affordable Care Act era over the past decade plus, we've seen a lot of testing of different models.

These have included population-based models like the ACO programs. And these have also included specialty-based care models like

6 Alternative Payment Models

Dr. Fowler highlighted a number of them, BPCI, BPCI Advanced, CJR, et cetera, oncology models as well.

And they have, in essence, collided. They have overlapped, although we may not have been able to coordinate them or strategize around how they have collided in some sense.

So, as we go forward and we think about using both of these vehicles to try to transform care and hopefully reduce the cost trend for our national health system, we must think more proactively around how we might harmonize these models across the continuum of care, noting that population-based models are heavily focused on continuum of care, as well as in the context of acute phases of utilization that may be related to specific diseases, specific events, think, for example, heart attack or a stroke, or specific sites, so, for example, thinking about chemotherapy in the context of a physician's office or a hospital outpatient department.

There certainly could be synergies between models, and we have seen those to some extent. So, population-based models, for example, have done exceptionally well at

reducing hospitalizations.

Whereas, specialty-based models, to date, have heavily focused on reducing institutional post-acute care, both in a very complementary fashion.

Or there could be redundancies where the care infrastructure used, for example, thinking about home health use under episode-based payment models and additional ambulatory infrastructure that was deployed as part of ACOs, may, in fact, be redundant.

Medicare policy to this point, as I mentioned, at least prior to the current Administration, has not been very outward, at least outwardly trying, to coordinate these models.

And to some extent, in that it would take some time to create a financially solvent program, as well as a pilot, financially coordinated program without too much double-paying or double-dipping that we have ended up in the policies that probably have been more discouraging rather than encouraging of model overlap.

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So, I'm going to dive a little bit

more deeply into the evidence here, specifically focusing on a study that I did with colleagues at the University of Pennsylvania and the University of Washington that examined what happens, empirically, when there is impact between ACOs, oh sorry, overlap between ACOs and bundled payments, and what is that impact on patient outcomes?

Secondly, we vary this looking at or explore how this varies for medical conditions such as acute myocardial infarction, congestive heart failure, COPD[7] exacerbations versus surgical episodes where the canonical example has been hip and knee replacement surgery.

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To give a few study details, just to orient you to the institutional setting of this study, here we're focused on ACOs, specifically, ACOs that were participating in the Medicare Shared Savings Program between 2012 and 2018.

For bundled payments, we're focused on bundled payment episodes under episode initiators from 2013 to 2018.

We are focusing here, to some

7 Chronic obstructive pulmonary disease

extent, on the bundled payment effect and seeing how that varies across beneficiaries who are already aligned with or attributed to an ACO versus those that were not.

We attempted a number of statistical econometric techniques to try to address some of the confounding that might exist. And here, we are looking, for example, at within ACO comparisons.

So, we're looking at if you're within the same ACO, and one patient goes to a BPCI hospital versus a non-BPCI -- another patient goes to a non-BPCI hospital, we're using that dimension of comparison to make comparisons within an ACO.

And in the bundled payment context, we're looking within a hospital. So, if a bundled payment, if there's a hospital that's participating in a bundled payment, we would then compare patients who are attributed to an ACO versus not within an ACO.

And that allows us to control for, perhaps not eliminate but at least control for many of the different selection issues, for example, that ACO patients may be different than non-ACO patients or patients that end up

in a bundled payment hospital, for example, may be different than those that do not end up in a bundled payment hospital.

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So, without further ado, the results here. So, first what we found here is that overlap in ACOs and bundled payments lower spending for medical conditions.

And to be very clear here, these are gross savings, meaning, these are savings relative to usual care, if you will. These are not net savings to the Medicare program. And, unfortunately, we weren't able to do the calculations here to know, given the complexity of the dynamics across programs.

Nonetheless, what you can see here is that, if we look at post-discharge institutional spending here, so this is spending on readmissions, SNFs[8], IRFs,[9] for example, and outside long-term hospitals as well, we can see that the non-ACO group also decreases to a certain extent, that's the left most black bullet.

Then we see that the ACO group, in

8 Skilled nursing facilities
9 Inpatient rehabilitation facilities

fact, decreases more. And that's the orange bullet in the middle.

And if we compare the non-ACO versus the ACO, we get a blue bullet point and a range there. And that's the estimate of the difference between the ACO and the non-ACO.

And this was a statistically significant, about $300 per episode, of savings.

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This effective savings came chiefly from reductions, relative reductions, in readmissions, which is the -- what we highlighted here in the box for ACOs versus non-ACO patients, as well as for discharge to skilled nursing facility and inpatient rehab facility, which is the set of blue points that is the kind of sort of third set.

So, once again, one of the things that's interesting, however, is you can note that the readmission rate itself is reduced for patients who are attributed to an ACO who end up with an episode at a bundle payment hospital.

And that difference between ACO and non-ACO patients is in fact, statistically

significant for a reduction in readmission rates.

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I should highlight that the prior two points that we're making were for medical conditions.

Now, here, we're switching gears to look at surgical procedures. So, again, thinking about hip and knee replacement surgery, other orthopedic surgeries, coronary artery bypass surgery, as the type of surgeries that are included in this study.

Here, you can see that we see a smaller but significant reduction in readmission rates, again, in the context of overlap between ACOs and bundle payments, another difference that is statistically significant.

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So, what we took away from this study, or this study seems to suggest, is that bundle payments seem to work well together with other value-based payment models. At least here in the context of Accountable Care Organizations or population-based payment models.

This resulted for medical conditions, for patients admitted for medical conditions, in lower spending and fewer readmissions relative to usual care, if you will.

As on the surgical side, it led to fewer readmissions, but no evidence of lower spending.

This was the first evidence at the time. And I think, to date, of synergies and overlap.

And one thing that's interesting that I didn't show you the empirical data for is when we stratify the savings and stratify the quality gains of reductions in readmissions, we see, in fact, that these benefits of model overlap seem to be larger when clinical complexity is larger.

So, for example, patients with congestive heart failure tend to have much higher ACC[10] scores, or Elixhauser Comorbidity Index scores tend to be sicker on average than a patient undergoing a knee replacement.

And the effects sizes that we see are larger for those conditions with more

10 American College of Cardiology

complex patients, as well as directly for more complex patients versus less complex patients.

This isn't -- these findings are important for policy makers to consider in the context of deliberate policy designed to think about fairly distributing savings.

And with a question mark here, we highlight, you know, are there are mechanisms in which we might try to encourage overlap between these models?

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So, in thinking through this, Will Shrank, Michael Chernew, and myself, we put together a potential approach to think about how we might harmonize models and turn this hierarchical payment models. This was a viewpoint that was published in the Medical Journal of JAMA[11].

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To quickly highlight what we were suggesting, we were focused here on a global budget of a population-based model as the, quote, umbrella of accountability, end quote, under which episode-based payments are applied.

The idea here is that ACOs, with

11 Journal of the American Medical Association

their population level and total spending level view, would serve as a coordinating entity and the episode-based payment system for specific conditions, and procedures would sit underneath that umbrella of accountability.

There's -- we reviewed some of the empirical evidence for why this might be a good thing to do, as well as to try to understand how the organizational dynamics or try to think about promoting a model which recognizes the organizational dynamics between the types of organizations that are accountable for episode-based versus population-based models.

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There's a thought of how we might do this to drive the right types of efficiencies. And here's a few examples of why we might get some benefits from this kind of hierarchical coordination.

First, we might stimulate more collaboration or closer collaboration among primary care clinicians who are so central for population-based management, specialists at facilities who tend to be even more important, if you will, to specialty-based models.

We could create a blueprint

flexibility for reimbursement specialists and facilities within this coordinated model structure.

You could imagine a system where organizations and population-based models would, in fact, earn savings by directing referrals or episode-based care, far more efficient episode-based types of providers, and clinicians providing care under episodes would earn savings only underneath those episodes, if you will, for generating additional savings.

This would preserve the episode-based payment model, which has been, to some extent, harder to get right from some of the financial accounting steps. And support continued innovation across the care continuum.

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The last point I wanted to highlight is that, we have to be very, very thoughtful here, even in thinking about coordination that value, at least as we have defined it in the first decade or so post-Affordable Care Act, does not equate to equity, and that we need to incorporate equity concerns into our value-based approaches.

There are reasons to worry about

this. So, first, greater financial accountability in physicians and hospitals has not historically lead to more equitable outcomes.

Risk adjustment tends to be more incomplete for marginalized versus non-marginalized groups.

And there is some evidence that clinicians may avoid patients from marginalized groups and/or even outright avoid participation in value-based payment models if they serve a disproportionately more challenging population.

An approach to think about this in the concept of value-based payments is to make equity an explicit goal as the current CMMI leadership and administration has done in any value-based payment model.

In other words, build equity into metrics and financial incentives. And I think we're going to hear from Mark Friedberg more about the work that Blue Cross and Blue Shield of Massachusetts is doing directly in this setting.

As well as measure this notion of disparate impact on access and quality for disadvantaged populations by expedited

reporting and data collection, very important to think about the monitoring aspect of this to complement the proactive piece.

Next slide, please?

So, here, I'll wrap up. Thank you, again, for an opportunity to come in and present these thoughts and empirical findings with you. And I look forward to the discussion that follows.

VICE CHAIR HARDIN: Thank you so much, Amol, very timely for our discussion today.

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

Next, we'll hear a presentation from Dr. Mark Friedberg who is the Senior Vice President of Performance Measurement and Improvement at Blue Cross Blue Shield of Massachusetts.

Please go ahead.

DR. FRIEDBERG: Okay. Thank you very much for inviting me to speak today. I thought, Dr. Navathe, your presentation was great and really set up, I think, in the way you just alluded to, some of what I'm going to

get to in this deck. Let's go to the next slide.

What I'd like to just share with you is how our company's thinking about evolving and expanding quality measures within total cost of care contracts, within our own version of an ACO-type contract, which is called the Alternative Quality Contract, or AQC. So, first, our long-standing principles for using high-stakes measures won't change. Payment is a high-stakes measure, as are other uses that have direct economic consequences for provider systems and for individual clinicians, such as public reporting and tiering.

For us to use the quality measure, it has to be valid, meaning it measures what it's supposed to measure, or purports to measure, it has to be important, and it has to be reliable, so has a favorable signal-to-noise ratio for the level at which we're using the measure.

In general, moving forward, we're pushing on importance to try to move quality measurement into new areas where we currently have blind spots in our existing measure slate. And I'll say that reliability's an ever-present

concern. It, basically, serves as the filter on validity and importance. We start with those two criteria. Whoever makes it through that initial screen, and that's a slim list, then gets further filtered by reliability.

And this means that, for different AQC organizations, which vary in size, the measures that are on offer can vary a little bit. Those who are the larger organizations have a wider range of measures than those that are the smaller organizations and may lose some measures due to reliability concerns. Let's go to the next slide.

So on improving measure validity, one area of interest for us, and this is a long-standing research area that we are actually looking at ways of piloting in a lead up to high-stakes measurement, is explicitly measuring the performance of shared decision-making. So, briefly, this is defined as the degree to which decisions are made in a way that's consistent with medical science and also consistent with individual patient values and preferences.

This is, to our mind, unquestionably superior ethical construct than following

guidelines, in general, for a broad population. If you look at many of the USPSTF[12] recommendations, there is a mention of shared decision-making in there as the optimal way to proceed. But then if you can't do shared decision-making, you do the second best thing, which is to follow the guideline. That ends up being the basis of most legacy measures.

We'd like to see over time, and we understand this is a big change, shared decision-making measures replace most legacy measures for primary care. So measures of cancer screening, chronic condition management, you name it. Because there are trade-offs to all of these services. And patients do vary in their values and preferences. And applying a single set of values and preferences that's set by a guideline committee is probably going to be suboptimal for many patients.

We believe the best way to measure these is to use patient surveys. Dr. Karen Sepucha and Mass General Hospital, for example, is just one of a couple of organizations out there that have really pushed the envelope on

12 U.S. Preventive Services Task Force

this and have generated NQF[13]-endorsed measures of shared decision-making. So it can be done.

The key challenge is going to be uniform fielding methods. It's going to be a little bit expensive to do this the right way, in our view. That might not need to go through providers and ask them to collect the data, since providers are already very busy, have a lot on their plate. And that can introduce unacceptable fielding method variation from provider to provider. If we're trying to compare providers, we probably need to get that washed out. And that'll include some kind of fielding method that's akin to caps. So where there's really very little variation, if any, if we're using approved vendor.

We have a long-standing interest in patient-reported outcomes as well. And, again, fielding concerns are huge there. When we move from patient-reported outcomes to PROPM, so patient-reported outcome performance measures, now we're using them for high-stakes uses. We do need to deal with heterogeneity in fielding issue.

I'm a practicing primary care

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physician myself. I see in my clinic and, I think, I would encourage everybody who's interested in these measures to do this, watch these measures being collected in person in, even in a well-resourced, clinical setting. It is very eye-opening and really, I think, argues for much better and much more focused attention on the fielding methods.

Finally, we are strategically trying to really up our game on mental health services, starting with patient-reported access to mental health services. There are administrative measures of network adequacy and out-of-network use of mental health professional services that are available already. But patient-reported access has, probably, a way to go in the future to get it more meaningful.

We need to ask our members how hard it was to find mental health services, to even find out if they were frustrated enough that they were not able to find mental health services at all for a mental health need they may have. And those kinds of scenarios are not always visible in existing measures. So that's another area of active development for us.

Let's go to the next slide.

Now, talking about extending high-stakes measurement into new and important areas, here I'm going to talk a little bit about our efforts on equity measurement. So we define equity as differences between groups of patients for which no systematic differences are ethically tolerable. So racial and ethnic inequities would clearly fall into this category. We've already, as of about a year ago -- I think it's actually exactly a year ago today, we published an equity report on our website. I think we're still the only health plan to have done this, which is a surprise to me.

Of all of our HEDIS[14] measures for which we had a sufficient sample size, that's about 46 HEDIS measures for calendar year 2019 on our website. We'll be updating that later this month with 2020 and a revision of the 2019 report, plus a couple of CDC[15] measures for severe maternal morbidities, since that's a Blue Cross Association priority.

This was intended to, first off,

14 Healthcare Effectiveness Data and Information Set
15 Centers for Disease Control and Prevention

just be transparent about the inequities we see, even within a commercially insured population. They're large. It's humbling for us to have seen this internally first and then to put it on our website.

Secondly, it's to signal seriousness to our provider network that we are moving, with speed, towards high stakes measurement on equity incorporated into those AQC contracts, so into an ACO-type program. And to enable all of our stakeholders, our members, and our accounts, most importantly, to hold us accountable for making improvements in the equity of care that our members receive over time. We'll be updating this again every year. And a big obstacle to all of this, of course, was gathering enough, race and ethnicity data that we could even test such things as statistical computation methods for race and ethnicity, which is the basis of this report.

Below this, I want to talk a little bit about clinical rationale. This is, really, relegated to the research realm right now. There are no measures NQF-endorsed, for measuring clinical decision-making rationale. But this is actually a very old quality

measurement method. Structured implicit review, meaning having peer clinicians review each other's decision-making rationale, can be, first off, universally applicable and can really move us into specialty care, where we lack many important quality measures by and large. This is true for HEDIS. This is true for our contracts as well. The measures are focused on the primary care setting.

But we take this as an area of promise and will, of course, in this case, not be doing this directly with our members. This will involve setting up structures and incentives for providers to do this with each other, within the context of the Alternative Quality Contract. And that'll be going on in a pilot basis for some time before it's ready for prime time line payment. Let's go to the next slide.

And return a little bit to the way we are incorporating equity into all components of the Alternative Quality Contract. So payment always gets the most attention, when we think about the AQC. But I think that's a disservice to the other two components, the data and support that accompany the payment

incentive. Those are, I would say, at least as important as the particulars of a payment arrangement. And those have actually gone first when we moved into equity.

So in addition to publishing on our website an equity report for our in-state members, we gave every single one of the AQC providers last year a report of their stratified by race and ethnicity AQC measures. And most of them had never seen this kind of thing before. They didn't have the capability to track this internally. For those who had, the thing they'd never seen before, which we gave them, was comparisons.

So this was a confidential report. But they could see, in a blinded fashion, if they had, let's say, a 10 percentage point gap in hypertension control between their Black and white members of our plan, how did that compare to other AQC groups? Is that a large inequity? A small inequity? Somewhere in the middle? Now they all know the answer to that question. And that can be, we hope, guiding and motivating for making investments in equity-improving activities.

Support is something we launched

last November in two ways. So first off, I'll just say a word about support in the context of the AQC for the last dozen or so years of its existence. This has always been a component of the program. And it's one that really distinguishes it from any other ACO-type programs. We invest a lot in giving tailored guidance and explanation of data and ideas for quality improvement. With each AQC group, I have a team of folks. This is all they do. Each one of them has a handful of AQC groups that they are, basically, the QI concierge for.

And, one thing we knew we needed to do for equity was to improve our ability to focus on equity, specifically, with that team which didn't really have that emphasis historically. So we contracted with the Institute for Healthcare Improvement, or IHI, which had five years' experience in coaching providers on equity improvement at the time we contracted with them last year.

They've been our partners in taking off an Equity Action Community, which is a way that we gather all the AQC groups. They're all participating in this to share best practices, to share learnings on how to approach equity as

an improvement target, and to get individualized coaching sessions. And that's really the phase they're in, mostly, now. Most of the meetings they're in are individualized with one of my team members and one of the IHI equity improvement consultants. And that'll go on for at least another year with IHI.

In addition, as a down payment, on the payment component of this, which is not yet in force, we granted $25 million to the IHI at the end of last year, which is one of the largest grants this company has ever made, to distribute to the AQC providers, plus some of the smaller providers who are interested in equity that are not large enough to be in the Alternative Quality Contract, for three purposes.

The first is just to defray the cost of participating in the Equity Action Community. It is costly. It takes time and effort of highly-trained individuals within these provider organizations to participate in these sessions. But also to, for many of them, upgrade their internal race and ethnicity data. It's like turning over rocks with many provider organizations when we started to get into

detailed discussions about the state of their race and ethnicity data.

Some were in a very advanced stage. But many were not. They might have multiple different VHRs[16], never really looked at how complete or accurate their race and ethnicity data were in those many instances, or even the data standards that they were on. It was not all that uncommon to find a data standard being used within a part of an organization that exists nowhere else in nature. Not consistent with OMB[17], not consistent with FHIR[18]. So there's a huge investment there that we think is very important so that these organizations can track their equity performance in real time.

In addition, for many of the groups, they are, in their grants they've been awarded, focusing on one or more AQC equity measures. And these are, generally speaking, in the chronic disease management area. A lot of interest in diabetes, and a lot of interest in hypertension control, and some interest, as well, in cancer screenings. It's not a

16 Virtual health records
17 Office of Management and Budget
18 Fast Healthcare Interoperability Resource

surprise. If you look at our public equity report, we have large inequities in all of those areas statewide. Pretty much all the AQC groups have those same internal inequities to some extent. And so it was a common target for them.

And we triple-weight those outcome measures in the structure of the AQC contract in general. We're doing the same weighting for equity. So those are great places to make investments, from the standpoint of sustainment of the program, which will come in the payment component as the third piece. And those will be live for at least some groups, as of January 1st of 2023. We are not yet signed with anybody. But once we do, we will be publicizing those. So stay tuned. Somewhere between one and five groups, I expect, will be live on pay for equity, starting January 1st. Let's go to the next slide.

That's my last slide. So thank you very much for your attention. I look forward to the remaining discussion.

VICE CHAIR HARDIN: Thank you so much, Mark. Very interesting as well. Next, we have Dr. Eric Schneider, who is Executive

Vice President of the National Committee for Quality Assurance. Please go ahead, Eric.

DR. SCHNEIDER: All right. Thank you very much, members of the panel, for the opportunity to be here with you today. And thank you, Dr. Navathe and Dr. Friedberg, for the fine presentations and the fine work that you are doing.

My comments today are going to focus on the topic I heard yesterday from Dr. Liao that the selection and use of performance metrics is among the top design considerations for physician-based total cost of care models. So I am going to focus today on quality accountability systems and describe how we at NCQA are thinking about an infrastructure for quality accountability and measurement that can better support value-based payment models of many types in the future.

With a bit of background, studies comparing health care in the United States to care in other high-income countries show that in the U.S., health professionals have the capability to deliver excellent clinical care, outstanding in many cases. However, Americans face many challenges in three key areas: the

access to care, coordination of care, and equity of care.

These challenges have a pretty adverse impact on health outcomes, and addressing them needs to be at the heart of our consideration of any payment model that involves the total cost of care. But neither access nor coordination nor equity are well measured, given our current health data infrastructure and our approaches to performance measurement.

So what I'll try to do in these remarks is ask the question, what quality accounting of the infrastructure is needed to support payment models based on total cost of care? And how will quality accountability systems address what I just described as key drivers of both health and spending? And those include unmet social needs, community inequities, lack of access, and other things. If we go to the next slide.

So I think that the issue of unmet social needs is something that has clearly come to the floor. And the association of unmet social needs with poor health outcomes is also something that's well documented. It's

estimated that anywhere from 40 to 55 percent of health outcomes are attributable to social determinants of health that occur outside the traditional health care system. Doesn't mean the health care system can't play a role. But, in fact it has to play a role.

But we know that, for example, infant mortality rates are higher among Black and Native American populations. Hispanic individuals are more likely to die from viral hepatitis. I won't read the slide here. But you see that the total cost of health inequities in premature death is actually a huge cost to the system and actually one of the reasons why thinking about how the health care delivery system can respond and create those savings, as well as address those inequities and problems, due to unmet social needs, is so important. If we go to the next slide.

The other thing that's sometimes not fully appreciated is that the unmet social needs are broadly felt across the population. So about half of respondents in a recent survey reported at least one unmet social need, with around a quarter reporting two or more unmet social needs. And the bars on the right show

you a sort of overall by payer, overall and by payer, how those numbers break out. And you can see that, among Medicaid and the uninsured populations, obviously, there are more unmet social needs, Medicaid in particular. But that also has to do with the eligibility criteria for Medicaid.

But, more importantly, the unmet social needs are reflected in all of the different insured populations: Medicare, individual insurance, group insurance. That's employer-based insurance. There are just profound, unmet social needs throughout the insured and the uninsured populations in the U.S. We can go to the next slide.

So the point being that in a physician-based payment model, presumably, the physicians participating in that payment model will see unmet social needs in their practices, regardless of the payers that they actually are engaged with.

I want to highlight how NCQA structures its accountability program thinking. There are three programs. The first is the HEDIS program, the HEDIS performance measurement system for comparing health plans.

That's a comparative measurement system that's been around for 30 years now and has evolved. But the central notion is the idea of measurement to make comparisons in payment-based incentive programs to actually adjust payments.

The second is our health plan accreditation program. So accreditation for health plans is about making sure that health plans have the structures, capabilities, and processes in place to serve their enrolled members.

And then third, maybe most important for this discussion, is our recognition programs, the Patient-Centered Medical Home Recognition Program probably being the most widely-known. And, in those programs, we also have diabetes recognition programs, a stroke and cardiovascular recognition program. But in those programs, the concept is to evaluate the structures, capabilities, and processes in place for clinicians and teams of clinicians and practices to deliver high-quality care.

And I think that third one is, the first and the third, to me, are fundamental to thinking about total cost of care programs. Go

to the next slide, please. Can I have the next slide?

So I have spent 30 years of my career in evaluating performance measures, developing performance measures, and studying how they're deployed and used in practice. And I also have, now, 30 years later, have a keen understanding of the limitations of comparative performance measurement. And, I think, one of the key, as we have moved into the sort of work that Dr. Friedberg described on measuring equity, that highlights, actually, many of the challenges that are not just in the equity area, but throughout performance measurement.

But to enable fair comparison and precise and accurate comparison of hospitals, teams, practices, plans, you name it, there are always going to be challenges around two major issues. The first, well, they may not always be there. The first that will always be there, and that's how do you get large enough samples to get an accurate and precise and valid and reliable comparison? So that sampling issue is probably one of the key constraints that we face.

And then the second is around the

data and the data we have available. That's the one that's potentially addressable through our approaches and, actually, can help a lot with addressing the first. I put on this slide, the comparison of organizations on equality and equity requires pretty large sample sizes. We've seen this over and over again in developing HEDIS measures for health plan comparison. But it requires fairly large populations to be able to measure the quality of care for even some common preventative services, for, when we get to chronic conditions, that's even more challenging.

And, when we get to stratifying by race and ethnicity, where 10 to 15 to 20 percent of the population may be in one of the two groups you're comparing, that poses special challenges. And I think the numbers, typically, would go beyond, at least for this purpose of really nailing down valid and reliable measures to adjust incentives, it will challenge even the largest physician-based payment groups, groups that are associated with payment.

So we are rolling out, right now, and I think we'll learn a lot, as Dr. Friedberg

was suggesting, about when we do stratify by race and ethnicity, as we are doing now and five measures in measure year for HEDIS, and another eight measures coming next year, we will learn a lot about what the challenges and limitations may be to understanding equity as it rolls out in practice. And, then as you mentioned, also, we're evaluating the data that are available to do this because we are not quite where we want to be in terms of data. Next slide, please.

So I wanted to also reflect on, and Dr. Navathe sort of set this up, the organizational capabilities that can support improvement. And what we have learned, from the foundational work, to create the Patient-Centered Medical Home model and the recognition program for that model. And I think an important insight for that is that, as he called the hierarchical approach to payment, is that these systems that can deliver high-quality, reliable care, are necessarily nested systems that, with foundational capabilities, such as leadership and quality improvement strategy, that then enable additional capabilities.

So this model, this is the Ed Wagner model from about 10 years ago now. But the thing I wanted to point out here is that the two challenges that I mentioned, enhanced access and care coordination, are actually in the fourth stage. They're actually built on a lot of other capabilities that need to be in place in order to be effective as a Patient-Centered-Medical Home.

The other insight that we've seen as the PCMH[19] has rolled out, is that the PCMH is only as effective as its medical neighborhood, to some extent. And, especially as we're looking at specialty and primary care joint models of total cost of care, we want to be thinking about the medical neighborhood and about those challenges and the foundational elements that are needed to achieve high levels of coordination and access. Next slide.

The other lesson comes from, this is example of another insight, which is that, if you compare low-performing and high-performing practices in the PCMH set, these are all practices that have gone through recognition program. One of the things that really jumps

19 Patient-Centered Medical Home

out is that many of the functions of an effective Patient-Centered Medical Home rely on digital data capabilities, the ability to collect, analyze, exchange, and interpret data.

And that's shown in this spider diagram. The practices that are sort of out at the edges of the diagram are the functions where it's at high-performing, almost 100 percent performing, are all associated with the ability to manage data effectively. And it's been said that data are the lifeblood of health care. And I think that comes across in this analysis. Next slide.

So, we are now moving into, I think, an area where I first wrote about the challenges of moving to a digital performance measurement system back in the 1990s. But we now are at a point where we can envision the health data standards coming into play, thanks to the U.S. National Coordinator for Health IT, to really bring together three areas that have been pretty disjointed and functioned almost in silos.

One is that the practiced guidelines, the evidence management arena. The second, at the lower left of the triangle, is

the measurement, performance measurement activities. And the third is our processes for collecting, transferring, aggregating, exchanging data. All of those have been operating somewhat in their own silos. And there's a cost to a lot of the manual process that results from the lack of coordination among these three activities. If we could go to the next slide.

What our vision for the future is, is that we need to really now start to marry these activities. So when we get to a point where guidelines are digitally enabled, clinical decision support is clinically enabled, then it's linked more closely to measures that are in digital format, and the data to support that, as we're now starting to see with new health data standards in exchange enable us to marry those two activities, I think we'll be in a much better position to support the physician-based cost of care metrics.

I'm going to go quickly here now. The next slide is about that journey toward interoperability that's been underway for at least a decade and maybe more. But we're now

beginning to look at VHR certification updates and data exchange mandates that will make much of this possible. I'm going to go to the next slide.

So digital quality measures are really, I think, where the future is if we want to effectively measure coordination and equity of care. I won't go through the definitions here, but CMS has been very clear that this is the direction that the Medicare program is going to move. There are lots of activities underway to achieve health data standardization. Providers don't need to be deep in the weeds of this.

But be aware that this technical infrastructure is coming that will make it possible to implement the type of program that Dr. Navathe was describing, of a sort of detailed ability to map the attribution and allocation of resources across teams, across provider groups. If I could have my last slide.

So, the conclusion here is that the quality infrastructure needed to support total cost of care models involves, I think, three pillars. The first is trusted consensus-based

evaluation standards and methods. Evaluating capabilities, not just measuring, but actually evaluating capabilities of the entities that would be part of the total cost of care program. And that those abilities and capabilities to provide high-quality care really need to be in place documented.

The second is we need better approaches to measuring and evaluating unmet social needs, barriers to access, coordination, and equity. And, then finally, I think that all of this will rest on a pretty substantial investment in standardizing health data exchange that will, in the future, support novel digital quality and equity measures that will enable us to overcome some of the limitations of our past measurement approaches. So, I'll stop there, and I thank you for your time. Look forward to discussion.

VICE CHAIR HARDIN: Thank you so much, Eric. Another really important perspective to consider. Finally, we have Brian Bourbeau, who's the Division Director for Practice Health Initiatives with the American Society of Clinical Oncology. I'll note that ASCO submitted a proposal to PTAC in 2020.

Please go ahead, Brian.

MR. BOURBEAU: Thank you very much. We can go to our first slide here, please. So today, I'll be speaking briefly regarding specialty care episodes and approach to nesting or carve out and how ASCO, in its submission and in thinking about specialty care models, have approached that issue.

First though, I want to share some numbers with the group. And this is a study that we did of 25,000 oncologists across GYN ONC, medical oncology radiation, and surgical oncology. And what we did is accessed records within the quality payment program system for those oncologists. What it showed was a great participation amongst the specialty in the Medicare Shared Savings Program. Here, you can see in the Medicare Shared Savings Program, there's some overlap in the numbers. But the total's about 11,000 of the total 25,000 oncologists studied who participated in one track or more of the Medicare Shared Savings Program in 2022, the July snapshot.

And you compare that to OCM[20] participation, which is a little over 3,100

20 Oncology Care Model

oncologists there. And I bring this up because, while OCM and its replacer, the Enhancing Oncology Model, is certainly important in care of cancer patients. There is much greater participation in a multi-specialty, population-based model in MSSP. And so, we have to think about specialty care within those population-based models. Or else a significant number of patients will be missed in quality measurement and care delivery requirements. Next slide, please.

And so, I think oncology and cancer care is a great example of the complexity that we need to think about in whether to carve out, nest, or otherwise coordinate care, between primary care and specialty care here. I worked, it's been six, seven years now, since working in the state of Ohio on Medicaid episodes for oncology. But just for breast cancer, we had three different episodes. We had the biopsy. We had the surgical mastectomy lumpectomy episode, and then we had medical oncology episode.

And each one had its own features of quality measurement and what was required for patient care and how to think about costs for

each one of those. But certainly, you have this complexity diversity here, where we think about surgical and radiation within a defined time period and what could be nested episode there, where overall coordination of care still happens at a primary care level.

But then when you get into medical oncology, you get into this indefinite duration where the patient may be under medical oncology care for months or years. And how do you approach that? Does primary coordination of care rest, predominately, with the primary care physician? Or does it shift to the oncologist to where you think about a carve-out episode there? And, then when we get into survivorship, we need to think about survivorship, in at least cancer care, as a chronic condition and the need for ongoing coordination of care between the specialists and the primary care physician.

So, if we go to the next slide, this is how, and trying to think, at least within my specialty here, of what is nested. What is something appropriate for a nested episode? What is something appropriate for a carve-out episode? And then what do we consider kind of

coordinated care of indefinite duration where a patient has a chronic condition, such as being a cancer survivor, and still needs that ongoing care coordination between the PCP[21] and specialty care physician?

But some of the difference here is, in a nested episode, we may have a defined duration where we can see in radiation oncology and the Radiation Oncology Model that CMMI put forth, a 90-day duration to where you can really put that guardrail around it and say, patient's entering into the episode. Patient's exiting the episode in the defined time.

That is different in something like medical oncology in the Oncology Care Model and other medical oncology models, in Medicaid or private space, where it can vary over time. And the indefinite duration not knowing, as you enter into that carve-out, whether or not it's going to last for months or years, is an important distinction there.

The financial impact of those type of episodes of medical oncology also vary in time. So in the first six months, that patient may have extremely high costs. And, then if

21 Primary care provider

they are curative, eventually in survivorship, that cost is going to come down over time and the intensity of treatment. In other cases, the patient may progress in their disease and have more expense over time. And it is difficult to know that, entering in, and near impossible to know that in some cases entering into that episode.

And, then in the care management area, we think about in a nested episode, in thinking about, for example, radiation episodes I've worked on, the care management and thinking about just kind of overall navigation, coordination of care, certainly within the radiation treatment area, care management resides with radiation oncologists. But in thinking about other specialties and general coordination of care, navigation, addressing health-related social needs, financial navigation, and so on, there's still a lot that resides within primary care because it is a defined duration of time there.

In the medical oncology space, a little different. Medical oncologists employ their own patient navigators, their own financial navigators, social workers that are

addressing nutrition for patients and so on. And so that's why I think of medical oncology as a carve-out episode area because you are really shifting that care management to the specialist.

And, given the, I think a final point in here on data collection, when we're going to talk a little bit about overlapping data collection here, nested episodes, I think, are a great opportunity to reduce overlaps in data collection. If data collection is happening at a population level in primary care, is there a need to duplicate that data collection? I'm thinking even things as simple as social demographic data. Can we reduce those administrative requirements of the nested episode versus a carve-out episode of really thinking about the need for, perhaps, different data, different quality measurements? And, of course, that exists within the specialist providing care under those type of episodes. Next slide, please.

So, some of the consideration for nested episodes. What we see, we've seen overlap within an OCM and the carve-out space with Medicare Shared Savings Program. There

certainly was going to be overlap if radiation oncology had moved forward. And, as part of that, there were duplicate discounts applied here. And so, there's a discount in one area within the population health models. But then also discounts apply to radiation episode payments.

And if you read through the Enhancing Oncology Model, that's the amount of money put forward for next year, there is a great deal of financial reconciliation if you participate in multiple models there. It's really scary to think about. And I, personally, at my former practice, we participated both in Medicare Shared Savings Program and OCM. And one of the pain points was figuring out when a payment was made to the OCM performance, how does that impact payment made under OCM and vice versa there? And so this is something that has to be thought about in trying to nest episodes.

Second is that duplicate, and sometimes conflicting, quality measures where a patient who's already trapped in, for example, patient feedback in and tracked under a population-based model, isn't also tracked for

a specialty model. And these patients are receiving multiple surveys. And you have think about coordination of surveys there. And so sometimes there's these duplicate, conflicting quality measures that we need some administrative simplification.

And I already talked about the data reporting aspect of that, where you have two parties trying to collect some of the same data for patients, and how can we reduce that burden. Next slide, please.

That differed from the carve-out episode area and how we think about medical oncology. I'm going to spend a little bit more time on this because this was our submission to PTAC in the Patient-Centered Oncology Payment Model. And the way we looked at that was our disease episodes really included a shift in the responsible provider.

The medical oncologist was responsible for patient engagement in education. They were responsible for navigating the patient through different aspects of care management, including with other specialists, when they needed to go to other specialists for care, when they needed tests and so on. We had

data collection requirements for the oncologists, including social demographic data and health-related social needs.

And then financial navigation. So we required that the oncologists have financial navigators to review cost of care for patients. We also had the different quality measures and performance scoring. And so, we were looking at different things that a population-based model that a patient could also be under, looks at for quality there. And there was a need for additional disease data that didn't exist within population-based models.

And so what we thought about, quite intensively here, is the care delivery requirements that we were going to put on specialists and the measures, really focusing on handoffs because if you talk about a carve-out and you talk about a shift in responsible provider, it is imperative that you think about that that handoff and communication between primary and specialty care. So next slide, please.

We're going to move past this one, because I think it's just repeating some of the things that we mentioned in care delivery

requirements, and talk about these handoffs. So, some of the care delivery requirements that we put in there and put some measurement to is, first, the handoff between primary and specialty care. What did we expect an oncologist to do when they were provided a patient from a PCP?

And the first one was patient education. Letting them know, what are they going to expect during that handoff? Who is their new care team, how to contact them, responsibilities, and so on? Communication back to the primary care physician on the individualized treatment plan. What is this patient going to receive? And that includes different coordination of care beyond just their primary treatment.

And then ongoing communication as patient style has changed, treatments change, referrals, other specialists. And, then finally, the handoff back to primary care. So, thinking about the survivorship care plan, treatment summaries, here's what the patient has received over their time in this carve-out episode, and what follow-up care is necessary between primary and specialty care. Next

slide, please.

And so, we put different payment phases into this model and really thinking about what is carve-out and then what is, what we call, active monitoring in survivorship, where there is coordinated care. Next slide.

And then, after that patient's kind of primary episode had ended, there is a need here in coordinating care, to really think about, for patients with chronic conditions, how does an ACO really share in care management, coordinate care management fees, based upon the individual patient needs, and really support that ongoing collaboration? Next slide.

And, then lastly, I think it's important, as we think about an ACO-based model and specialty care model, sometimes these participants aren't in the same health system. So, the health system may have a primary care specialist and lead the ACO, where an independent oncology practice or other specialists are in the specialty space. And they have to think about it.

And, really, it's hard to design this within your model, but they have to think

about it, in their relationship, some of the other economics of an accountable care model and how to address things like leakage, where the ACO may be focused on that as a health system, yet, here the specialist is independent of that health system. And next slide, please. So that's the end of my opening remarks. Thank you.

VICE CHAIR HARDIN: Thank you so much, Brian. Very helpful analysis for us to consider. Next, we're going to go and open up the discussion to the Committee. If you have a comment or question, if you could place your name placard on its side, and we'll ensue the discussion. Who would like to go first? Paul.

CHAIR CASALE: Thank you, thank you to all the speakers, very interesting presentations, and very helpful. A question for Dr. Navathe, but others also feel free to provide their view as well. Dr. Navathe, on one of your first slides, you talked about population base, versus specialty care base. And on the specialty care base, you highlighted that there were more options for policy makers to incentivize participation.

And so then I'm just wondering when

you think more broadly about incentives as we're thinking about specialty models within population health models, in your view what are the most promising incentives for encouraging that sort of clinical coordination, and integration between primary care, and specialty care?

DR. NAVATHE: Thanks, Paul, for a great question. So, I just want to make sure I'm understanding the question exactly. So, you're saying when we focus within population health-based models, population-based models, what are the most effective incentives, or reflections on incentives to coordinate between primary care and specialty care?

CHAIR CASALE: Yeah, and I guess more broadly, how to engage those specialists within -- if you think about an ACO, because you presented a lot of data around the ACO, and especially sort of within the bundles within ACOs, and being more effective. In my experience, I've found it's still very difficult to engage specialists in general within these ACOs.

And I know you've thought about this a lot, I mean within the -- if you have bundles

within the ACO, or you just have specialists within the ACO, how best to incentivize that? Whether it's around care coordination, or managing patients whether they're in a bundle, or just part of the ACO?

DR. NAVATHE: Sure, thank you for the clarification. I think it's a fantastic question. As you're highlighting, outside of this notion of deliberate overlap between a specialty model and an ACO, I think we have not yet seen systematic coordination between specialists, and primary care at the scale perhaps that we want to.

And so, to some extent, I think it's a question of maturity of ACO, using ACO as an example here. So, I think there's advocates, and ACOs, and I strongly consider myself to be one as well, who would say if you think about the hierarchy if you will, of low-hanging, versus high-hanging fruit, most of the lower-hanging fruit approaches, and opportunities for ACOs do reside in the primary care infrastructures area.

And so, I think it's not surprising when we have a huge system that's hard to shift directions on, and so most ACOs, most

organizations have focused on primary care as the quote lower-hanging fruit if you will, and invested in that infrastructure. I think that being said, if we take a step back, and we look at some of the more sophisticated, more mature types of organizations that have been exposed things, or risks before its ACO participation, participated in some of the more financially stringent ACO type models.

They have made some progress, they have had some success in a variety of the specialty care areas, certainly, for example, in reducing hospitalizations as I mentioned, but also in the post-acute care space. And there is some emergency evidence in the oncology area that overlaps between these models, and ACOs in general, sophisticated ACOs may be better in managing complex patients.

So, I think the evidence is to date, there's not ACO models at large that generate those types of effects, but I think that the sophisticated ones most likely are. That kind of brings us to your actual question, so I kind of reviewed the evidence really quick. Your actual question is so what works, right? And I think probably the simplest answer I could give

is very explicit concrete incentives that are directed to the specialist.

Because if we take the general ACO incentives, they're not directed necessarily to specialists, in fact we're depending on the middle layer of the ACO organizational structure to then translate those incentives down. And as I mentioned, the preponderance, the large majority of those incentives are actually not sitting directly within a particular service line.

And I think that's our hypothesized reason for why when you have specialty-based models that are sitting alongside the population-based models, we get this synergistic effect. Because now the cardiologist like yourself, Dr. Casale, the oncologist, whoever it is, the orthopedic surgeon, they're engaged in practice transformation.

They're reviewing their data, they're thinking about what the most appropriate post-acute care setting is, and perhaps they're actually coordinating it. There is some infrastructure overlap to some extent that I think we need to think through.

So, in general, ACOs have invested a lot in ambulatory infrastructure, they tend to do great with post-discharge follow-up visits, for example, in the next seven days.

And they tend to do that with a PCP, or an NP[22], or somebody like that. Specialty oriented models have tended to rely much more on home health workers, for example, home health aides, home health nurses, and that is duplicative to some extent. But I think the simplest answer again, just to restate it, is having an explicit approach to specialist incentives within a population health construct is imperative.

We can't just depend, if you will, on the total cost of care umbrella incentive from being translated down to fairly concentrated focused specialties where we might not see that.

CHAIR CASALE: Thank you very much. I don't know if any of the other presenters, again, either from the quality performance lens, or others, how to best incentivize.

DR. SCHNEIDER: Thank you, Dr. Casale. I'll jump in, because I think one of

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the things we've learned out of the performance measurement initiatives over the last 20 years is that creating that joint accountability around patient-focused measures, patient-focused outcomes can produce, or make possible the culture change. Which is around how do we, as a team, provide the best care, and the best outcomes for particular patients with particular conditions?

Where it may fall short is that we have patients with multi-morbidity, patients with multiple complex conditions, and then the measurement enterprise gets to be challenging. But I'll say in my own primary care practice experience, we used to operate even within the primary care practice in a fairly siloed way.

It was when diabetes performance measurement came into the practice that we -- and then financial incentives followed on those measures, that we did the work of reorganizing the care to make it more team-based. And the Patient-Centered Medical Home is sort of the next extension of that, and there is a progression that's needed.

But I think performance measurement, and the sort of explicit accountability

requirements that Dr. Navathe mentioned can be very helpful in that regard. One example would be the data exchange example. We don't have great incentives in the system for providers from different parts of the system to exchange data with one another. That could be helpful.

I think that was highlighted by Mr. Bourbeau as an opportunity. I think the more we make it sort of a condition of participation, that the system exchanges, that participants exchange data, so it would reduce some of that redundancy in the system that those sorts of quality standards, or expectations can be helpful.

MR. BOURBEAU: Yeah, I just wanted to bring up, I think Dr. Navathe correctly said that the financials often get lost within the ACO, and you've got that, it's a common feature in a population-based model to perhaps adjust financially based upon patient risk. So, if you have two examples, one example is you adjust care management payments for an ACO that has higher-risk patients.

And you say okay, now you're going to get 10 percent more than an ACO that has less-risk patients. Often those financials get

lost. If rather that difference in care management payment, and what you expect from that service follows the patient, and you're saying a high-risk patient with multiple conditions is going to receive $200 care management versus $15, it is much easier.

You've laid it out for the ACO to then coordinate that care amongst multiple providers, and enough dollars to go around there in incentivizing coordination.

DR. FRIEDBERG: I'll just say briefly, we see some inexplicable things sometimes within provider organizations about how the specialists are paid, given how we pay the organization. And that has to have one of three explanations. First, either we don't have the contract right, we don't have the incentive strong enough.

We don't have the right kind of business case on an accrual basis for the organization to make an investment, and really changes how it incentivizes those specialists financially, or otherwise. Second explanation is a cash accounting issue, and I think this probably is an under-attended issue in the construction of Alternative Payment Models.

If you're paying fee-for-service along the way with a settlement of a shared savings payment that might come two or three years later, the organization has a cost of cash. They have to deal with a float; that's a real problem for many organizations. And for that reason, they end up turning fee-for-service for some service lines just to maintain the cash flows, and sometimes it's a specialty one.

Which works against long-term interests, our members' interests, or accounts interests, everybody's interests in the long term. But the short-term thing has to be solved. There's lots of ways of doing that, get off of fee-for-service to the extent you can, you give advances against settlements, anything like that could be explored.

The third is the possibility the organization just doesn't really understand the incentives that are put in front of them. It's very easy to construct complicated incentives. Organizations may need help understanding when they have an internal payment structure that really goes against their long-term interests.

VICE CHAIR HARDIN: Very helpful.

Larry?

DR. KOSINSKI: Very stimulating presentations this morning. I'd like to direct my question to Mark Friedberg. You are the sole representative from a health plan in this panel, and I was impressed with the degree of change you are building inside your ACO models with patient-reported outcome measures, and social determinants. And it begs the question to me, how prescriptive are you getting within your ACO contracts?

Are you trying to construct skeletal infrastructures inside these ACOs? Where do you draw a line between what you're trying to accomplish from the health plan point of view versus flexibility you allow to the designers of the ACO itself?

DR. FRIEDBERG: Yeah, it's a great question. We are pretty agnostic as to how one of the agency groups or the ACOs chooses to fulfill the goals of the contract. So, we want to make very clear about what kind of activity we're encouraging, and what the outcome measures will be that will result in financial -- favorable settlements for the organizations.

But we don't get into here's how you

should pay your physicians, here's what you should invest in necessarily, with the exception of those grants. When those grants went out, groups had to apply, and IHI ended up making the awards ultimately. But there, I would say a different filter was applied, because it was start-up money without attachment to outcomes.

But once it's attached to outcomes, by the way, the amount of money on pay for equity is going to dwarf that 25 million on a long-term basis for these groups. We can be, I think pretty sanguine about how the groups choose to solve problems internally, and make investments internally because they have to work in order for them to have a business case to make those investments.

So, there won't be a whole lot of like, what I would call equity theater going on within these organizations. That would not prove out on the kind of measures that will give them a payout from us. Another coordination problem we have is we are only one payer, and we are the largest commercial payer in the state. But we don't account on our own for the majority of almost anybody's panel.

So, we're trying to coordinate as best we can, understanding we're the first on pay for equity in our market with everybody else. But what that means is just sharing our designs with other payers in the hope that when they stand up their own pay for equity programs, first that they'll do it. Hopefully what we've done will help them stand up those programs just in terms of how it could be constructed.

But if it isn't identical to us, at least it should rhyme, so that the kinds of investments that an ACO might make to get a payout from us will also serve their contracts with other payers, including Mass Health, our Medicaid program.

VICE CHAIR HARDIN: Look forward to hearing more about that work. Chinni.

DR. PULLURU: Thank you everyone for your presentations. So, wanted to direct this question to Dr. Schneider, and then Dr. Friedberg, as well as everyone else. When you're thinking about pay for equity, and collecting data, how are you approaching the variability in data, and ensuring that there's consistency in collection, and then syndication

afterwards?

DR. SCHNEIDER: Yeah, great, thank you for that excellent question. It's actually Dr. Friedberg's organization and NCQA are collaborating on exactly that issue, how to improve our race, ethnicity language data. I'll just say from the NCQA perspective, the other effort that is under way is advancing social needs screening, and intervention measure.

Which will also present some opportunities around standardizing the collection of social needs, or social determinants data, as well as I think race, ethnicity data. There's a strong need to standardize, and I think the FHIR enablement of the data infrastructure that allows this exchange, and the other tools that people are using to collect the data can be -- will advance this, and make it more consistent, and more actionable.

But I should turn it to Mark, because he's done some really groundbreaking work in this area.

DR. FRIEDBERG: Yeah, it's a fantastic question, and we couldn't do anything

on pay for equity, or even our own external report without enough data on race and ethnicity. And Dr. Schneider's point about small sample sizes really complicated our reliability calculations for pay for equity. And we'll have a whole -- we have like 40-page methods appendix for our contract about how that's all done, and we'll have some publications about that, so stay tuned.

Also, a presentation at the Academy Health Dissemination and Innovation Conference I believe in December, so that'll be a place where we're presenting some of that in more detail. We have a PhD biostatistician that does nothing but this for us right now, Gabby Silva, and she's written some great papers on this exact topic. Bottom line is there's nowhere -- it's very hard to start on this without having a substantial amount of gold standard data that you've collected yourself directly.

And so, we've done that with our members over the past almost two years now. We have about 20 percent of our members have shared self-reported race and ethnicity data with us. That's more than enough to evaluate

the accuracy of every other data source we receive. Whether that's imputed data, vended data, which we don't use by the way, imputation outperforms every vendor we've tested.

Provider source data, which varies by provider in terms of completeness and accuracy, as well as the data we get from accounts, and data from state data basis, which is not gold standard by the way, that we've found. And all of that kind of gets modeled together in a way that we can construct a payment incentive that accounts for measurement error.

At the population level, it turns out imputed data work pretty well. So, I'll give you an example. State-wide we have an imputed Black, white, inequity, and hypertension control of around 8.2 percentage points. And if we -- sorry, that's on only the members who have given us gold standard data, so that's not a random sample, but that's what we get using gold standard data only.

If we then pretend we don't have that gold standard data, and use fully imputed data for that same exact population, that 8.2 percentage points turns out to be something

closer to 7.8 percentage points. So it's not huge, it's not way off at the population level, and I would encourage folks to proceed with imputed data.

VICE CHAIR HARDIN: Thank you. Bruce.

MR. STEINWALD: Thank you all for your presentations. There has been considerable discussion within this Committee in the context of integrating specialists into models in ACOs about nesting, nesting specialty care within a large organization. Brian, your presentation to me, and I'm not a clinician, seemed to suggest that the choice between nesting and carve-outs is largely based on clinical criteria as opposed to others, economic, or any others.

So, my questions for all of you, is that the right way to look at it? Or are there opportunities for nestling -- nesting, sorry, not nestling. Nestling is good too, but I meant to say nesting specialty care within large organizations, and are they really constrained by clinical considerations, or are there more opportunities to accomplish that?

DR. NAVATHE: So, this is Amol, I

can start here. I think it's important that we keep in mind to some extent what is the system of the future that we would like to build? And I think we look at the models that have kind of served as the flagship models, or the most representative models that provide great cost-efficient population health management type care, they tend not to be models that are highly fragmented.

In that they're carved into a bunch of different episodes or carved into a bunch of different segments. They tend to be models where there is still a population health model that's kind of governing. There is a fixed budget to some extent, and a direct incentive for providing high-quality care within that budget. And then there are mechanisms to engage specialists more effectively in a variety of different ways.

And we can talk about this in the context of integrated delivery systems, like Geisinger, or Intermountain, Kaiser, certain Medicare Advantage plans like Care More, and others that have demonstrated higher outcomes from a patient perspective. And so, I think we should be thoughtful and careful about creating

a heavily carved out set of models.

I think it could make sense in the traditional step. But we should be thinking in the long run of we're moving toward a model. And I think Liz Fowler and others have spoken about this, where the goal is to have a model where every beneficiary is aligned, or every patient is aligned to some sort of accountability gauged model, and over time, to a population-based model.

And so, I think we should be again, thoughtful and careful about this, and that has implications, Bruce, for your question. Because I think if we're thinking about population health model constructs to some extent as the destination of where we're headed toward, then while it made clinical sense to some extent, there is focused accountability, that doesn't mean that we want to fracture that, or separate that.

Even if the clinical considerations might lead us in that direction relative to economic or geographic ones. We might in fact want to think about the economic, geographic, and other care patterns, and community-based structures as ways to create cohesion where we

otherwise may not have cohesion purely viewing things from a claims data, utilization-based clinical lens.

And so, I think we should be very careful and thoughtful about these mechanisms, and obviously, certainly welcome Brian's thoughts as well here. Thanks.

MR. BOURBEAU: Yeah, so I would go back to the numbers I shared on participation, and share another stat with you here. So, of oncologists who qualified as an Advanced APM participant in the Medicare program, and received an APM bonus, or will receive it in two years now, 70 percent of them did so because they were a part of an ACO.

And I think it's great that they're a part of an ACO, but I think it's also a challenging question to say are we getting the money's worth out of that? Are those ACOs making investment through receipt of the APM bonuses on oncology care within oncology care? And if they're not, how do we see improvement in care, and quality for the patients?

And so, if that is carving out, if that's really preferring more within participate, and specialty care models that

have the quality measurements, and have the appropriate care redesign that we want to see, I think something needs to change. Whether or not you nest new requirements within your ACO for patients of certain conditions, or you do carve-outs and make those requirements.

One way or another we really need our investments, whether they be the APM bonus or other incentives, to go to the patients who need it.

VICE CHAIR HARDIN: Thank you. I'm going to turn it next to Josh.

DR. LIAO: Great. Amol, Mark, Eric, and Brian, thank you for really thoughtful presentations. My question I think is probably directed primarily to Brian and Amol, but welcome Mark and Eric, your thoughts to the extent it has implications for data gathering, and capacity building.

But as we think about primary care, and subspecialty care integration, two things surface for me. The first is that I think subspecialists have important roles not just in procedures, but also in conditions. And so how can we think about condition versus episode-based, condition versus procedure-based

episodes? And the second is we talk about providers as a group.

But as we all know, it's not a monolithic group, and so as I think about how participants in these population-based models might interact with specialists, and whether it's nesting, or carve-outs, how do we think about organization types? So, hospitals, or just physician groups, or other types of organizations.

So, I wondered if you could comment on kind of both of those. Episodes align to conditions versus procedures, and then organization type, and how that might affect how you think about integration.

MR. BOURBEAU: Sure, I'll take the first one. The difficulty is when you talk about a given specialist, and if they are part of different organizations. So, an independent practice group, it's very difficult to do it on condition base, because the patients flow to certain specialists at different times, right? And so not everything will go to the surgeon, go to the rad onc, go to the med onc in that order.

And so I attempted to work with a

large employer on this particular issue, and it was so difficult to try to do navigation at a specialist level that captured all those patient scenarios of where they go. So, then you have to think about it proactively, whether you're an ACO, or whether you're an employer wishing to do some type of navigation program, and try to catch patients upon diagnosis, or even sometimes that's too late, in oncology, on prospective diagnosis after screening.

And start them in their navigation process. Or else patients get lost, and they go outside your system, and so on, and you don't know all the care that they're receiving.

DR. NAVATHE: So, I can add a couple points here. I think to some extent in our work, and I think in CMS's contractor-based work as well, I think there's been a partitioning of the way we think about episodes as medical versus surgical, or condition versus procedural. And to some extent, I think that makes sense, because patients with conditions like congestive heart failure, for example, tend to be a lot frailer, and tend to be a lot sicker than patients who are going through elective orthopedic conditions.

On the other hand, I think to some extent, we're missing the most important point, which is, is the care in fact episodic, or not? Or is it part of a cyclical chronic disease management type of profile? When we look at patients with congestive heart failure, guess what, it turns out that they're not just admitted for congestive heart failure a lot.

They're admitted for pneumonia, they're admitted for COPD, they're admitted for heart attacks, they're admitted for sepsis, they're just admitted a lot, right? And so in fact, drawing lines in the sand to say this is a congestive heart failure episode versus a pneumonia episode is really hard for these patients. And I would contend in fact, for care, it's essentially arbitrary, because of the cyclicality of the way the care is happening.

So, I think to some extent, the way we're categorizing things is sort of missing the most important -- we're sort of missing the forest from the trees here a little bit. We should be instead looking very carefully at what the practice patterns are, and saying what patterns truly have this episodic nature where

you have a sort of baseline level of utilization, and spending that truly spikes, and then almost returns back to that baseline?

That's a situation where yes, it makes sense to really think about some sort of episodic model, and specialty oriented model, especially if that spike being relayed is heavily managed, or concentrated within a particular specialty. So, that means by the way that there will be some medical consent, perhaps an acute myocardial infarction just to throw it out there, and I don't know this empirically to be true, but I could speculate.

Maybe that's the type of condition, medical condition that fits an episodic model, and there might be other procedural conditions, some orthopedic conditions that require a lot more ongoing procedural care that might fit into a condition-based model quote unquote, rather than into an episodic model.

So, I think we should be thinking about it from a practice pattern perspective rather than trying to artificially apply some sort of clinical construct onto it where it doesn't necessarily follow the right pattern. Your second question, which was around what

about the organizational entity, and to some extent I'm going to paraphrase your question, Josh, as does it matter?

And I think in fact it matters a lot. And the reason it matters a lot is because the types of organizations, and therefore their approaches to practice transformation, and change management if you will, differs. If you have a hospital-based group that is accountable, they still have the four walls of the hospital, and a lot of the approaches are going to center around the hospital as the locus of activity.

Whereas if you have an ambulatory base, a conditional multi-specialty group, their approach is going to be less facility centric in some sense, and you're going to get different types of organizational investment. So, I think we do need to think about that. That's one axis to really think about. I think the other dimension that we should be mindful of here is if we think about total cost of care accountability in the context of a population-based model.

It takes a lot of lives, I think Mark has been talking about this in the context

of quality measurement, and reliability. It takes a lot of lives to get reliable measures, and the ability to actually turn around, and say yes, we can decipher signal from noise. That also means organizationally, you need large organizations that have bigger populations.

And one of the benefits to some extent of thinking about engaging specialists, and sort them sort of aligned, or coordinated episodic-based approach, or specialty-based approach, is that because you're dealing with a spike in your organization perhaps, and therefore a lot of spending, we might be able to reduce that sample size if you will, and then get a more targeted financial incentive, and quality measurement approach.

That actually meets the reliability standards that Mark, and his team at BCBS[23] Massachusetts would feel comfortable with, and say you know what, this makes sense. So, I think there are some cuts and takes there in terms of thinking about organizational type, as well as the implication for how we might actually translate an incentive down to get

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more focused care we design where we might not be getting it fully today.

VICE CHAIR HARDIN: Thank you so much. Mark, and Eric I'm sure you have more to say, but we are actually at time. We want to thank you all very much for this very rich dialogue. It will be very informative to our discussion later this afternoon. Now we'll be taking a short break, and we'll be returning at 10:50. Thank you all so much for joining us.

(Whereupon, the above-entitled matter went off the record at 10:43 a.m. and resumed at 10:50 a.m.)

*** Listening Session 4: Payment Considerations and Financial Incentives Related to PB-TCOC Models**

CHAIR CASALE: So I'm excited to kick off our afternoon panel. At this time, I ask our panelists to go ahead and turn on their video if you haven't already. To further and foremost about payment considerations and financial incentives related to population-based models, we've invited a variety of esteemed experts from across the country.

After all four have presented, our Committee members will have time then for

questions. The full biographies of our panelists can be found in the PTAC website, along with other materials for today's meeting. So I'll briefly introduce our guests and their current organizations. So presenting first, we have Dr. Mark McClellan, the Robert J. Margolis Professor of Business, Medicine, and Policy and the founding director of the Duke-Margolis Center for Health Policy. Welcome, Mark, and please begin.

DR. McCLELLAN: Great. Thanks very much, Paul. It's great to be with you and all of PTAC. I'd like to give a special thanks to PTAC. Since the beginning of this organization, you all have worked really hard to try to make payment reform and related supports for transforming health care work for every diverse type of physician.

I found the work very valuable. And Paul, a special thanks. I'll be talking about some of the topics that we've discussed around especially payment reform and especially engagement in comprehensive care models today. So just moving quickly, you all have seen this next slide, the CMS comprehensive vision which was just referenced in the last session.

I'm sure it has been over the last couple of days to get everyone on Medicare, almost everyone on Medicaid, really try to get our entire health care system moved towards comprehensive relationships that are founded on a strong, coordinated, accountable primary care foundation. There's been a lot of work in payment reforms done to address that.

I want to focus on the next slide on some extensions to make these comprehensive models really work. Three areas where our center at Duke has been focused, number one is on multi-payer alignment. And there's some references down there at the bottom to take steps to increase directional alignment across multiple payers towards common goals, to reduce the burden of adopting effective alternative models, and to increase the critical mass of support for them.

I'd refer people to the Health Care Payment Learning Action Network, a public-private collaboration at CMS, and we and many other organizations support around the country to advance those goals. Glad to talk more about that. Second is to make these models work for addressing equity and work for

underserved populations.

Remember most of the financing for those populations comes not from Medicare but from Medicaid, from HRSA[24], from other sources. So there are steps that CMS can take but also a need to integrate financial alignment steps around the goals of comprehensive care from a range of other payers. There are a lot of organizations in that space that are doing some things differently and steps that we can take to help them.

And then what I want to talk about today, which came up a little bit in the last panel, building off on the excellent work on evaluating payment reforms to date and especially payment space is how to engage specialists more effectively and comprehensively in being part of these models. The next slide highlights that we've had some limitations so far. Even though ACOs are 30 percent plus of the traditional Medicare population, probably in some form a larger share of Medicare Advantage, they've grown a lot.

We've seen limited impacts with many

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specialists not even knowing or really being well supported in participating in these comprehensive care models and some limited changes in operations. I'll come back to this and glad to discuss it further in some of the evidence we've seen on hospital-based ACOs. In fact, many physicians, especially ACOs, are taking their first steps into engaging specialists by trying to do more care coordination themselves with that expanded advanced primary care payment and looking at data and seeing if they can selectively refer.

That's not really a comprehensive, coordinated effort engaging specialists. So there is this misperception that ACOs and comprehensive care has so far mainly been about primary care providers, even though there are some exceptions, specialists managing some patients and even some conditions and some longitudinal specialty care models like Nancy will talk about oncology a little bit later. We're seeing some steps in this direction, but a long way to go.

Next slide is just a reminder this is important. So even if we're expecting shared savings and bigger primary care payments

to account for an expanded primary care role in this effort, the fact is most of the money and most of the care that people get when they have a serious condition involves a specialist. And that isn't going to change anytime soon.

So the more that we can do to engage specialist care directly and align those finances too, the faster we're going to get to those comprehensive year goals for CMS. And this is really important as the next slide shows. As you think about care from the patients' perspective, specialists are important. And CMS has recognized this.

They've released an initial specialty care integration strategy earlier this year. They're planning, I think, to add to that. They've highlighted the importance of specialist engagement to support comprehensive care coordination to advance health equity since a lot of the equity issues exist where there's not good comprehensive specialty care engagement, good access to comprehensive care, and a lot of steps that CMS is in process of taking now.

So PTAC focus on this topic right now is particularly timely. Next slide. And I

would also just also highlight if you think about care from the person perspective, comprehensive care involves advanced primary care. But increasingly as you go through your care journey, having more advanced conditions, whether it's cardiovascular, musculoskeletal, you name it, involves more specialty engagement as well.

Part of it's for the specialty care needed. Part of it's for overall coordination. So some of this is acute episodes where episode payments have focused, for major procedures and hospitalizations with complications.

But a lot of specialist involvement involves collaboration with primary care and other providers outside of those particular episodes where we've seen some impacts from a set of payment reforms so far. But that's not where most of health care--and most specialty care--is actually delivered and can influence. Next slide.

Just to highlight an example of this, in some of our papers, we go into this in more detail. This is work on musculoskeletal conditions from a longitudinal patient journey perspective that we've done with Kevin Bozic,

colleagues at Dell Medical, and others. Just highlighting how many opportunities there are compared to current practice for an early triage engagement, maybe involving a combination of a specially trained physical therapist and orthopedic coordination to evaluate the best path forward for a particular patient based on their orthopedic findings, their pain, and especially tracking their functional status over time, something that's not done in routine care.

In these care models, Dell and in a pilot at Duke and other places have found, we can substantially reduce these admissions for major procedures; get better functional outcomes for patients, which is what really matters for this condition; and lower costs at the same time. But it requires a significant redirection of resources and redirection of engagement of the specialist, as well as primary care, to set up these and sustain these team-based care models. Hard to do with shared savings or primary care focus ACO model alone. Next slide.

This kind of finding I think exists for other common conditions. Paul and I have

talked a lot about cardiova -- (audio interference)-- care. Cancer, we've already got as we'll hear about later, the Oncology Care Model and evidence, and would think about that even from a more longitudinal perspective like oncologist engagement and efficient pathways to diagnose a patient, get them into timely and appropriate initial treatment.

And then oncologist engagement and coordination after a patient survives that initial episode, which fortunately a vast majority of patients are doing today. We have many, many, many more cancer survivors who need chronic coordinated management to prevent recurrence and provide ongoing confidence in their condition too. Next slide. So these are important.

And if you look at spending, this is from work by Francois de Brantes and some of our colleagues previously at Signify. In these specialty conditions, some of that spending occurs in episodes. But as I just was illustrating with musculoskeletal and some of these other examples, if we could direct some of the resources that go into those costly complications, those specialty procedures, et

cetera, into better longitudinal management, better experience across that care pathway with specialists actively engaged, you can see by specialty just how much resources could be redirected and potentially spent better if we can avoid some of the acute procedures, acute admissions with complications, other specialty services that reflect complications, not effective disease intervention and ongoing patient management. Next slide.

So we've developed some proposals for nesting condition-based payment models within the ACO program. This is not a separate and independent effort. The idea is building off the acute episodes with a specialty kind of per member, per month payment around it for the organizations that are engaged in comprehensive care that want to work more directly with specialists and create a clearer obvious path for sustaining some of these models that require new care pathways, different approaches to team management, et cetera, for specialty care.

Some MA[25] plans are already doing

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this. They've gone to PMPM[26] condition-based payments to the specialist to coordinate with. This only works well within a total cost of care model where you got primary care groups or a health system already engaged. Or they've moved to just a flat -- not per patient payment-- but just a flat population-based payment for providing this care that creates new flexibility.

And you can combine that with accountability that really engages specialists much more than in a model directed to primary care providers. So how did you get there? Just a few last quick points here on our next slide.

First of all, CMS and other payers have data now that can be used to describe longitudinal condition experience for patients. Not just acute episode or procedure but experience over time that patients are having (audio interferences) procedures or admissions. You can work with a specialist on identifying ways in which outcomes could be improved and maybe utilization could be modified if not spending, savings, with data that's available

26 Per member per month

now for organizations that are trying to implement these models and everybody else.

Second, you could start with a condition-based model, offer a few options. Maybe one is a small (audio interference) and that too can make a big difference. Third, the bundled payment programs, this is a little bit beyond my scope today, has shown some important effects that's (audio interference) like to see a path towards more mandatory adoption of those acute episode payments but nest that within these condition-based models.

And fourth, making this a more integral part of ACOs we think can happen in two ways. First, for the physician-led ACOs especially, these condition-based payments would be voluntary. CMS could set up a model for how they could be implemented to substantially reduce the cost of specialists who want to play more of an active, coordinated role in longitudinal patient management to coordinate with the primary care groups.

And they can renegotiate just how big to make that payment. The primary care group thinks that they can do more of this specialty type management. They could take on

more of that role as well. But we need a clearer certain path, an easier path for those negotiations and that coordination to occur.

Second, for hospital-based models, we think perhaps these approaches should be mandatory. I don't have time to go into it here. But for many hospitals, the margins for the procedure-based elective admissions are higher than they are for medical, creating an opportunity to do okay as a hospital-based ACO by reducing your medical admissions, doing some population-based management but increasing the number of specialty procedures performed, some of these elective procedures.

In contrast, if there was a mandatory shift of some of those resources into specialty population management, it changes the financial dynamics for a hospital-based ACO in a way that would make it much more sustainable to implement these team-based approaches to longitudinal specialty management. So Paul, others, thanks very much for the time today. And I look forward to the rest of the discussion.

CHAIR CASALE: Thank, Mark. A very helpful presentation. We are going to save all

questions from the Committee until the end of all presentations. So next, we're going to hear a presentation from Dr. Joe Francis, the executive director of analytics and performance integration in the Office of Quality and Patient Safety at the Veterans Health Administration. Please go ahead.

DR. FRANCIS: Thank you, Paul. And I think I'm going to amplify some of the remarks that Mark just had about what you can do within a global payment environment. If I could have the first slide, please.

So to give you a sense of context because as Amol said in the prior session, the type of delivery system really matters. Here's just a brief overview of who we are and the Veterans Health Administration. We are arguably the largest integrated health care system that covers both the entire United States, as well as many places overseas, Guam, the Philippines.

We even have clinics that serve veterans in Europe. And we have a telehealth reach that's global. We have four statutory missions, which impact how we perform and the efficiency. In addition to care delivery, we

provide education for the majority of the U.S. health care trainees.

That's medical students, as well as nursing, Allied Health, physical therapy, and many others. We have a research mission, and we have a statutorily defined emergency support mission. We provided assistance to thousands of non-veterans during the COVID pandemic.

We provided millions of articles of personal protective equipment, supported vaccination and testing drives all across the country. These are important contextual factors and probably account for a little bit of additional inefficiency in our system. We call that resilience and flexibility so that you can respond when something unexpected happens. Next slide.

Our health care system as I mentioned is national in scope. It is divided into 18 integrated service networks, each with their own administrative and clinical leadership. We have 1,300 sites of care, and that's not counting our telehealth and our mobile clinics, which again allow us to be very flexible across the country. Next slide, please.

Our characteristics, I'll just say, a global budget, which is set annually by Congress. But it's a biannual system so that we get two years of funding. So we aren't necessarily constrained by continuing resolutions.

And we can do a little bit of longer-range planning than simply for 12 months. Our providers are salaried. And most of their pay is determined by base pay which is set by government, market pay which is a formula based on specifically specialties, and a very small proportion, and we're talking maybe five percent on average, is performance-related pay.

And that's typically related to quantitative performance metrics around quality, as well as other things that are probably more locally driven like service on committees, responsiveness to veteran needs, and so on and so forth. Our system is platformed in primary care. And unlike many private health care systems, we have direct attribution of performance to the primary care team that the veteran is assigned to.

So we don't use formulas. We look

at the folks that are basically standing up and taking account for that veteran. Other things that we work with are a national prescription drug formulary, and we have a growing presence in the community for becoming both a payer, as well as a provider and a lot of care coordination by our own physicians, nurses, and other clinicians as part of that piece. Let's go to the next slide.

It's sort of my last background slide to help you understand what our global payment looks like. We allocate our annual budget to our facilities based on a risk-adjusted capitation model, 90 percent of which is driven by clinical diagnoses and care practices. And we have additional adjustments for geographic differences in pay for the amount of research and education that goes on.

Think of this as kind of like the adjustments that Medicare has for teaching and research. And of course, we do have kind of a system to account for high-outlier, high-cost patients. That accounts for less than one percent of our budget allocation.

We tweak this model every year because fairness requires us to make these

adjustments. And we're looking against both system performance on efficiency and also our quality performance. So let's go to the next slide to talk about our availability of data.

For a lot of practices in the community, you're relying on data that may be aged six, 12 months, sometimes even as long as 18 to 36 months. Our performance feedback to our provider teams is near real-time. I say it's near real-time because I pulled this report on August 22nd.

And you can see in the fine print that it was refreshed on August 21st. So we do allow some processing times. It's updated roughly on a weekly basis. And for primary care, this is adequate.

But our performance reports not just provide the practitioners and teams with how they are doing currently but also anticipating. What are the opportunities for the veterans that are scheduled to come to clinic in the coming week? And what gaps may exist?

You can click on these links, and you can pull up actual veteran identifiers and see what interventions like a flu shot or a Pneumovax might be missing. And so we find

that that's extremely important because simply providing performance feedback without the context to make it better on the individual patient level is basically a form of torture. And it's contributing to burnout across physicians in this nation.

Let's go now to talk about efficiency. I have a slide, though I'm not going to discuss how we monitor efficiency. We use a multi-variable regression analysis called stochastic frontier analysis.

I think many of you on this call are familiar with that. For those that aren't, that additional slide and the references in this deck will help you. But even with our system with strong incentives to efficiency and a variety of other mechanisms to look at the performance, we have variation.

Now some of this is kind of interesting when you get down into the local contextual level. So you see, for instance, higher inefficiency -- lower inefficiency in the Northeast and the upper Midwest, that tends to be a little bit different than the Medicare picture on utilization. And that is largely reflecting population shifts where veterans

both from attrition, as well as active out-migration, are moving to the Sun Belt.

North Carolina, for instance, recently passed legislation that exempts veterans from income tax. And we are seeing a huge movement of veterans to that state. And that's implications for workload.

But our payment systems have to catch up because our risk-adjusted capitation is based on performance a couple of years prior to the present. And so you can see now if you are relatively under-resourced, you are forced to become more efficient. If you are over-resourced, those shifts don't take place immediately, and so that's a big factor.

The other factor we see are practice patterns that are developed through private sector contact. Our clinicians do not work in a vacuum. They come out of medical schools that often have local practice cultures.

They often spend time on both sides of the street. So they may have a faculty appointment or a private practice, and they spend a certain number of half days in a VA clinic. And so capturing all of that and anticipating it is extremely difficult. And it

requires a very granular analysis with performance which this level of analysis doesn't give us.

So let me move on to something else that we do with this stochastic frontier analytic approach. We are able to see some things. First of all, these boxes represent individual VA facilities where we've plotted efficiency against quality, as well as patient experience.

And what you'll see by the way is in general, the more efficient sites are actually doing better on quality and experience. So we don’t think there is a trade-off, a negative trade-off between being efficient and providing high quality of care. Our best practices are doing well both on the quality end and on the efficiency end.

And let's go to another slide. This is just a conceptual diagram. We can take out our high-level analysis and parse it down to the components that are driving cost efficiency. And I just want to highlight a few things for you.

In the 11:00 and the 12:00 o'clock position on this chart, what we see are

potentially unnecessary days in the hospital. And ambulatory care sensitive admissions still being areas of opportunity. So even in a system grounded in primary care, we have room to improve on the effectiveness of primary care.

Many of the excess days of care, by the way, are also driven by things like the challenge in post-acute care. That's something that we don't have sufficient capacity for. And it's a problem for the private sector as well.

The other big opportunity, which is roughly at the 6:30 position on this clock, is community care. As we grow our referrals to the community and we have practitioners that are not aligned with our practice culture and we lose direct contact with the veteran, fragmentation becomes a big problem. So quite honestly, we are looking to the proposals that CMS is discussing, that Mark just discussed to help us in our new hat role as a payer of care.

And this is now driving billions of dollars of our total health care budget. Finally, I'll leave you with the next slide, which is the challenge of low-value care. So

we just walked you through some high-level regional differences and efficiency.

But getting down to a more granular level, we partner with our health services researchers -- Tom Radomski is at the University of Pennsylvania and the Philadelphia VA and a colleague of Amol's -- to look at testing. And you would think that in our environment, there is not an incentive to over-test. And in fact, we probably have less low-value testing like PSA screening in older adults or non-specific back pain imaging than Medicare.

But it's only a little bit less, and we still see differences. Some of this is accounted for by veterans that are referred to a community provider. But we still have work to do internally with individual physician practice teams. And work is ongoing right now to develop specific performance metrics to give people real-time feedback on these types of low-value care.

And I think that this is probably one of the biggest frontiers for quality measurement in the coming years. And I think that's probably our last slide. Just again,

the references and some background for your reading pleasure later. Back to you, Paul.

CHAIR CASALE: Great. Thank you, Joe. Next, we have Kate Freeman who is the manager of market transformation at American Academy of Family Physicians. Please go ahead, Kate.

MS. FREEMAN: Thank you. And thank you all for inviting me to be here with such a powerhouse panel. I'm very genuinely flattered to be here and speak to kind of the thinking of the Academy. Next slide, please.

So to set the stage, I wanted to just kind of outline who we are as an organization. We're the National Association of Family Physicians which represents close to 130,000 family physicians, students, and residents. And we're the largest single specialty medical society in the United States, and we're the only one devoted solely to primary care.

Our membership obviously spans diverse ages, ethnicities, races, practice types, geographies. And specifically within that, we also monitor kind of the distribution of the employment status of our members. So

over 70 percent of our members are currently employed by a health system or a smaller independently owned practice.

This actually becomes even higher among new physicians. New physicians are employed at a rate of about 93 percent. So with all of that being said, go to the next slide, I think this is a pretty well-known report to this audience.

But I think it's worth repeating that we believe primary care is a common good. And the public interest is best served when we strengthen the primary care system as the foundation to a high-performing health system. So the payment approach to primary care should reflect this important status and the unique position that primary care holds.

Payment approaches that work well for others to provide kind of very specific episode or time-limited care to individuals are not the same and not as appropriate for the kind of continuous comprehensive and coordinated care that primary care provides. So, you know, the NASEM[27] report really was an opportunity. And it really enhances the

27 National Academies of Sciences, Engineering, and Medicine

Academy's position that we need to move away from an undervalued and overburdened fee-for-service system for primary care towards a sufficiently funded prospective primary care payment system. Next slide.

So with this in mind, the Academy developed a set of principles for primary care payment. And really what is foundational to this is that the core tenets of a well-functioning health system rooted in primary care includes increased investment through predictable prospective revenue that is risk-adjusted to reflect both the medical and social risk factors and supported by multiple payers and informed by robust information that really supports optimal patient care and provides timely feedback to both physicians and their care teams. We do believe that it really should be everyone's goal to move out of this pilot test demonstration model mode of thinking to supporting this kind of primary care payment in a more sustainable manner.

And when we think about the LAN[28] definitions of value-based care and value-based payment, paying for primary care differently,

28 Health Care Payment Learning & Action Network

in our experience, not all value-based payment arrangements adhere to the principles of primary care payment that we've set forth. So I think it's really important that we're clear about what we think will support and strengthen primary care's role in health care improvement. So today I'm going to focus my comments on a couple of things: risk accountability and health equity. Next slide.

We're going to start with risk. Next slide for me. You might have to click a couple times. I think there's animation on this slide. So we know on average that AAFP members contract with seven to 10 payers. And a least a quarter of our members are working with 14 or more payers.

And each of these payers have disparate payment programs, reporting requirements, prior authorization requirements. So when we're thinking about accountability given the segmentation of the payer market, there are actually very few primary care practices that have the critical mass of patients, let alone individual positions to assume significant risk on their own. When you think back to the slide that talked about 70

percent of our members being in an employed setting, those other members that are really in an independent practice, they just don't have the margins to take on significant downside risk.

That's not saying they don't have the margins to take on any risk. But really significant downside risk I think is a challenge for them. The other thing is that the assumption of risk is about much more than just the size of a practice.

In order for primary care organizations and practices to assume risk, they actually really need to be well informed about the populations for which they are at risk in ways that also don't place all of the burden on them, particularly when there are multiple payers involved. So this is really where we see payers playing a really important role through participation in things like efficient multi-payer models that aggregate data and provide centralized support, including information sharing and performance feedback. And this might sound aspirational, but I think there are actually some really great examples of this in the real world, especially in

several of the CPC-Plus regions that should be considered successes of the model, even though the overall model evaluation did not appreciate the regional variations of those successes. Next slide.

This is another consideration when we're thinking about risk and scale. So most of our members again are employed. And this is an article that looked at kind of the value-based performance and quality incentives in physician and specialist -- primary care and physician specialist contracts.

And what they found is most primary care and specialists compensation arrangements do include performance-based incentives. But they averaged less than 10 percent of compensation. So I think another flag for when we're thinking about moving to these types of arrangements is we shouldn't be putting downside risk on employee primary care physicians who don't benefit from upside gains in their employment contracts.

So thinking about re-envisioning those employment contracts to reflect the incentives and the payment methodologies, which currently is not happening as appropriate.

Next slide.

The last thing about risk is really thinking about it through a health lens. So the current methodologies for risk that have been tested to date really inadvertently penalize practices serving low-income and other vulnerable patient populations with more clinical and health-related social needs.

As they may currently have higher total cost of care than is expected based on, say, their HCC[29] score. Lower Medicaid payment rates also leave little room for savings to be actualized. So there are a few ways to think about how we can better structure payment models to alleviate this.

One is really incorporating equity at the onset of payment design and considering it as a fundamental component of the value proposition, especially for these kind of practices serving these vulnerable populations --it may be rural or smaller practices -- we also should consider more of an emphasis on improving patient outcomes and on reducing total cost of care.

And then I think kind of the obvious

29 Hierarchal condition category

statement of including robust risk adjustment. That includes demographic, clinical, and social determinants of health is also critical. Next slide.

So next I wanted to focus on integration, coordination, and accountability. And this kind of gets to the conversation that we've been having today. There's a distinction, I think, between specialties who should be integrated within primary care, such as behavioral health, pharmacy, social work, nutrition, as opposed to those that are being coordinated with primary care. And that's not to say that those types of models like cardiology and oncology couldn't or shouldn't be nested into these total cost of care models.

But I think the incentives need to be appropriately structured to reflect the types of relationships and responsibilities and accountabilities that are within those relationships. Next slide.

So for those of you who are not aware, AAFP is headquartered in a suburb of Kansas City. So we do know good quarterbacks, and I believe the AAFP also knows good family physician quarterbacks.

So I thought we'd talk a little bit about this, the quarterback analogy. So if you think about what it takes to be a successful quarterback, it really takes having a set of well-planned plays -- your playbook with delineated responsibilities for each member of the team. And they also receive kind of real-time ongoing feedback about their performance to course correct from their coach, right, and usually just one or two coaches. To be successful, primary care physicians and their care teams need the same thing.

This is challenging when they serve as a quarterback for patients who come with their own individual playbook, team, or network, and different feedback mechanisms determined by their payer. So if you imagine back to the kind of most of our members have 10 to 14 payers that they contract with. It's really hard to be successful when you're receiving feedback from 14 different coaches with 14 different playbooks at the same time.

So I think really what this highlights for us is that a multi-payer strategy that includes a common approach to payment and evaluation including expectations

around what's integrated within the care team versus what's coordinated is absolutely essential to equipping primary care physicians and their teams to be successful as their patient's quarterback. Next slide.

And the last thing I wanted to focus on is this idea around incentivizing, screening, and referrals for health-related social needs. Next slide. So I think it's pretty clear that we have a fractured reality when it comes to thinking about screening and referrals, how they're paid for, how they're incentivized.

The AAFP is very supportive of the goal of reducing health inequities and believes that social drivers of health should be identified as risk factors and used for risk adjustment, as I stated. We also agree that it's really important that health care teams screen for health-related social needs and are able to connect their patients to social and community-based organizations that could help address those needs. But I think some of the challenges there are that these types of things are typically not billable under fee-for-service.

And with the fee-for-service model really paying for discrete services, physicians and other clinicians have a challenge of appropriately being incentivized. So I think there are a couple of things. The overarching goal should be to drive improved health for historically marginalized and medically underserved populations.

And addressing health equity and social drivers of health are community issues that really require community solutions. A lot of this is very local and regional. So many communities don't have adequate social resources or community-based organizations to help meet their patients' needs, nor are they resourced with the funding, skills, or staff, to accept referrals from the health care system. Next slide.

So if the dual intentions of the health care system are to move to value-based payment and to advanced health equity and reduce disparities, I think we need to reconcile this fractured payment and support system. So there's a couple of things that we think are really essential to do this. The first is that, especially for primary care,

prospective payment and increased investment really will support screening a referral that's typical not covered by fee-for-service in line with the payment principles that I spoke about in the beginning.

The second is thinking about the community infrastructure. There are a lot of communities that have bidirectional referral, closed loop referral systems with community-based community care hubs. And I think incentivizing the development and use of these community care hubs where other kind of payer and provider agnostic centralized referral systems would ease the burden on all parties involved, including those community-based organizations that are best equipped to address the patient's social needs.

So I think -- and then I would just really like to plug that screening is a care activity that merits payment, both in fee-for-service and in Alternative Payment Models. But I do think that a prospective payment approach really helps allow -- allows flexibility to care for patients in the ways that they need to be cared for. Next slide.

So just to wrap up, we believe

primary care is a common good that is best resourced by increased investment through prospective payments, but changing the payment structure is really not enough.

We need to re-envision physician employment contracts to really reflect the payment environment in which they're participating. And payers really need to understand that primary care physicians' first priority as a patient's quarterback is to their patients. And coordinating the playbook at a regional level can really have high returns.

In terms of risk, accepting accountability is really about how practices are equipped for success as much as the size of the practice or the number of patients. And I think foundational to all of this is that health and social care systems need to be adequately funded and connected to achieve the visions of health equity. With that, I'll turn it back over to you, Paul. Thank you all.

CHAIR CASALE: Thank you, Kate. Next, we have Dr. Nancy Keating, who is a professor of health care policy at Harvard Medical School and professor of medicine and practicing general internist at the Brigham and

Women's Hospital. Nancy, please go ahead.

DR. KEATING: Great. It's a pleasure to be here today speaking with you. And while I'm a general internist, I study oncology. We're going to focus today on what we can learn from oncology care. Next slide, please.

I'll start by saying that I'm clinical lead of the CMS Oncology Care Model evaluation team. I'm going to mention OCM today, but any mention reflects work that's been published on our annual reports. My comments and opinions are my own and not reflective of those of CMS. Next slide, please.

So what do we know about accountable care payments and alternative models for oncology care? To date, there have been several studies that have demonstrated little to no effect of ACOs on overall spending, care at the end of life, surgical care quality for patients with cancer. Next. This is one example that studies the differences analysis to compare care in practices before and after they joined ACOs and looked at compared with other practices that were not in ACOs and found

no difference on care for cancer patients with a definitive impact estimate of $11. Next slide.

This graphic depicts the complexity of cancer care across the disease spectrum from screening and diagnosis to primary treatment, surveillance, recurrence, and end-of-life care. At each phase, there's various different types of physicians who provide care to patients, including primary care physicians, medical oncologists, surgeons, radiation oncologists, palliative care doctors, and others. And next, click. And here if you think about people that are diagnosed with cancer, primary treatment also involves multi-modality therapy from surgeons, medical oncologists, and radiation oncologists. Next slide.

Yet, this receipt of multi-modality care is really provided by doctors who are billing in the same practice or tax ID number. These are data from a study of patients, Medicare beneficiaries newly diagnosed with lung, colorectal, or breast cancer. And among patients who receive more than one treatment modality, surgery, chemotherapy, and/or radiation therapy for their cancer, the

proportion who received all of the modalities from the same practice tax ID ranged from six percent for colorectal cancer to 17 percent for lung cancer. Next slide.

The next question we would ask is what is the choice set for an ACO that wants to identify high-value practices looking to refer patients? This map shows hospital referral regions across the U.S., or HRRs, by quartile of the number of medical oncology practices treating fee-for-service Medicare beneficiaries. And HRRs in red have only three or fewer oncology practices in their choice set across the entire HRR, suggesting that they may not have a whole lot of options when they're thinking about where to refer their patients. Next slide.

I next want to share some findings from our team's evaluation on the Oncology Care Model, or OCM. OCM is an episode model for patients with cancer undergoing chemotherapy defined by CMS as traditional chemotherapy, as well as targeted therapy, immunotherapy, or hormonal therapy. And there were 201 practices participating at the start of the model. They volunteered. It was a voluntary model. And

through 2019, these practices treated over 700,000 chemotherapy episodes. Next slide.

In OCM, patients provide -- the practices provide care for fee-for-service Medicare beneficiaries or a small number of patients from some other models. This was actually envisioned as a multi-payer model, although very few other payers participated. So the patients in blue in the middle are the patients that are fee-for-service Medicare beneficiaries who are initiating chemotherapy.

All the practices of the other patients are in the gray box below that. These are patients from other payers or patients at other phases of illness who are still seeing a medical oncologist. And for payment, the Medicare pays fee-for-service for all of the care.

But in the blue right box, you see they also pay a $160 per patient per month payment during the six-month episode. These payments provide funds to support practice transformation, which was a key component of the model. OCM also incorporates performance-based payments here in the purple.

If quality and spending goals are

met, practices had the opportunity to share in savings. Practices participating in two-sided risk contracts could also face penalties, although this was not a popular choice in the early parts of the model. Next slide. This slide shows total episode payments for the six-month chemotherapy episodes for OCM on the left and comparison episodes on the right.

And then there's the baseline period, 2014 to 2015, and the intervention period, 2016 to 2019. As you see here, total episode payments increased in both groups over time from about $28,000 in the pre-period to about $33,000 in the intervention period. The colors reflect the different types of Medicare payments.

So orange is Part A payments, which didn't change at all over time. The blue are Part B payments, and the green are Part D payments. Both of these increased over time. And notably, the dark shading bars in the blue and green reflect the chemotherapy infused drugs in blue and the oral chemotherapy drugs in green.

And these increased substantially over time. These drug payments by 2019 were

reflecting over 57 percent of the total episode payments for these episodes. Next slide, please. This slide shows our difference in difference analysis.

To orient you, the baseline and intervention periods for OCM and comparison episodes are toward the left side. And in the red box is the difference in difference estimate. As you see here, we found a relative payment reduction of $279 for all episodes combined.

And on the bottom, you see where we stratify based on the higher-risk episodes and the lower-risk episodes, the latter being primarily breast and prostate cancer patients receiving hormone therapy only which were included in the model. And what we found here was that, in fact, for the higher-risk episodes, total episode payments decreased by $503. The lower-risk episodes, we found a relative statistically significant increase of $151.

I'll point out that these estimates do not include the monthly enhancement oncology service payments, these $160 dollar per patient per month, which on average were about a little

over $700 for the episodes. Next slide, please. So this slide shows changes by cancer type in total episode payments. And you see here that the savings that we observed were primarily among four high-volume cancer types, high-risk breast cancer, lung cancer, lymphoma, and colorectal cancer. Next slide.

So what about quality? OCM had six quality measures. Two assessed using claims, emergency department visits, and hospice use. Three assessed using patient practice reporting, pain intensity being quantified, or having a plan of care in place, or screening for depression and follow-up. And then finally, there were patient experiences of care that were reported by patients and collected and surveys that we conducted quarterly through all of the practices. Next slide.

Three of these measures could be assessed in both OCM and comparison episodes. And those measures are shown here. Our definitive estimate showed no change, basically zero in quality for OCM relative to comparison episodes for these measures. And these again are measures for which practices were being held accountable.

There were also no changes in quality for a variety of other measures that we studied in our evaluation. Next slide. CMS has just announced the follow-up to OCM called the Enhancing Oncology Model. This is another voluntary model.

It will focus on patients with seven higher-risk cancer types, including breast cancer, chronic leukemia, colorectal, lung, multiple myeloma, prostate cancer, and lymphoma. Notably, they will not focus on the lower-risk cancers that were part of the Oncology Care Model. And the model addresses quality by requiring engagement in care transformation through redesign activities and engagement in quality measurement and reporting, all similar to OCM, as well as in this new model, activities to advance health equity. Next slide.

CMS has also been developing other models relevant to oncology care. The Radiation Oncology Model was proposed as a mandatory model that would provide prospective payment for 90-day episodes of care for 15 cancer types undergoing radiation therapy. There are rewards for maintaining and improving

quality and patient experiences.

However, Congress delayed the model to start no sooner than January of 2023. CMS then delayed it further to a date to be determined through rulemaking following public comments that were due in June of 2022. Next slide. So there are a number of challenges to Alternative Payment Models and oncology, some of which have been pointed out already.

So first, cancer care is quite heterogeneous. It depends on the cancer type, the stage, the tumor characteristics, as well as the phase of illness. And current risk adjustment is limited in its ability to account for differences in case mix.

Second, patients receive cancer treatment from surgeons, radiation oncologists, medical oncologists, and others. And as we discussed earlier, they're often in different practices or at least billing under different tax ID numbers. And finally, quality measurement in oncology care is early in its development. Next slide.

So how can oncology care be integrated into ACOs or other total cost of care models? Well, we need to help ACOs

identify high-quality, low-spending practices with whom to contract. But as we talked about earlier, the choice of practices may differ depending on cancer type and stage and treatment. And some areas have very few choices of oncology practices altogether.

Finally, there's substantial challenges to measuring quality given the heterogeneity of disease, as well as small numbers of patients with certain cancer types in a given practice, which affects the reliability of quality measures that you might want to assess. Next slide. But there's also challenges. Obviously, the episode method models as we've seen with what we've learned from OCM so far.

Episode models need to focus on a specific phase of disease and a type of care like chemotherapy or radiation. And even then, there's substantial heterogeneity as we saw for OCM when there were savings for only a handful of cancer types. This increasingly narrow focus then omits many patients who are receiving care, and it also omits a lot of different types of care delivered like survivorship care and end-of-life care.

But that type of care might be best shared with primary care providers. Finally, there are complexities of model overlap. Next slide. I'll just highlight a few pressing needs.

I think we urgently need better data on quality and spending at the practice level. Unlike the VA, most practices have very little data from outside of their own practice and often very little data even from inside of their own practice. We also need more testing of various strategies for episode carve-out models.

And here mandatory models can be particularly informative because they avoid the selection issues of voluntary models, even if they're unpopular among physicians. And finally, we need testing of models for shared care. And I'll leave with this one more set of data from a large national survey of oncologists who reported about who manages the surveillance care for patients following primary cancer treatment.

This shows the proportion of oncologists reporting that they took responsibility themselves in blue, that they

share responsibility with the PCP in purple, or that the PCP or another physician leads the care. And you see that there's a lot of purple. And you also see that these things vary a lot depending on what that issue and problem might be of survivorship care.

And obviously, this creates a lot of challenges when the oncologist and the PCP or other docs are not in the same practice. Next slide. And with this, I just want to acknowledge some of the collaborators who contributed to some of the work that I presented today, as well as some of the funders. And I look forward to the discussion. Thanks very much.

CHAIR CASALE: Thank you, Nancy. Lastly, we have Rob Mechanic who, is the executive director at the Institute for Accountable Care and senior fellow at Brandeis University, Heller School of Social Policy and Management. Rob, please go ahead.

MR. MECHANIC: Okay. Thank you, Paul, and thank you to the PTAC team to inviting me here today, to talk about ACOs and specialist care. We go to the next slide, please? I'm going to start off with a summary

and then get into some more details later.

But my main observations of this topic, number one, special alignment, it's a high priority today for ACOs. Obviously, the data on the proportion of care that is attributed to specialist care, it's the majority. And so this is important to them.

But as I talk to ACOs, the current level of alignment or engagement is generally low. There are a lot of challenges, manufacturers that make this work challenging, including the complexity of organizations, the complexity of ACOs which I'll talk more about, the fact that there's poor interoperability which limits communication and collaboration, the prevailing fee-for-service incentives, even within ACOs and within large systems and the whole specialty culture and the volume culture are all factors that create some challenges. A number of folks have talked about the lack of data and metrics.

This is particularly important, I think, in quality where we feel like there's just a desert in terms of good quality measures for specialists. ACOs have claims data for all of their patients. But it's really only

partial data when they look at any individual clinician.

They have some of their data we believe to really evaluate specialist care. You need some type of an episode grouper. And there is, as I said, very limited quality data.

And then I believe sort of on the margins that specialist financial incentives are probably not going to be key drivers of change. There are other things that may be more important, referral volume being one of them. I think one of the things that Nancy ended with about helping ACOs identify high-quality, low-spending practices, if I were going to propose a direction for policy, that's the direction that I would go in. Go to the next slide, please.

Just a brief description, the Institute for Accountable Care, since many of you may not have heard of us before. We were formed a few years ago. We're an independent nonprofit formed to conduct research into policy and best practices around accountable care.

We've got a small team of analysts who work on the Medicare database where we have

access to all the fee-for-service claims, A, B, and D, and a number of other data files. We do a lot of work around modeling and analytics of the MSSP program and performance and benchmarks. We work with a number of episode groupers, particular the episode grouper for Medicare, which was developed under a contract with CMMI, as well as the BPCI advanced model.

We do program evaluations for individual organizations to look at their program, such as care management or home-based care. We've run a number of learning collaboratives on various topics in collaboration with the National Association for ACOs. And we're currently working with six large ACOs on just this issue on using episodes of care to try to improve specialist engagement. Go to the next slide, please.

So ACOs are complicated. And people say when you've seen one, you've seen one. In the Medicare Shared Savings Program, ACOs range from a size of about 30 providers to over 11,000 providers.

And they're made up of a number of distinct physician groups. Many of these physician groups never worked together prior to

the ACO being formed. And so on average, the average ACO today has about 34 physician groups as part of its ACO.

If you look across the continuum, each bar represents about 50 ACOs. And the number there is the mean number of physician groups. So really you have very few ACOs that are just a couple of physician groups. More likely, they have multiples, and they are independent and of various sizes and various capabilities. Go to the next slide, please.

One of the results of having multiple independent groups brought together in these arrangements is that they are not on the same technology platform. So this was a study that was published earlier this year. It's based on a survey of roughly 160 ACOs.

You'll see here that of the 160, only nine percent of them have all of their providers on a single EMR[30]. And 77 percent of them have six or more electronic medical records among the provider groups. And so that makes it very difficult to aggregate, to communicate, and I think it limits, of course, the ability to coordinate care between primary

30 Electronic medical record

care and specialists that are in different groups. Go to the next slide, please.

Another important point is that a lot of the specialist care provided to ACO patients is provided by non-ACO specialists. And just to give you an illustration, what we did is we took the 2020 ACOs. We broke them into four groups which I'll call PCP focus, PCP oriented, specialist oriented, specialist focused.

You can see the number of groups and the third column here is the percentage of primary care physicians as a share of total physicians in the ACO. If we could go to the next slide. So what we did is we took each of these four groups, we looked at the patients inside each ACO, and we said what proportion to care was delivered by ACO physicians?

And you can see on the left-hand side, the majority of the primary care for all categories of these groups was provided within the ACO. That's a little bit tautological because patients are assigned to ACOs based on their use of evaluation management services. But when we get over into medical specialist and surgical specialist care, you see on the

left-hand side, the PCP focused or the red bars, some of those groups have no specialists or just a couple of specialists.

They get virtually all of their care outside. And we go on to more specialty oriented ACOs, and they're still on average getting about 30 percent of their care, what I'd call in network and the rest of it out of network. Now some of that out of network care may actually be specialists who are part of their organization, but they don't participate in the ACO.

You go to the next slide, this is just breaking it down by percentiles. So you can even see over in the far right-hand side, even the ACOs that do the most -- the highest proportion of the specialty care within their ACO physician network are still 50, 60 percent of specialist care. So you've got half still going outside. Go on to the next slide, please.

All right. We did a survey of specialist engagement across ACOs. This is -- by no means is this statistically -- it's a convenient sample. It's not mean to be generalizable.

We've got 64 responses. And the respondents are really non-typical. They tend to be larger. They tend to have hospitals, and they tend to employ their specialists. But this does give you sort of a flavor for where ACOs feel they are in this area. If you could go to the next slide, please.

So we asked them about -- we listed a number of activities. And we said, is your ACO involved in this? Would you consider this to be a major activity, a minor activity, or you're not involved?

So you can see across these four activities we have listed there, working with specialists to develop care pathways. About a third, that's major activity. Giving specialists unblinded performance reports, 12 percent say it's major probably due to the lack of, again, good quality data.

Directing referrals to high-performing specialists, this is an area of very high interest in the ACO community. Less than 20 percent say it's a major activity. And then finally entering bundled payment contracts, of these 64, 17 percent said, yes, we're doing a lot of it, 58 percent were not involved with

episode payments at all. Go to the next one, please.

We also asked them about their use of financial incentives to reward specialists. And the largest response was we don't, 42 percent, followed by a third giving some incentive based on cost or utilization; 31 percent other, which is typically citizenship, participation in committees, other things like that; 19 percent, clinical outcomes, patient satisfaction; and then a couple of them have an incentive for risk coding. Go to the next one.

So one of the big questions here was what are the challenges? What are the barriers to engaging specialists in the work of value-based care and controlling spending? So far and away, the number one, lack of data or metrics, especially quality metrics.

Number two, the dominance of fee-for-service incentives which are driving specialist behavior and specialist compensation. I think as Kate noted importantly, regardless of how the organization is paid, most of the providers comp models are primarily based on RVUs[31]. And so the more you

31 Relative value units

do, the more you earn in most cases.

There's a bandwidth issue because many ACOs, they have a fairly lean staff and specialist practices also. They're working on providing care, and they may not have time to sit down and say, how do we engage better or how do we do our work better with ACO personnel? Many of them commented that the specialists were not interested in engaging with them in their work.

And finally, there's a lot of uncertainty about how would you structure financial incentives given or how would you select high-performing practices given we don't have good data. And for those that got into the issue of game sharing, there is some concern about diluting shared savings dollars by taking money that was intended for PCPs and taking some of that and paying that to specialists. So these were some of the concerns that were reported in the survey.

And if we could go to the last slide. Actually, it's not the last slide, second to last slide. And this chart I think really gets to the root of the problem because when we look at ACOs, you say, well, is ACO

part of the dog or is ACO the tail?

Now, okay, here's the little ACO came up. There are some organizations that participate both in Medicare Advantage, commercial, private ACOs, a group like Atrius Health. They're mostly capitated or full risk. The organization is an ACO. That's how they think of themselves.

But in many cases, ACO is a part of a health system. They're a group. They may have some influence. But in the end, the power is with the hospitals. The power is with the specialist because those are the revenue drivers. And so the ACOs have some influence, but they're not really driving the train. Let's go to the last slide.

So what are ACOs doing, and what are ACOs thinking about? And these are sort of four things that have been referenced to us commonly. One is getting out there and trying to meet with a specialist, talk about their goals, trying to find ways that they can collaborate, trying to tell them what the ACO is trying to do.

Second piece is using episodes to measure a specialist resource. Most individual

organizations don't -- they don't have -- a handful do. But mostly, they don't purchase episode groupers or run their own data.

They go work with different contractors to look at specialty care. A third thing that some ACOs are doing is they're going to their own primary care physicians, and they're surveying them on their specialist performance. In this case by performance, really they're talking about service level.

Does this specialist communicate well with you? Does the specialist return your calls quickly? Does the specialist send the patient back to you with good documentation? Are they providing good satisfaction for your patient?

Some of the health system-based ACOs are trying to set up within their systems more opportunity for PCP-specialist collaboration. And that includes what I'll call hoops. I think one of your prior presenters in an earlier session talked about referral hoops.

But for example, one groups that we talked with recently said a primary care physician can't just initiate specialist referral. They have to document that they've

had a conversation with the specialist and that the referral is appropriate before they actually make the referral. And what this particular ACO is looking for is they want their specialist to work with the ACOs to give them kind of more expertise and to better determine when you can manage the patient without the referral versus when you have to make the referral.

Finally, directing referrals to preferred specialists, obviously for people who get most of their specialist care outside of their own physician network. This one is important. And more and more people are talking about specialist care.

But again, to do that, they need better data. They don't have all of the data. And so as a matter of policy, I think beginning to provide some of that data as Nancy and Kate and others talked about, it's going to be really important. So thank you, and I will conclude with that.

CHAIR CASALE: Thank you, Rob. Thanks again to all the terrific presentations. We're now going to open it up to the PTAC members for questions for our panel. Chinni?

DR. PULLURU: I wanted to address this to Robert but everyone as well. So one of the things that when we look at ACOs, it often is criticized is that the burden tends to be placed on the primary care physician from an administrative perspective. And I think as well intended as a lot of programs are, it continues to place a huge burden on the PCP to just fill out paperwork, make phone calls, do that kind of stuff. So how would you address that as you start to hold more specialty centric accountable organizations?

MR. MECHANIC: Well, so I think some of the burden comes from the requirements that are put on by the payers are the requirements by the government to report information. I think a lot of the ACOs and I've spent a lot of time in my academic career interviewing ACOs. One of the things they try to do with primary care is to give primary care more tools and more resources so that they can spend more of the time caring and less of the time administering.

I think when we talk about trying to get primary care providers to have more conversations with specialists and coordinate,

it's not so much making phone calls, but it's really having the conversations about the clinical work. And so I think those are conversations that I would say are really important for the patients and the patient care. So to the extent that the ACOs have resources and can put it into it, I think it is trying to strengthen the practices again so the PCPs can focus on the care and less on the administrative burdens of the models.

DR. FRANCIS: Let me add for VA, our primary care providers grumble about this as well, even though I think we have more mechanisms to support collaboration. It takes, I think, active intervention that many sites, and for many specialties there are formal contracts which we call service level agreements that specify what individuals will do. A lot of this is really putting the expectations up front.

On the education end, what we've done -- again, and you can do this in a national system with infrastructure that's supporting -- is provide teleconsultation services. And again, these tend to be very targeted things like critical care with tele-

ICU but also a tele-pulmonary care for some of the outpatient lung disorders that are quite prevalent. And that actually tends to support the kind of curbside consultation that happens naturally at a big medical center.

But then when you have, say, a rural community-based clinic, those following interactions can't occur. And so you have to develop means to do that. But you got to also include some way to give workload credit to the specialist and the primary care clinician who's engaging in these interactions.

And that always is a challenge. And we have lots of discussions what we want to give credit for because we capture an RVU equivalent, and that's how we grade efficiency. But also what we don't want to capture because we don't want to create a culture in which you basically check a lot of boxes and ring up the tab without being focused on the veterans' needs. So it's a struggle.

DR. McCLELLAN: Yeah, can I just add to Joseph's comments about, like, workload recognition and put that is (audio interference).

CHAIR CASALE: Mark, your connection

-- sorry, Mark. I'm going to interrupt. Your connection is not very good. You may want to just turn your video off, and then we may -- because we didn't hear your response. You were freezing.

DR. McCLELLAN: Okay. Sorry about that.

CHAIR CASALE: That's okay.

DR. McCLELLAN: We've done a lot in ACO to try to find a pathway for primary care physicians to have more resources to do important things that aren't supported under fee-for-service, like educating specialists, constructing data on episodes, trying to do selective referrals, expanding out their capabilities to manage more of especially aspects of care. But we're only using a tiny part, as Rob showed, of the overall resources that are going into care involving specialists. And just like it's really hard to ask primary care physicians to do all those things, if they're just being paid on a fee-for-service basis, it can be hard to ask specialty providers to do more to be partners and engage in that effort if they're only being paid for doing elective procedures efficiently or

handling admissions efficiently or other fee-for-service things.

So I think these -- that's why I think this idea of, like, having a nested model for specialists who want to engage and can engage to put some resources into being on the other side of that care coordination. Providing -- and we've seen lots of examples of this around the country. It's very hard for specialists to sustain under the current fee-for-service models of person-focused.

Musculoskeletal care models are coordinated with primary care physicians. Cardiovascular care models that involve more longitudinal management of patients with advanced or complex conditions, end-of-life models involving specialists. You make some of the same kinds of changes on the specialty payment side to facilitate that like per person payments and even if it's just stepwise to help get that alignment to happen.

CHAIR CASALE: Great. Oh, go ahead, Nancy, yeah.

DR. KEATING: I'd like to say one more comment to underscore --

CHAIR CASALE: Sure.

DR. KEATING: What Mark was saying which is that as a primary care physician myself, our current model so over-incentivizes procedure-based care that it is impossible to get engagement when you have a patient that they did surgery on two months ago, yet the patient is having problems. And they wind up in my clinic because our current fee-for-service just has them wanting to fill their OR[32] slots and not see patients in follow-up. So I did think this is so important to really figure out how to gauge the specialist and have the specialist see themselves as someone who can help support the PCP. Like, I'm happy to see my patient if you will answer the questions that I can't answer. So it's just a clinical example where it's really key.

CHAIR CASALE: Right. Thank you. Lee?

DR. MILLS: Yeah, I appreciate all the great presentations. I think that maybe we're starting to hear a consensus emerge between comments today from both Mark and Kate, as well as our presentations yesterday. But I'd invite more comment about this concept in

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multiple overlapping population-based and specialty-based or episode-based value-based models, whether there really is a consensus that we think we're hearing that they should be nested in versus carved out, then how if they're really going to be nested in, how you actually see with some more details or commentary about how overlapping incentives could be structured. And then the third strain to this question I realize is complex, is if we see a developing policy goal that seems like the country needs to be shifting more resources into primary care from the fairly low five percent investment, how that can work in a nested total cost of care episode-based model.

MR. MECHANIC: So I'm happy to start with that. Ever since the beginning of these CMMI programs, there's sort of been struggles about how do we deal with the overlap between bundles and between ACOs. And I think it's fair to say that nobody has really come up with a satisfactory way to do it because it's very hard to sort of independently say, well, what's the value that the specialist provided or the bundle participant?

What's the value that the ACO

provided, and do that really in a concrete way. I guess I would think about it as I like the idea of a nested model. But I think not all ACOs would be capable today of using a nested model.

I think you would want sort of a larger organization that has its own specialists and can work with it internally. Again, I think what many of these organizations are missing are some of the tools and some of the data analytics. And if they had those and they're working with their own specialists, I think it would make a lot of sense to bring this in as having some internal structure to how they work with their specialists.

And I think that could be a really good tool for engagement. I do say even though I've made the comment about financial incentives on the margin, I do agree with Mark and Nancy that you do have to compensate the specialist for the time they spent in coordinating the PCP. You can't just have it cut out of their income.

DR. McCLELLAN: Just to add to that, I do think that the path forward is different for, as Rob characterized, the ACOs that are

primarily physician-based, especially primary care-based and those that are comprehensive or consolidated, including hospitals and a lot of the specialty care. There are some advantages as Rob said to having specialists in hospital care within your ACO. Unfortunately, right now as we've just been hearing, most of the financial incentives in those organizations are still really tied to make your admissions efficient.

Maybe avoid some of the preventable medical admissions. But the financial margins are still there for a lot of specialty procedures and not necessarily really that focused on what's the best longitudinal care pathway for a patient for preventing their pain or maintaining their functional status or they've got a musculoskeletal condition or maintaining their function if they've got a cardiovascular condition or getting the right initial treatment and the right long-term follow-up and end-of-life care for a cancer patient. That's where there are real gaps.

And even a step, even if it's limiting funding shifting in that direction will be important. We think in our goals for

recommendations that this shift to a component of person-level specialty care payment for conditions should be mandatory actually to provide a shift in those dimensions. There's no reason and principle that organizations that do have specialty care and hospitals within the organization can't put that together, the money is all going to them.

It just would be coming less in a sort of fee-for-service acute episode only direction. And that can happen incrementally. You don't have to make dramatic changes over time. But I think it really would send a very clear signal that specialty care coordination time with primary care is valued and it's specially efforts.

There are lots of creative efforts out there to do a better job of longitudinal care management, preventing admissions, intercepting diseases earlier, is highly valued. For the smaller physician-led groups, we think it should be at the discretion of the physician-led group. I personally am not sure that we want in the future is all fully integrated organizations.

There are a lot of very well

functioning primary care ACOs and a lot of independent specialty groups that are pretty good at doing what they're doing too. And those could work together and maybe create some more competition and innovation as well. There the hard part is making clear to the primary care ACOs it's not just all on them.

They don't have to do everything within their additional PMPM payments or their shared savings. But there is a pathway here if they want it to not only tell a specialty group, hey, we like the way you're delivering care. But here's some ways in which you could get paid differently that if the math is done right, are going to make us all better off, that will add more resources into this care coordination.

So just having a model, a template they could go to so they don't have to start from scratch with every group. And CMS putting some push behind that I think would -- I think you'd find that some group, maybe not all, would take it up. And maybe we'd learn more about how to do that well over time. But we've got to augment the resources available for specialty care coordination for those primary

care-led ACOs and for the specialists that want to work with them.

MS. FREEMAN: And Mark, thanks a lot for your comments. One thing I would like to underscore that I think is similar for both kind of primary care-led organizations and those that are more specialty-focused is this need for kind of two things. So the data, the information is so critical.

And I think that this is important for both specialists and primary care. And for a model, I think Mark described it really well that some of these smaller ACOs probably don't need to be fully integrated. But they do need the data.

And that is the same for those larger organizations, more integrated networks. The other thing that I just would like to bring up again is that this doesn't work unless there's alignment across payers. It takes a substantial bubble of alignment in quality and payment and all of these things to really make a difference, especially for those smaller organizations who really don't have a lot of wiggle room in their margins to kind of deliver care differently, that if we alter the payment

structure, give them the data they need, that's when we really see a shift in how primary care practices integrating with specialty, coordinating can really deliver high-value care in patients.

CHAIR CASALE: That's great. Thank you. Angelo, did you have a question? Oh, you got it answered? Okay. Larry?

DR. KOSINSKI: Excellent presentations. The gears in my head are spinning. I'd like to ask Mark a question. I'm intrigued about your model of baseline payments combined with bundled payments for procedural services to specialists.

Sometimes we've heard both days of this conference about getting specialists an on ramp, trying to find an on ramp to get at least some of the specialty services rolling. Have you experimented at all with looking at the specific characteristics of the disease for deployment of specialists, for example, more high-beta type diseases that would be higher-cost per capita that would be maybe have a higher percentage of disease-specific cost that would make it more specialty-focused? Have you done any work on that degree of granularity?

DR. McCLELLAN: It's a really good question. I think once you get set outside of the hospital-based episodes, those four walls that Amol was talking about earlier, there are not many specialties where the care is only or maybe even mainly -- not many conditions where the care is only provided by specialists. You run right into exactly the issues we've been discussing (audio interference) and maybe very different kind of longitudinal care models and what we're seeing today in this fragmented fee-for-service driven approach.

A great example of that is musculoskeletal, both for osteoarthritis and for back pain. I'd refer everybody to work by Kevin Bozic and colleagues, some of which we've collaborated on, which can show 30, 40 percent reductions in procedure rates while giving (audio interference) status and capabilities which is what matter (audio interference) some enhanced primary care roles but also enhanced roles around physical therapy and the like. And here, Larry, I just would emphasize that there's a lot of heterogeneity out there.

There's some specialty groups that can do this now and are really stuck because

they don't have these more person-level financial arrangements to support them getting paid for things other than doing procedures. There are other groups that don't. And there are many primary care groups that say, well, we can do a lot of that management, triage, the behavioral or pain management where that's appropriate, physical therapy where that's appropriate.

We expand our capabilities. We can do that. I think that's fine, but that's why I like this nested model idea for physician-led ACOs. Give them the option of setting up a partnership if they want.

They can adjust the payment amounts with the specialty group if they think the specialty group can really help them. Or they can take on some of that themselves within their ACO if they really are that advanced. I think we don't know what the capabilities are.

I think we do know that most organizations and most specialists are not able to deliver this kind of truly person-focused longitudinal care model yet. And so we need at least some initial steps to get that going and a recognition that some just like we saw with

primary care. Some are going to be more advanced, be able to take to it right away. Others are going to need an on ramp and more time.

CHAIR CASALE: Jennifer?

DR. WILER: Thank you very much to each of the speakers. Your presentations were really fascinating. Over the last two days, there's been a common theme around priorities. The first is around data or lack thereof, it being accessible and actionable and meaningful. The next is around quality measures and really the big opportunity that exists around measurement from a process and outcomes perspective.

But yesterday we talked a lot about -- or we heard from our experts that they agreed that there should be large disincentives for participating in fee-for-service, some recommending mandatory participation. I'm curious if you all agree with their recommendation that there should be large disincentives for fee-for-service, and if so, what that would look like. What do those incentives look like?

MR. MECHANIC: I guess I'll start.

I'll give you my personal opinion. First of all, one of the things that the ACOs, I'd say, are advocating in Congress right now is for the extension of the advanced APM bonus under MACRA[33] which goes away in 2024.

But essentially, this year is the last year to qualify for it. And it's a five percent bonus for the providers and the ACO. Some of your presenters from the prior day, I know in their writings have talked about maybe something like an enhanced primary care payment for providers in value-based payment models, say, 10 percent.

You could really focus this. Again, I think that the APM model has some flaws. And you could really sort of refocus the payments onto the patients who are attributed who are in those total cost of care models. But if we think about physician fees essentially being flat since 2015, I think some added incentives on top of that certainly for primary care and maybe for targeted specialists, I would be in favor of that.

MS. FREEMAN: I will just add from a primary care perspective that I think that

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without an appropriate place to go, disincentivizing fee-for-service, especially for practices that are serving medically underserved or vulnerable populations. This is a health equity issue, right? So if we disincentivize fee-for-service and we make it for those practices that already have really slim margins to serve their patients in these communities where they really need a primary care physician, I think without an appropriate place for them to go, we risk exacerbating disparities.

And I don't think that's what the intent of any of this is. So I think maybe flipping the question and saying, what's the appropriate incentive and how are we getting that to all of -- how is that kind of being dispersed broadly? And how do we kind of move away from fee-for-service? And we build models that aren't built on fee-for-service. I think those are all maybe questions where we could spend some more time and energy because I do think the more attractive you make alternative payment arrangements, the less attractive fee-for-service is.

DR. KEATING: Yeah, I agree with

Kate entirely and just wanted to underscore I think CMS is doing some really innovative work here with some of their new models. And for example, with the Enhancing Oncology Model, the monthly payment for your average Medicare beneficiary is going to be $70 per patient per month. So it's less than it was for OCM, but it's still up there.

And if you are taking care of a dual eligible patient, you actually get $100 per member per month. And that additional $30 does not count toward your total episode payment. So I think this -- I totally agree with this idea of the more we can make the Alternative Payment Models more attractive and particularly for practices that are taking care of historically marginalized and otherwise disadvantaged patients, I think that will make it attractive for some of those groups.

And it seems like fee-for-service is becoming less attractive because the rates have been so stable. But I think a particular procedure or specialists are still making lots of profits. And so I do think we need to make the Alternative Payment Models attractive to them as well.

DR. McCLELLAN: There are good reasons to make the Alternative Payment Models more attractive, I think CMS has seen over the past decade. And Nancy's work showed too it's hard to get significant budgetary savings in the short term in voluntary models.

It does take investments, especially in safety net and historically under-resourced organizations to make these changes. The organizations that are doing fine thank you right now under fee-for-service are not going to tend to sign up under voluntary arrangements. So perhaps a path that maybe starts with voluntary but gets over time towards mandatory would help.

And this gets to the point about getting to critical mass. CMS has laid out a very clear goal for 2030 where I think we still have a lot of work to do. What are the interim steps between 2022 and 2030 that get us there? And I don't think from a health care sustainability standpoint or speed standpoint, we can get there just with voluntary models that have some sort of extra add-on payments to begin with, even though that's a really important step now.

So some continued effort on how do we turn this shared 2030 vision into a clearer pathway to progress that's going to get to more alignment on reporting and all the burdens that multi-payer facing practices have to deal with today. Those are really important steps to bring down the cost and make it more attractive and give a higher level of comfort that we can make these changes mandatory. We don't have to just keep increasing the fee-for-service as a stop-gap measure for our uncoordinated health care system.

CHAIR CASALE: So, with that, I want to thank all of our speakers. This has been a very valuable discussion. Your input will be very helpful to the Committee as we prepare our report to the Secretary.

So at this time, we have a lunch break until 1:15 Eastern. We will have our public comment period and then the Committee's discussion of draft comments for the report to the Secretary. Thank you again to all of our speakers.

(Whereupon, the above-entitled matter went off the record at 12:25 p.m. and resumed at 1:15 p.m.)

*** Public Comment Period**

CHAIR CASALE: Welcome back. Now we have two people who signed up to give a public comment. I will announce your name and your organization, and our moderator will unmute you so you can speak.

So I want to open it up to Anne Hubbard, the Director of Health Policy at the American Society for Radiation Oncology.

MS. HUBBARD: Hi, Dr. Casale and members of the PTAC Committee. Can you hear me?

CHAIR CASALE: Yes, we can.

MS. HUBBARD: Fantastic. I don't think you can see me though. I guess there is no video option, but that's --

CHAIR CASALE: No. There's no video, yes.

MS. HUBBARD: Okay. Good stuff. That's fine. It's probably better that way. So, again, I am Anne Hubbard. I am Director of Health Policy for the American Society for Radiation Oncology, or ASTRO.

I want to say first of all thank you all for the very informative two-day discussion on population-based total cost of care models.

It's always very exciting for people like me who are kind of, you know, health policy wonks to hear from the rock stars in payment reform, so this has been very informative.

As you all may know, radiation therapy, or radiotherapy, is the use of various forms of radiation to safely and effectively treat cancer and other diseases.

Radiation therapy works by damaging the genetic material within cancer cells. Radiation oncologists serve as key members of the cancer treatment team that also frequently, of course, involves medical oncologists and surgical oncologists.

I really appreciate that there has been quite a bit of discussion around oncology care over these last two days, so I certainly appreciate that.

In the discussion, there have been significant areas of alignment between the discussion that you all have had in ASTRO's comments that were issued in response to the PTAC RFI[34] on total cost of care models.

I thought I would just kind of walk

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through some of those that are really top of mind for us. First of all, of course, is, you know, up-front funding to offset the cost of transitioning to value-based payment.

Some of the work that we put into the RO[35] Model with our members as they were preparing to participate in that particular payment model indicated that there is a significant amount of time and effort and cost associated with transitioning to value-based care. I think this is important to consider in any future total cost of care efforts.

Other areas of alignment include incentives for integrated care coordination. There has been a lot of discussion about PCP to specialty, but even I would add within specialty care models, there should be incentives for collaboration.

Of course, cancer care is a good example of that with so many specialists who are very much involved in a cancer patient's treatment.

Recognition of guidelines, concordant care is another area of alignment, as are ensuring that the payment is reasonable

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and sufficient to cover expenses, as well as providing additional reimbursement recognizing the care for higher-risk populations tends to cost more, and so, therefore, you need to be able to invest in wraparound services to ensure that those patients have continued access to care.

The final item I wanted to raise is the need to provide timely data sharing. This is another key area where providing that data helps practices make that transition from fee-for-service to value-based care and understanding kind of what those predicted payments will be and how they might be able to operate under a value-based payment system.

These key areas of alignment also happen to correspond to key areas where CMS's RO Model, or the Radiation Oncology Model, actually fell short.

Unfortunately, that model involved an over-emphasis on demonstrating savings that really sacrificed the achievable goals of quality improvement and payment stability.

Despite the indefinite delay of the RO model, ASTRO remains committed to working with CMS, PTAC, and Members of Congress to

establish a radiation oncology payment reform initiative that contributes to President Biden's strategy to reduce cancer mortality.

We want to ensure that we can establish a payment model that includes a simplified payment methodology that ensures fair and stable reimbursement recognizing the efficient delivery of care.

Additionally, there should be investments in cancer treatment infrastructure to ensure that all patients have access to high-quality care using advanced technology.

Secondly, there should be mechanisms to establish a payment model that identifies and supports those patient populations with limited access to radiation therapy to ensure that they are able to initiate and complete their treatment.

Additionally, a commitment to evidence-based approaches to care and investment in wraparound services, including patient navigation and transportation, will improve care for patients who are from historically marginalized populations.

And, finally, within a population-based total cost of care concept, there must be

a pathway for these types of models to recognize the value and quality of radiation therapy within a broader continuum of cancer care.

Incentives that include and encourage multi-disciplinary collaboration, as well as the inclusion of discreet or nested episodes that recognize the value of services like radiation therapy in multi-modality treatment, really must be part of that overall equation.

Again, I really appreciate the time and appreciate the discussion during the past two days. Thank you.

CHAIR CASALE: Thank you. Alyssa Newman, a health policy analyst from the National Association of ACOs.

MS. NEWMAN: Good afternoon. Hi. Are you able to hear me all right?

CHAIR CASALE: Yes, we can.

MS. NEWMAN: Okay, great. I'd like to start also by thanking the Committee, as well as all of the PTAC staff, for the time and attention that has been dedicated to these important discussions about population-based total cost of care models this year.

(Audio interference) and our members are committed to improving the quality-of-care delivery, population health, patient outcomes, and health care cost efficiency.

Clearly, we have lots of feedback on this and provided detailed remarks in response to the RFI, but today I will highlight a few key points on incentives and payment strategies.

First, appropriate incentives are necessary to ensure success when shifting risk downstream to providers, which is why Congress established the five percent APM bonus payments.

However, as Kristen from LTC ACO noted yesterday, this bonus is set to expire at the end of this year. While we are strongly encouraging Congress to extend the bonus, it's also critical that policy makers consider additional incentives to promote increased and long-term participation in risk-bearing APMs.

In addition to financial incentives, we would like to highlight that waivers and increased flexibility can also encourage providers to join APMs that support their delivery transformation.

This can include, as others have mentioned, access to timely actionable data and use of telehealth, as well as some beneficiary of programs, such as being able to cover transportation or wellness programs. All of these can enable success in a population-based model.

In terms of payment strategies, we would like to see payment strategies for a population-based total cost of care model include optional capitation payments for primary care.

Strong primary care is critical to success in a population health model, and these types of population-based payments can better support comprehensive primary care that improves outcomes and reduces unnecessary care and avoidable hospitalizations.

It is also important to include appropriate flexibilities for providers to select their risk and capitation options, as well as other downstream payment arrangements, such as bundles nested within an ACO, that meet their needs and recognize the practice's ability to manage risk and administer capitation.

Finally, fair, accurate, and predicable financial benchmarks are fundamental to provider success and long-term financial sustainability in a population-based total cost of care model.

We heard from several speakers yesterday about some of the challenges with relying on fee-for-service expenditures to inform APM benchmarks as more providers move away from traditional fee-for-service payments to participate in APMs.

As policy makers explore moving towards administratively that set benchmark, a thoughtful approach will be necessary and should account for reasonable variation and spending and spending growth or to address health equity and create parity and alignment across programs and payers all around sound program fundamentals, around benchmarking and risk adjustment methodologies. An appropriate balance of risk and reward are necessary to attract participants and ensure ongoing success in a population-based total cost of care model.

We know CMS and other policy makers are exploring ways to improve these methodologies, and we look forward to working

with many of you on these policy improvements.

I would like to say thank you, and if people have other interest in our comments, you can read our full RFI response on the PTAC page, and you can feel free to reach out to us with questions. Thank you all so much.

CHAIR CASALE: Thank you. Thank you for both public comments. I am going to check with the host before we move on. Are there any other folks who want to contribute?

(No audible response.)

*** Committee Discussion**

CHAIR CASALE: No, okay. So hearing none, that is the end of the public comments. So now the Committee members are going to discuss what we have learned yesterday and today from our guest presenters, the roundtable discussion, background materials.

PTAC will submit a report to the Secretary of HHS that includes our findings from the March and June public meetings, in addition to what we want to highlight from yesterday and today.

Similar to yesterday, we will start with time to reflect more generally before staff continue with the slides identifying

potential comments.

So with that, I am going to turn to the Committee, thinking through the conversations today specifically any particular areas come to mind that we want to be sure we highlight or think about for the report to the Secretary. Bruce?

MR. STEINWALD: Yes, thanks. I am trying to find the name of the presenter. Kate Freeman from American Academy of Family Physicians made a very good point at the end of their session about fee-for-service.

I think we need to as we write on this because I think we are in agreement that we want to take a position that at least, you know, if we don't use the word "uncomfortable" at least guides us away from reliance on fee-for-service.

The point she made was that if that's the stick, she didn't say it this way, if that's the stick, what's the carrot? We would like to think that the vast majority of providers who are depending on fee-for-service have an alternative, an ACO, a population-based something, but she made the point that not all of them do.

So I think it would be wise to acknowledge that first of all, we're not trying to be punitive to people who are in fee-for-service. We are trying to enlarge the incentives to moving to value-based care and understanding that not all of them can do it right away.

So I think maybe the words "glide path" could be in that description somehow. So we're not saying let's do it tomorrow, but let's move in that direction.

CHAIR CASALE: Great. Thanks, Bruce. Jennifer?

DR. WILER: I know we've commented on a lot of the themes that we have heard about already, but I will summarize four that I heard and I think are important.

We just keep hearing over and over data, data, data, how do we share, how do we access, what are the definitions, how is it actionable, and then ultimately that also leads into benchmarking and risk adjustment. I think we cannot continue to prioritize that as an opportunity.

Second, I heard today, which I hadn't thought about before, but I think it was

a really nice distinction, and that is in the current business model space where we talk a lot about care models and payment models but ACOs is the business model, that maybe we shouldn't think of them all the same.

That is a description today we heard around a hospital-based ACO model, a provider-based ACO model, and then a distinction was made between a primary care specific-based ACO and one that includes specialists.

That kind of rubric might be helpful as we then think about payment models because, certainly, that kind of infrastructure influences care models.

The next is that we heard about multi-payer engagement, and I think today really hammered home that it's not just around engagement, it's around alignment.

So the discussion around, again, data and quality measures and where there is an opportunity to decrease administrative waste in the system by creating that kind of alignment and improving outcomes.

And then last but not least was this idea around for at least some specialties and the conversation was primarily focused around

primary care, but the idea of a prospective payment, and, you know, a business cannot manage its risk if it doesn't know ultimately what its revenues are going to be.

And so, for services that we think are essential, this idea of a prospective payment and really drilling into what does that look like, who is it for, and how does that move us into ultimately this idea of creating deliberate incentives to create a tipping point for participation which also, I liked what Mark McClellan's note was, still creating a landscape where there is innovation and flexibility.

CHAIR CASALE: Great. Thanks for those summary comments. Lee?

DR. MILLS: I really enjoyed the presentations today. I've got a number of kind of take-home notes to me and most of these multiple speakers touched on.

In only the chronological order that I took the notes, but Amol talking about that the clearest data available supports an overlap of population-based total cost of care model and a nested-based model, which I just thought was really insightful and interesting, so it's

not a conclusive dataset, it's a real-life experiment.

But the current CMMI policy of trying to structure and define these very, very differently so that they are completely excluded for a clean dataset in comparators doesn't support that.

That just may speak to earlier comments yesterday that the APMs are essentially becoming ubiquitous in many markets, and so it's really, really hard to get a comparator group.

So, there is kind of disconnect between the pilot mindset and framing up CMMI's initiatives and what we see that there is actually marginal benefit to the overlap on purpose and maybe ought to be encouraged to push that direction. So that was one take-home point for me.

The second, I love this, Eric had this really interesting phrase yesterday about we're needing to move towards a quality accountability infrastructure.

I love that phrase, but it did immediately speak to me that that's only going to be possible when we move health data to a

health data utility or infrastructure model.

There is a real tug-of-war right now between a federated disconnected pull system like CommonWell, operated by the EHR[36] vendors, and an HIE[37] national backbone-push system utility model where health data under the appropriate controls is ubiquitous like electricity. So, I think that was really an important dichotomy set-up for me.

The comments that Eric made about measuring health equity just takes a very, very large sample set really hit home that there is going to be a rush in many settings to move these quality metrics down to a provider group.

His implication was even at large health systems, datasets may not be big enough to make them accurate measures, and so they may really only be health plan/Medicare/Medicaid level metrics.

So, I think there is going to be a rush to move forward faster than science lets us there, and that's kind of interesting.I think I heard several comments that settled in my mind. We've been talking about nested-in

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37 Health information exchange

versus carved-out specialty-based models in a population-based model, and I heard fairly clearly that most experts are thinking actually a total cost of care population model for everybody consistent with CMMI's direction and then specifically focused episode of chronic disease nested models make sense, and there is good support for that.

No one spoke to a carve-out model, although Larry and I had an aside that Medicare's current treatment of ESRD[38] and dialysis is essentially a massive carve-out model.

My last point I will make is there was some focus on starting this transition from purely fee-for-service that often the earliest lowest hanging easiest fruits are all in primary care investment and data infrastructure, but that that isn't, and we've had several people speak to this, isn't where the majority of health care dollars are directed if they are directed in specialty costs.

So that's, you know, more expensive and more difficult to get at, and it takes all

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these inter-lapping incentives that we have been speaking to to get towards, so that was interesting. That concludes my remarks.

CHAIR CASALE: Great. Great comments. Thanks, Lee. Larry?

DR. KOSINSKI: My additional comments today over what we discussed yesterday were from two Marks. From Mark Friedberg, even though the structural recommendations into the ACO were based upon grant at this point.

We do see the health plan trying to influence the infrastructure of the ACO by, you know, incentivizing them to put patient-reported outcome measures and social determinants of health, equity.

It's being done at this point based upon an independent grant, but you can definitely see that that is not a trend that is going to stop there.

Mark McClellan, I thought his slides were outstanding and specifically, you know, some of the slides around where the true cost of care is, the longitudinal view of where cost of care is.

I thought it was fantastic, but I really focused the most on his vision of how to

implement specialty nests inside ACOs.

I really liked his concept of base payment for taking the care of this patient with whatever condition it is and it's based on the patient, so it's a patient-specific payment based upon their disease, and I guess it would have to be on their constellation of multiple diseases.

But then the procedural services are then brought in in bundles that are most likely under the typical fee-for-service payment for those so that you start ratcheting in the adjustments that you have to make to get specialists as part of a team embedded with the team working with the primary cares. That's why they are getting their base payments, and although they do get supplemental payments for procedural services, they are bundled, they are restricted a little bit. I really liked his granularity there.

And then, finally, we heard over and over and over again strong disincentives for perpetuating the current fee-for-service system. You know, it certainly would – everybody spoke similarly on it, but I think it's going to take more than just freezing the

payments.

CHAIR CASALE: Yes, thanks, Larry. Josh?

DR. LIAO: Yes. Great presentations today to supplement what we heard yesterday. I still have to probably fully internalize everything, but just some thoughts that I have right now, you know, going back to that PCDT[39] presentation theme of the spectrum of different methodologies if kind of more pure fee-for-service on one end, capitation, which might be exemplified by Medicare Advantage on the other, and kind of fee-for-service-based APMs in the middle.

I agree with others on the Committee that people did talk about the limitations of our current fee-for-service system, but I think it was also one acknowledging it was mixed, right.

We heard things like, well, fee-for-service if you have global budgets or other parameters around it, that changes it a little bit. You can't pull the proverbial rug out from underneath people, you know, if there is no good place to go. So I want to just say it's

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more nuanced than that, and I think our comments should reflect that.

On the other end, I think lots of good things about MA, and I also heard comments about how we are subsidizing that, and as penetration gets to a certain point, you may not have a lot of room to promote other types of payment models if it gets there.

So I think even one commenter said, are we thinking about MA as an APM, and I think those are important things to reflect as well, that force on that side.

And then focusing on kind of the middle, kind of the fee-for-service-based APMS, two themes that I think organized the comments around were opportunity and certainty.

So, you know, whether the opportunity comment was made in terms of extending the five percent rate increase or, you know, using an external benchmark to create more room and to avoid this ratcheting effect, the opportunity seemed like, it jumped out to me in almost every session we had, and then the certainty about is this model going to change in a few years, certainty around revenue, and certainty around, you know, where are we headed

with the inevitability or lack thereof with these APMS.

So I think opportunity and certainty to kind of create that middle space if we want it and then acknowledging kind of the mixed nature of the two at the ends, to me I would love that, those highlighted.

Then, finally, I think a few commenters noted that this idea of short term and long term, and I think a few people appropriately orient us to say, you know, what do we want the payment system to be, and there are going to be puts and takes, but in the short term not allowing the short term.

I don't want to use the dog and the tail analogy after today's slides, but not letting the short-term affect what we want in the long term, you know, budget savings versus, you know, program savings and what we want to design.

That's tough, but keeping the eye on the big picture.

CHAIR CASALE: Great. Thanks, Josh. Walter?

DR. LIN: So a great two-day session. I also appreciated all the Committee

member comments so far, very thought-provoking.

You know, I was reflecting upon our meeting back in June, which was focused on care delivery, and one of the things that I felt was a strong thread running through those two days was the outsized impact investments and primary care could make in achieving a sustainable, thriving, value-based care model.

In contrast, I think these two days that we just had kind of emphasized the importance of engaging in specialists and doing so in a thoughtful way that made them feel part of the movement, you know.

I think Mark McClellan's comment that many specialists appear to be unaware that they are even part of an ACO struck me and actually as I reflect upon it, it rings true to my experience as well.

This whole idea that ACOs are for primary care providers, another point that Mark brought up, I think speaks to both the challenge and the opportunity that we have before us in terms of engaging specialists appropriately.

I also really appreciated the comments by CMMI this morning as well and kind

of their thoughts about it.

But just kind of -- I think -- And I also think that many of our experts, starting with our first session yesterday with Mike and Mark and all the way to our last session today, talked about what Larry mentioned in terms of having nested bundles of specialty care within a broader total cost of care construct.

I think that all kind of makes sense intuitively. Ultimately though I think there is a lot of detail to be worked out, just for example, the ASTRO comment we heard just now about radiation oncology.

If I think about colon cancer, for example, and the involvement of maybe a gastroenterologist to the colorectal surgeon, their radiation oncologist, the medical oncologist, how would you construct an episode of care, who would hold the risk, how would that bundle be constructed? All very difficult questions.

I think it would be really informative for us to kind of learn more about what has been done out there. So that's one request of the March PCDT for next year as we look at this. Maybe we can look for some

experiences that can speak to some of these complexities.

The other aspect that was mentioned in passing but not quite dealt upon to the same extent by our experts was the specialist involvement in chronic care, you know, so congestive heart failure or inflammatory bowel disease. How are specialists to be engaged in chronic care under a value-based system?

So a lot to think about, a lot to learn, and I felt like these two days were very productive and look forward to our sessions next year.

CHAIR CASALE: Great. Thanks, Walter. Thanks for those comments. Angelo?

DR. SINOPOLI: Yes. Thank you. So I will echo I think the last, yesterday and today were just great days, lots of great information and a lot of expertise.

I agree with everything that has been said around the table. A couple of things that I would just add is that I also very much liked Mark's presentation, and I liked the slides he had.

I liked the payment model he had. I think that can be a solution to a lot of the

specialty engagement nesting within an ACO.

When I saw that slide though, you know, once it got past, you know, that's the fix. I'm trying to think from an operator standpoint how to operationalize that and the data that it's going to require, the staff that is going require. It's a big project.

Then I think most ACOs today, the amount of savings that they generate today is minimal, and once you start spreading that around the primary care docs and the specialists and the specialist within the year gets a check for $1,000, and it nowhere near covers his efforts in terms of participating in those kind of models, particularly if you looking at just an MSSP group of patients.

So then I remembered Kate's slide where she had the Medicaid on one side and the Medicare on the other and all of those individual contracts in between, and her statements about not being able to have enough bandwidth to participate in all of this variety of ways that payers want to do that.

It really hit home again that either those that can have got to move into global risk where they are taking the global risk.

They've got enough upside potential to be able to cover those costs not worth the investment to make those things happen, but that's not everybody in the country.

And so, again, I think for us it's, you know, how do we encourage people to move further up that chain to global risk and then how do we help incentivize multi-payer models, because until all those blocks in Kate's slide get aligned, there is not going to be enough volume of patients for the specialists to want to nest their programs in an ACO and really be productive enough to make it worthwhile.

So I think I know this Committee is more, you know, for the Medicare products, but we also got to be thinking about, along with others, how do we create a multi-payer environment?

CHAIR CASALE: Great. Thanks, Angelo. Chinni?

DR. PULLURU: I iterate how these two days were really incredible as far as being able to engage in the dialogue and listen to these experts.

A couple of things that struck me was, one, you know, a few people brought up the

concept of being able to involve specialists by doing tele-consultations and bringing that into rural areas.

I think that that is an important thing to embed into compensation mechanisms, and particularly parity for specialists, because, you know, without that level of parity, it's still the time that they are spending.

I loved Mark's illustrations and slides as well, and I think that as you start to break down how prospective payment can function in a specialist world, it's good to look at, you know, there is only one health care dollar.

So when people think about things like workload credit and prospective payments for specialists that has to come out of somewhere, so just having some insight into, you know, when you do a prospective payment does that mean that you are disincentivizing procedures and so then when they do do a procedure, it gets reimbursed at a lesser rate, you know. I think these are things for people to look at.

The other thing that I found really

insightful was at the very end, Nancy Keating mentioned a methodology, and I know Lee and I looked at each other, and it was about an equity payment that would then not count under the construct of the total cost of care benchmarking, and it was like that $30 equity payment.

DR. MILLS: Three hundred.

DR. PULLURU: Three hundred. I found that particularly insightful because I do think that that's a way to sort of balance both things.

CHAIR CASALE: Yes. Great. Thanks, Chinni. Lee?

DR. MILLS: I was just sitting and reflecting on all of our comments and take-homes, and something that kept resounding to me is that we keep talking about, you know, we have to incentivize this and incentivize that and incentivize the other.

To Chinni's point, exactly, there is only the health care dollar, and it's not going up, or it's not going up indefinitely, right. I don't know if there is any other leadership culture change geeks here, but, you know, the GE accelerator model, we're focusing on the

glorious future.

I would say a modest incentive to already highly compensated physicians is not a glorious future they are going to charge towards. It's maybe a modest inducement at best.

The other part of that change model, however, is a burning platform behind you and that speaks to the inevitability that has been lost.

CHAIR CASALE: Yes.

DR. MILLS: And so all that to say, I think we really do need both sides to get this to tip over, and that takes me back to we should not shy away from figuring out how a modulated carefully thoughtful fashion to make fee-for-service a very uncomfortable place to be that ratchets up in its uncomfort over a predicted and transparent timeframe, right.

I did appreciate Kate's comment that there are plenty of physicians practicing in rural areas where there are no options, and fee-for-service is the mechanism.

But unless they see a future that's better and a path that's burning up behind them, there isn't any motivation to change that

situation, and there are multiple, we have heard multiple times, there are many really effective good ACO models that operate in rural areas all over the country.

So I don't think that should let us shy away from our guns of trying to make a model that changes incentives and makes fee-for-service uncomfortable.

CHAIR CASALE: Great. Thanks, Lee. Bruce?

MR. STEINWALD: With all due respect to Chinni and Lee, I wouldn't say there is only one health care dollar.

I would say there is three trillion health care dollars, which makes me want my last public comment on this Committee relate to the reason I think I was appointed to the Committee and to begin with, which is we've got a well-funded, possibly over-funded, health care system.

In the very broader context, what we are thinking of as transformational ought to at least bring the rate of increase on that $3 trillion down, if not the absolute amount, and still be plenty of funding to provide good care to Medicare beneficiaries and others without

any loss.

So a lot of what we should be thinking about is, you know, focusing our attention on what's good for the patient, which is easy to say, but, you know, we can do that I think without having to say, well, we've got to fund this, and we've got to fund this and add dollars to the system in order to grease the skids to move where we want to go.

CHAIR CASALE: Thanks, Bruce, I appreciate that. The only other comment, and I'll add in again all of the comments have been great, is I thought we heard the word "mandatory" more than once in the last two days.

And it wasn't so much mandatory that, you know, physicians won't do this unless we make it mandatory, it's really the thought that a couple of things that were brought up is that, again, the growth of MA has taken a large piece away.

If you just rely on voluntary, it's going to be very hard to test things going forward. And the fact that we have had, you know, we saw the analysis oncology came out, you know, but there has been a fair amount of

analysis on voluntary and, you know, there has been some wins and some sort of areas where maybe the models haven't performed as well as we have liked.

But we're still sort of in this testing and pilot phase, and I think we are at a point where more of these need to be mandatory in order to more expeditiously evaluate them so we can move things forward.

So I thought having heard that from more than just one of our presenters I think that was interesting. Jay?

DR. FELDSTEIN: Good. Out of sight, out of mind, Paul.

CHAIR CASALE: No, no, I was looking for the little yellow hand, Jay, and I didn't see it come up.

DR. FELDSTEIN: Okay. No, obviously, not a whole lot to add after what everybody said, but I just want to focus on two points.

One is, and it was alluded to yesterday almost in passing, but I don't belief enough, and that's, you know, we focus on the patient, but at the end of the day we're always talking about physician behavior, but that

translates down to patient behavior.

So how do we get the patients involved? A lot of it has to be done through benefit design because if you don't think the specialist know they are in the ACO, I guarantee you no patient knows they are in an ACO.

If you ask the average patient what an ACO is, they'd probably tell you it's a streaming station. So I think we've got to do a better job on the patient education side and have the benefit design be in concert for the behaviors we are trying to drive.

I think, you know, Mark McClellan's point that 60 percent of the care and expense is delivered through specialists. Part of that is just a real elephant in the room that, you know, we've got 500,000 specialists in this country, and we've got about, when you look at family practice and general internal medicine, you know, about 200,000 let's say primary care physicians.

The rest of the world, especially in the European countries, that's flipped. They are 70/30 primary to specialists. So we've got to figure out specialty compensation if we are

going to be successful in either bending the curve, reducing cost, or increasing quality.

CHAIR CASALE: Thanks, Jay. I appreciate those comments. So now, Audrey, I am going to ask you to continue walking us through the slides.

I know we have a few areas to try to, hopefully we can get through. So I'm going to turn it over to you.

MS. MCDOWELL: Thanks, Paul. So in the interest of time, I think maybe we will finish up the discussion about I think we were looking at enablers to support desired care delivery features.

I believe that was the next one we were going to discuss.

(Off microphone comment.)

MS. MCDOWELL: That is, it's 4(a). So 4(a) I think a lot of this does overlap with some of the things that were discussed today.

CHAIR CASALE: Yes.

*** Review of Draft Comments for the Report to the Secretary: Part 2**

MS. MCDOWELL: And so I guess one question is that it could be beneficial for us to update the comments that we have so that

they incorporate what you guys have said so that we are not kind of repeating what we just spent a half an hour discussing.

That might be more efficient as opposed to kind of taking the comments that we have as written. I think in some cases, we may already have some of the things that you said, but in other cases, we are not fully capturing that.

So, for example, on the real-time access to actionable data, we have two bullets. There probably are more bullets just based on what you guys have already discussed.

CHAIR CASALE: Yes.

MS. MCDOWELL: We had access to information and metrics on best practices. We have had a couple, actually three presentations today on performance metrics.

Infrastructure investments, we've heard a lot regarding and probably need to further refine what we have there.

So I guess my suggestion would be for staff to kind of go back and update what we have here to incorporate the comments that we heard from you guys over the past two days and then come back to the Committee as we are

drafting the report to the Secretary.

CHAIR CASALE: Yes.

MS. MCDOWELL: I think -- Steve, does that make sense? I think we've pretty much heard – are there any other questions that we need to ask the Committee in the context of preparation for the RTS?

PARTICIPANT: No. I think that we've covered that.

MS. MCDOWELL: Yes. So I think our main goal is just to make sure that we have heard from you what we need to know in order to prepare the RTS, so I think we've got what we need.

CHAIR CASALE: Oh, okay.

MS. MCDOWELL: Yes.

*** Closing Remarks**

CHAIR CASALE: Great. Okay, wow. 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 payment within in population-based total cost of care models. A special thanks to my colleagues on PTAC. There was a lot of information packed into these two days, and I

appreciate your active participation and thoughtful comments.

The Committee will work to issue a report to the Secretary on what we have learned over this year on population-based total cost of care models.

On a personal note, this is my last PTAC meeting as a member of this Committee. It has been a privilege and an honor to serve as Chair of PTAC as it undertook this important work on population-based models.

I will also note that it is also the final public meeting for my colleague Bruce Steinwald. He and I were part of the original group of PTAC members appointed shortly after MACRA was enacted in 2015.

We have both reached our term limits on the Committee. And, again, I think I speak for Bruce when I say it's been an absolute privilege to be a member of this Committee for the past six years, past seven years. Seven, yes.

MR. STEINWALD: Arithmetic was never your strong suit.

(Laughter.)

MR. STEINWALD: But I feel the same

way, it has been an honor and a privilege, and I am going to miss all of you.

CHAIR CASALE: Yes. Thanks, Bruce. So together we have been able to watch PTAC evolve over the years, and I think we are both eager to see what you do next.

Thank you all. It's been a pleasure serving with you. With that --

DR. SINOPOLI: Paul, before you close, and I think I probably represent the entire PTAC Committee, just in public I wanted to thank you, Paul, and you, Bruce, again for your leadership over the last seven years and just what a wonderful job you have done leading this group and getting us to where we are today. I just wanted to say that publicly.

(Applause.)

*** Adjourn**

CHAIR CASALE: Well, thank you all so much. With that we will adjourn the meeting.

(Whereupon, the above-entitled matter went off the record at 1:59 p.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Meeting

Before: PTAC

Date: 09-20-22

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter