PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

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PUBLIC MEETING

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Virtual Meeting Via Webex

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MONDAY, MARCH 7, 2022

PTAC MEMBERS PRESENT

PAUL N. CASALE, MD, MPH, Chair
LAURAN HARDIN, MSN, FAAN, Vice Chair
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

PTAC MEMBERS IN PARTIAL ATTENDANCE

JENNIFER L. WILER, MD, MBA

PTAC MEMBERS NOT IN ATTENDANCE

JAY S. FELDSTEIN, DO

STAFF PRESENT

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

A-G-E-N-D-A

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

10:06 a.m.

* CHAIR CASALE: Good morning and welcome to the meeting of the Physician-Focused Payment Motel Technical Advisory Committee, known as PTAC. I am Paul Casale, the Chair of PTAC.

As you may know, PTAC has been looking across its portfolio to explore themes that have emerged from proposals received from the public. Today, we're excited to kick off a three-meeting series of theme-based discussions on population-based total cost of care models.

* **Chiquita Brooks-LaSure, MPP, Administrator, Centers for Medicare & Medicaid Services Remarks**

But first, we are honored to be joined by members of leadership at the Centers for Medicare & Medicaid Services. I am thrilled to introduce Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services.

She oversees programs including Medicare and Medicaid, the Children's Health

Insurance Program, and the healthcare.gov health insurance marketplace.

A former policy official who played a key role in guiding the Affordable Care Act through passage and implementation, Administrator Brooks-LaSure has decades of experience in the federal government on Capitol Hill and in the private sector, and now it is my pleasure to welcome Administrator Brooks-LaSure.

MS. BROOKS-LaSURE: Thank you so much, Paul. It's really a pleasure to join all of you today for this first Physician-Focused Payment Model Technical Advisory Committee, or PTAC, public meeting of 2022.

As I'm sure you're aware, our Innovation Center, under the leadership of Liz Fowler, CMMI, has undertaken a complete strategy refresh of our health care payment and service delivery models.

This includes building a deeper and more fruitful relationship with stakeholders such as yourselves. We value what you bring to the table. We want to work with you, to listen

to you, and to partner with you.

CMS is pursuing every opportunity to incorporate stakeholder viewpoints and perceptions, particularly those of physicians and other providers, into every phase of the development and release of new and modified CMMI models, and we hope that you'll soon notice these deeper partnerships. That's one of the reasons I'm so glad to join you today.

Over the past decade, CMMI has developed and tested over 50 health care payment and service delivery models, but going forward, we are refreshing CMMI's strategy in order to advance value-based care.

The new strategic direction is based on five goals which will help ensure that every model is beneficiary-centered. They are to drive accountable care, to advance health equity, to support innovation, to address affordability, and to partner to achieve system transformation.

Of course, as with everything we're doing now at CMS, we are especially concerned about that second goal, health equity, and

without exception, we'll be embedding it into every CMMI model.

To us, health equity means the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

We're working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all people served by our programs by eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and by providing the care and support that our enrollees need to thrive.

That means, at CMS, how we are promoting health equity will always be the first question we ask, not the last. I want to ensure that our programs are operating to

reduce health inequities that underlie our health care system.

We saw this was especially necessary with our models when, in 2021, we conducted an in-depth performance review and found that health equity was not always a priority in model design, participant recruitment and selection, implementation, or evaluation.

To specifically advance health equity in our models, we're doing four key things: developing new models and modifying existing ones to promote and incentivize equitable care, increasing participation of safety net providers, increasing the collection and analysis of equity data, and monitoring and evaluating models for health equity impact.

Overall, to achieve our new CMMI strategic direction based on the five goals that I've just outlined, and our efforts to advance health equity will be guided by three key principles.

First, any model that CMS tests within traditional Medicare must ensure that beneficiaries retain all of the rights that are

afforded to them, including freedom of choice of all Medicare enrolled providers and suppliers.

Second, CMS must have confidence that any model it tests works to promote greater equity in the delivery of high-quality services.

And third, CMS expects models to achieve their reach into underserved communities to improve access to services and quality outcomes. Models that do not meet these core principles will be redesigned or will not move forward.

This focus is among the reasons we announce that CMMI is transitioning our GPDC[1] model to the ACO[2] Realizing Equity, Access, and Community Health, or REACH model.

This redesign, intended to provide better care for people with traditional Medicare, addresses stakeholder feedback, participant experience, and administration priorities, especially the creation of a health

1 Global and Professional Direct Contracting
2 Accountable Care Organization

system that achieves equitable outcomes through high-quality, affordable, person-centered care.

At its crux, the ACO REACH model builds on CMS' 10 years of experience with accountable care initiatives such as the Medicare Shared Savings Program, the Pioneer ACO Model, and the Next Generation ACO Model.

It improves the GPDC, I always want to say GDP when I see that acronym, and it features several new design elements and a more rigorous applicant screening process, which will ensure that participants' interests align with CMS' vision for value-based care.

The new model will strive to meet the following aims: a greater focus on health equity and closing disparities in care; an emphasis on provider-led organizations and strengthening beneficiary voices to guide the work of model participants; stronger beneficiary protections through robust compliance with model requirements; greater transparency and data sharing on care, quality, and financial performance of model participants; and stronger protections against

inappropriate coding and risk score growth.

The model participants will be led by health care providers and require representation from patient and consumer advocates.

To support equity, the ACO REACH model will specifically require participants to develop health equity plans that identify health disparities in their communities and how to address them, use innovative payments to better support care and delivery of coordination for our underserved communities, select demographic and social needs data to monitor progress in reducing disparities, and expand access to care through nurse practitioners.

Beneficiaries with traditional Medicare who receive care through a REACH ACO may have greater access to enhanced benefits and certain incentives such as telehealth visits, home care after leaving the hospital, and help with copays. Overall, beneficiaries can expect the support of REACH ACO to help them navigate an often complex health system.

We're committed to continuing testing the ACO REACH model because Accountable Care Organizations make it possible for patients in traditional Medicare to receive greater support managing their chronic diseases, to receive assistance transitioning from the hospital to their homes, and to receive preventive care that keeps them healthy.

Additionally, REACH ACOs will also provide novel tools and resources for different types of health care providers, including primary and specialty care physicians, to improve the quality of care for people with traditional Medicare.

The model will also offer providers more predictable revenue and flexibility to meet patient needs. This will allow providers to be more resilient in the face of health challenges like the current public health emergency.

CMS is committed to promoting value-based care that improves the health experience for all of our enrollees, including people with

Medicare, Medicaid, and CHIP[3], and marketplace coverage through our health care delivery and service payment models, and we are committed to being strong partners to the providers that participate in our models.

Of course, we cannot do this alone. We need you, and we look forward to future discussion and collaboration with you and all of our stakeholders.

As I said in my opening of my remarks, we want to work with you, to listen to you, and to partner with you, as we very much value what you bring to the table.

So, with that, let me turn it over to Liz Fowler as we continue to discuss our priorities. Liz?

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

DR. FOWLER: Thank you,

3 Children's Health Insurance Program

Administrator Brooks-LaSure. I really appreciate the chance to hear from you, as I'm sure everyone else does.

So, good morning, members of PTAC and everyone else who is participating in today's meeting. I'm really delighted to have the opportunity to speak with you again and share where CMS, the Innovation Center is heading in terms of implementing the strategy.

As the Administrator just explained, last fall, we launched a strategic refresh and detailed our vision for a health system that achieves equitable outcomes through high-quality, affordable, person-centered care.

And while many of you already are aware and familiar with our white paper on strategy, I will take a moment just to highlight the five objectives which the Administrator introduced earlier and just talk a little bit about how these are serving to guide and prioritize our work, and then also, I think, it offers a chance for us to coordinate more closely with PTAC.

So, the five priorities, first of

all, starting with drive accountable care, it's really our central goal to increase the number of people in relationships with providers that are accountable for their patients' costs in improving their care, and this requires beneficiary access to advanced primary care and ACO models that coordinate with or are integrated with specialty care to meet the full range of patient needs.

And when we think about entities that can be accountable for the patient care, it includes physician group practices, hospitals, other health care providers, Medicare Advantage Plans, PACE[4], or even Medicaid management care plans.

And we've set a goal for ourselves that by 2030, all Medicare fee-for-service beneficiaries and a vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost.

And I think here it is really relevant, the remarks and agenda that you've

4 Program of All-Inclusive Care for the Elderly

set out for your meeting today and tomorrow, to help inform some of our thinking in this area.

So, we are considering incentives for specialists to participate in models focused on improving the referral process, reducing unnecessary referrals, limiting low-value tests and procedures, improving communications, et cetera, when those services are a significant source of specialist revenue.

So, how do we empower ACOs with the necessary leverage to engage specialists given that ACOs are not able to drive volume in the same way that commercial payers can?

Second, advance health equity, and the Administrator spoke eloquently about the focus and importance of advancing health equity, not just for the Innovation Center, but for CMS more broadly.

And as she said, we are embedding and committed to embedding equity into all aspects of our payment and service delivery models and increasing the focus on underserved populations.

Stakeholders can help us understand

how the Innovation Center can better collaborate with community-based organizations and other entities to increase the reach of value-based models to underrepresented and underserved populations.

We want to understand more about what financial supports and payment methodologies could incentivize and sustain safety net participations [participation] and help manage risk.

I also want to take this opportunity to spotlight an article published by Health Affairs last Thursday, March 3, titled CMS Innovation Center Launches New Initiative to Advance Health Equity, and authored by Dr. Dora Hughes, our Chief Medical Officer. It outlines the Center's new initiative to advance equity in greater detail.

And I also invite you to listen to a roundtable discussion on how we can support safety net provider participation in value-based care in CMS innovation models. It's scheduled for Wednesday, March 16, from 1:00 to 3:00 p.m. Eastern Time. Please register and

join us.

The third pillar is supporting innovation. We can do more to support model participants as they look for ways to innovate care delivery approaches, and some of these supports include actionable and practice-specific data, technology, dissemination of best practices, peer-to-peer learning collaboratives, and payment flexibilities.

Address affordability. In addition to our payment models, reducing expenditures in Medicare and Medicaid, our models also should have an impact on lowering patients' out-of-pocket costs.

And you heard the Administrator earlier this morning that this is a priority, and we'll be looking at strategies that target health care prices, affordability, and as I mentioned, reduce low-value or duplicative care.

And finally, partner to achieve health system transformation, and this is aimed at really furthering the reach of health transformation.

We need to align our priorities and policies across CMS and work in tandem with commercial payers, purchasers, states, and beneficiaries, and I think here is another area where we see possibility for collaboration and coordination more closely with PTAC.

So, a core part of our strategy is creating a more streamlined model portfolio, and we are committed to having a more cohesive articulation of how all of our models fit together.

This strategy provides the principles and lessons learned that will be the basis for what we do going forward. We're prioritizing models that advance transformation via accountable care, advancing health equity, and care innovations.

We want beneficiaries to have a provider that is accountable in the system for providing high-quality integrated care that supports patient-specific health and personal goals.

So, we have a long history of testing bundled payment models to drive

improved quality and lower costs for episodic care, and we don't want to lose momentum from our current episode-based payment models and the care transformation that we've seen in different specialties, for example, oncology, orthopedics, and cardiology among others.

However, we have realized, and it's come to a stark realization, we cannot create episode-based payment models for every specialty in silos moving forward.

So, I think there's a role for PTAC in really helping us think through this integration and what makes the most sense as we think about population-based total cost of care and specialty care working more hand in hand and coordinated.

So, we're excited that the PTAC meeting presentations and discussions planned for today and tomorrow are focused on addressing some of these very same challenges, and I just want to thank Dr. Casale and PTAC for their valued work and continued support for health care transformation, and thank the Committee for putting together a vigorous

agenda and impressive panel of experts. So, thank you for your attention and best wishes for a great meeting.

CHAIR CASALE: Thank you, Liz, and thank you both for joining us to provide those remarks. We look forward to continuing to work with your teams.

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

CHAIR CASALE: Since our public meeting last September, the Committee has issued two reports to the Secretary of HHS[5] with our findings on themes related to physician-focused payment models. The first was on optimizing care coordination, and the second was on addressing social determinants of health and equity.

You can find our reports and other materials related to these topics, including detailed environmental scans and public comments, on the ASPE PTAC website. There, you

5 Health and Human Services

can also find resources for designing payment models, including a reference guide we created on common APM[6] approaches.

Also, I'm excited to welcome three new members of PTAC: Dr. Larry Kosinski, the founder and Chief Medical Officer of SonarMD; Dr. Walter Lin, the founder and CEO of Generation Clinical Partners; and Dr. Chinni Pulluru, Senior Director of Clinical Transformation at Walmart Health.

PTAC's Vice Chair Lauran Hardin and I welcome you. These new members were appointed by the Government Accountability Office in October and have really hit the ground running with the Committee's work.

I'll note that, as always, the Committee is poised and ready to receive proposals from the public on a rolling basis. We currently offer two proposal submission tracks for submitters to offer flexibility depending on the level of detail that is available about their payment methodology. You

6 Alternative Payment Model

can find information about how to submit a proposal online.

As I mentioned at the outset, we are kicking off a new series of theme-based discussions today. The Administrator's strategic vision for CMS includes six pillars, one of which is driving innovation to tackle health system challenges and promote value-based, person-centered care.

The Innovation Center's strategic refresh includes a bold vision in which all Medicare beneficiaries with Parts A and B will be in a care relationship with accountability for quality and total costs of care by 2030.

One of the goals is to increase the capacity of providers to participate in value-based models with population-based payments and total cost of care approaches.

Implementing that vision involves addressing countless complexities, from definitional and structural issues to care delivery models, attribution, and benchmarking.

That is why we have chosen to look across proposals submitted to PTAC and to hold

our first ever series on population-based total cost of care models.

This series of theme-based discussions will span three public meetings, each on a different aspect of issues related to population-based total cost of care approaches.

Today and tomorrow, we are going to focus on key definitions, issues, and opportunities related to population-based total cost of care models.

We will explore which services should be included when defining total cost of care in the context of population-based models, as well as the conceptual and structural issues related to designing them.

We also want to understand how to enhance provider readiness to participate in these models, another one of the Innovation Center's goals.

We're particularly interested in how to structure population-based models, including the payment mechanisms, benefit design, and patient assignment.

We're also curious about how future

larger population-based models might relate to episode-based and condition-specific models, incentivizing coordination between primary care and specialty providers, equity implications, and opportunities for multi-payer alignment.

That is a very ambitious agenda and a broad topic, which is why we will examine these issues throughout 2022.

In June, we're going to focus on best practices for care delivery, improving quality, and measuring the success of population-based total cost of care models.

We will invite physician executives and other thought leaders to discuss care delivery innovations and improvements that have the potential to improve quality and reduce total costs of care.

We'll explore performance metrics, data collection, evaluation, and the best ways to address areas like behavioral health and social determinants of health.

Our September public meeting will focus on the payment considerations and financial incentives related to population-

based total cost of care models.

That is when we will discuss options for financing these models, to incentivize care delivery improvements, and provider participations. We'll also explore issues such as attribution, benchmarking, risk adjustment strategies, and moving towards downside risk.

So, if we don't cover a specific total cost of care topic today or tomorrow that you are interested in, you are likely to hear about it later this year.

You can also read our environmental scan online, which is part of our background materials for this theme.

This series of three public meetings will culminate in a report to the Secretary of Health and Human Services with our findings about best practices.

Today, we have multiple presenters ready to describe their vision and experiences related to developing population-based total cost of care models; then the Committee will discuss what we've learned before adjourning for the day.

Tomorrow, we have another set of experts giving presentations, followed by a panel discussion on definitional issues.

We have worked hard to include a variety of perspectives throughout the two-day meeting, including the viewpoints of previous PTAC proposal 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 in advance to give an oral public comment tomorrow, but would like to, please email PTACregistration@NORC.org.

After public comments, the Committee will have a discussion to shape our comments that will be included in the report to the Secretary of HHS that we will issue later this year.

Finally, we'll adjourn after announcing a Request for Input, an opportunity for stakeholders to provide written comments to the Committee on population-based total cost of care models.

Taken together, the prep work, the presentations and discussions, and the public comments are aimed at informing PTAC about the latest knowledge from the field about the development of population-based total cost of care models in the context of APMs and physician-focused payment models.

* **PTAC Member Introductions**

At this time, I would like PTAC members to please introduce themselves. Please share your name and your organization. If you would like, feel free to share a brief word about any experience you have with population-based payment or total cost of care models.

Because our meeting is virtual, I will cue each of you. I'll start. I'm Paul Casale. I'm a cardiologist and Vice President for Population Health at NewYork-Presbyterian. I lead NewYork Quality Care, which is the Accountable Care Organization for NewYork-Presbyterian, Weill Cornell, and Columbia University. Next is Lauran?

VICE CHAIR HARDIN: Good morning. I'm Lauran Hardin. I'm a nurse and Senior

Advisor for the National Center for Complex Health and Social Needs and the Illumination Foundation. I've been involved in care management design for pretty much every value-based payment model that we have created across the country, and currently work on flow design of models for underserved, under-resourced, and complex populations.

CHAIR CASALE: Thanks, Lauran. Larry?

DR. KOSINSKI: I'm Larry Kosinski. I am a gastroenterologist, having practiced for 35 years. Currently, I am the Chief Medical Officer of SonarMD, the company that I founded back in 2016.

I have been involved with value-based care for the last 10 years, attempting to move my gastroenterology colleagues from fee-for-service to value-based care. I am honored to be part of the PTAC Committee and look forward to today's presentations and discussions.

CHAIR CASALE: Thanks, Larry. Josh?

DR. LIAO: Good morning, everyone,

Joshua Liao here. I am a physician and an academic at the University of Washington in Seattle where I study the impact and relationship between payment models in patient and population outcomes.

In addition, I'm also fortunate to provide leadership to several accountable care models that my organization is in.

CHAIR CASALE: Great. Walter?

DR. LIN: Good morning. My name is Walter Lin. I'm the founder of Generation Clinical Partners. We are a medical practice that focuses on caring for frail Medicare beneficiaries in senior living organizations with the vision of helping these organizations, as well as medical practices like ours, transition into a world of value-based care.

CHAIR CASALE: Great. Lee?

DR. MILLS: Morning. I'm Lee Mills. I'm a family physician, and I previously have served as chief medical officer and chief quality officer of two different Accountable Care Organizations.

And I now serve as Senior Vice

President and Chief Medical Officer of CommunityCare of Oklahoma, which is a regional, provider-owned health plan that operates in the commercial exchange and Medicare Advantage space, a fully capitated at-risk model for all of our lives.

CHAIR CASALE: Great. Chinni?

DR. PULLURU: Hi, everyone, and good morning. I'm Chinni Pulluru. I'm a family physician by trade. I lead our clinical enterprise in care delivery for Walmart Health and manage care delivery across our underserved areas, as 80 percent of our stores are in underserved areas.

Prior to that, I was the clinical lead of a large multi-specialty group independent, and managed value-based care across the risk spectrum, including total cost of care delivery.

CHAIR CASALE: Great, thanks, Chinni. Angelo?

DR. SINOPOLI: Yes, thank you. Angelo Sinopoli. I'm a pulmonary critical care physician by training. I most recently was the

chief clinical officer for Prisma Health, where I ran a large clinically integrated network of about 5,000 physicians, and was the founder and CEO of an enablement company called the Care Coordination Institute.

I'm now the Chief Network Officer for a company called UpStream, which is a risk-bearing, value-based company that partners with primary care docs to support them in their value-based journey.

CHAIR CASALE: Great, thanks, Angelo. Bruce?

MR. STEINWALD: Hi, I'm Bruce Steinwald. I'm a health economist right here in northwest Washington. Along with Paul Casale, I've been a member of PTAC for six-and-a-half years.

CHAIR CASALE: Thanks, Bruce. And Jennifer?

DR. WILER: Hi, I'm Jennifer Wiler. I'm currently the Chief Quality Officer of Metro for UCHealth. I'm a tenured professor of emergency medicine at the University of Colorado, and I'm also the cofounder of

UCHealth's CARE Innovation Center, where we partner with entrepreneurs in digital health companies to grow in scale their solutions to improve health care outcomes and value.

I've participated in a number of groups around migration from fee-for-service to value-based care, and I was a co-developer of a model, prior to my being on the PTAC, that was evaluated and approved by PTAC and considered by CMMI. I'm really looking forward to the conversation today.

*** Presentation: An Overview of Proposals Submitted to PTAC with Components Related to Population-Based TCOC Models and Other Background Information**

CHAIR CASALE: Thank you. So, now let's move to our first presentation. Three PTAC members served on the Preliminary Comments Development Team, or PCDT, that has worked closely with staff to prepare for this meeting. I'm thankful for the time and effort they've put into organizing today's agenda.

We'll begin with the PCDT presenting

some of the findings from their background materials available on the ASPE PTAC website. PTAC members, you will have an opportunity to ask the PCDT any follow-up questions afterward. And now I'll turn it over to the PCDT lead, Larry Kosinski, and the rest of the team, Chinni and Josh.

DR. KOSINSKI: Thank you, Paul. As the lead

of the Preliminary Comments Development Team for this meeting on total cost of care, my task today is to present to you an overview of the proposals previously submitted to PTAC that included components related to population-based total cost of care. The entire team also included Chinni Pulluru and Josh Liao. I'd like to begin by providing some background information. Next slide.

From 2016 to 2020, PTAC received 35 stakeholder-submitted physician-focused payment model proposals. During this period, PTAC voted and deliberated on 28 of them, assessing whether they met the Secretary's 10 regulatory criteria, with specific emphasis on quality and

cost.

Nearly all of the submitted proposals addressed their specific potential impact on cost, but 10 proposals specifically discussed the use of total cost of care measures in their payment methodology and performance reporting.

This presentation provides a summary of the characteristics of the 10 selected PTAC proposals that included components related to total cost of care. It also includes additional background information on definitions and issues related to population-based total cost of care models.

If you need further information, please refer to the environmental scan on population-based total cost of care in the context of Alternative Payment Models and physician-focused payment models. Next slide.

I'm now going to present a few slides of background information. The first of which you see here is the purpose is to emphasize that CMMI, as you have heard earlier, has set one of its goals as having every

Medicare fee-for-service beneficiary to be in an accountable care relationship for quality and total cost of care by 2030. Next slide.

On this slide, you see an illustration taken from a 2017 white paper by the Healthcare Payment Learning and Action Network which established an APM framework with the goal of moving payments away from fee-for-service and into population-based payments.

CMMI's statement is definitely focused on bullet B in category four, comprehensive population-based payment models. That is not to say that condition-specific substructures cannot be nested within more comprehensive models, but our focus should be on large, comprehensive population-based models.

This will require an increase in the number of health care providers that can participate in these accountable models, including their ability to accept outside risk. It will also require an increase in coordination between different providers, be

they PCPs[7] or specialty care physicians. Next slide.

Our major focus in this meeting will be the defined total cost of care. Unfortunately, there are differences in how total cost of care is currently defined across Alternative Payment Models.

PTAC is using the following working definition for defining total cost of care in the context of these models. Total cost of care is a composite measure of the cost for all covered medical services delivered to an individual or group of individuals.

In the context of Medicare APMs, total cost of care typically has included only Parts A and B expenditures and is calculated on a per-beneficiary basis over a specified time period.

This definition will likely evolve as the Committee collects additional information from its stakeholders. Next slide.

We'd like to show two examples of

7 Primary care providers

selected CMMI models where total cost of care has been defined. The first is the Maryland Total Cost of Care Model. In this model, total cost of care is defined as the aggregate Medicare fee-for-service costs for all items and services delivered to Medicare fee-for-service beneficiaries. Again, this all includes Parts A and B.

In the Global and Professional Direct Contracting Model, now known as ACO REACH, total cost of care is defined as the average Medicare beneficiary Parts A and B expenditures for aligned beneficiaries between a baseline in a performance year. Next slide.

Let's look now at a definition of population-based total cost of care models. PTAC is using the following working definition of a population-based total cost of care model as a guide for focusing us during this theme-based discussion.

We've defined it as a population-based Alternative Payment Model in which participating entities assume accountability for quality and total cost of care. They

receive payments for all covered health care costs for a broadly defined population with varying health care needs during the course of a year.

Within this context, we are not referring to episode-based, condition-specific, or disease-specific specialty models. However, these type of models could potentially be nested within population-based total cost of care models.

Again, this definition will likely evolve as the Committee collects additional information from its stakeholders. Next slide.

So, what are the key characteristics of future population-based total cost of care models? There are areas where there appears to be general consensus.

Models should facilitate accountable relationships for quality and total cost of care. They should encourage care coordination and integration of specialty care with primary care, particularly for beneficiaries with complex needs.

They should improve the patient

experience and their outcomes. They should facilitate identification of and sharing of best practices.

They should use performance metrics, including patient-centered metrics, to incentivize quality improvements. They must focus on improving health equity, and they should align provider and beneficiary incentives. Next slide.

There are areas where additional discussion is needed though. The definition of total cost of care which prescribes the services that are included, specifically those that are best for the patient -- this is the focus of our meeting: identification of types of accountable entities and types of clinicians and groups that participate; the duration of an accountability period; the minimum threshold number of patients that could be included or should be included; options for the desired care delivery model; variations in structure of payment models; how to do patient attribution, benchmarking, and risk adjustment; how to incentivize participation and facilitate

transition -- not all providers are prepared to have 365-day accountability for total cost of care with two-sided risk; encouragement of multi-payer alignment on model design components; and how to address overlap between these models, and that's the carve-outs.

These all need further discussions, and I hope we will be addressing them through this meeting and the future meetings later this year. Next slide.

So, what potential services should be included in population-based total cost of care models? As we saw in our examples, current population-based Medicare APMs typically include accountability for only Parts A and B expenditures.

This typically includes professional and facility expenditures for inpatient ED[8] and outpatient care. It usually includes provider-administered medications like biologic drugs, but not patient self-administered drugs, which can be equally as expensive.

8 Emergency department

There may therefore be interest in including additional services in future population-based total cost of care models to support self-administered specialty drugs, behavioral health, long-term services and its support, home and community-based services, and screening and referral to address social needs.

These additional services would promote patient-centered care and address the social determinants of health. Next slide.

So, how have these components been incorporated into the 10 PTAC proposals that focused on total cost of care? We're going to discuss this now. Next slide.

Let's look at the characteristics of the 10 selected PTAC proposals that included total cost of care components. At least 10 of the submitted proposals were identified as having components related to total cost of care in their payment methodology and performance reporting.

One of these proposals had an advanced primary care focus, three had a population-specific focus, and six of these

proposals had an episode-based focus.

As you can see in the table at the bottom, the 10 PTAC proposals varied by clinical focus and setting of care. Six were only PCP-focused, seven were only specialty-focused, eight did focus on both, six were hospital clinic-focused, three were in the patient home, one was in a skilled nursing facility, four were oncology-related, and three focused on chronic or advanced illness. What we do not see are large population-based total cost of care amounts. Next slide.

All 10 of these PTAC proposed models did seek to reduce health care costs. Common cost reduction objectives in these proposals included decreased hospitalizations and ED visits, limiting costs associated with a particular episode of care, and avoiding unnecessary services and medications. Next slide.

Common cost reduction approaches in these models included improving care management and establishing financial accountability through payments with two-sided shared risk,

with or without a stop-loss provision, and performance-based incentive payments contingent on quality, cost, and/or utilization of care. Next slide.

Performance measures in these models varied across three domains: cost measures, utilization measures, and quality measures.

Looking at the cost measures, many of the PTAC proposals included total cost of care for a specific group, episode, time period, or care component as a cost-specific performance measure.

Additional cost measures included net savings or losses to Medicare Parts A and B, and supportive and maintenance drug costs.

With respect to utilization measures, all 10 of the PTAC proposals included utilization measures related to total cost of care, including the number of ED visits, ICU[9] days, and hospital admissions, including unplanned hospital readmissions within 30 days, and then medication-related complications.

9 Intensive care unit

Finally, looking at quality measures, all 10 of the PTAC proposals included quality measures related to total cost of care, including patient satisfaction, medication review, timeliness of care, comprehensive assessments and screening, and advanced care planning. Next slide.

Let's look now at some additional background information from the environmental scan. Next slide.

Various CMMI models and other CMS programs have included relevant approaches for the development of future population-based total cost of care models.

The evolution of various CMMI models and other CMS programs includes a range of approaches that can provide relevant information for developing future population-based total cost of care models. We've included them in the figure to the right.

They fall into three categories: population-based like MA,[10] MSSP,[11] ACOs, and the

10 Medicare Advantage
11 Medicare Shared Savings Program

Maryland Total Cost of Care Model and ACO REACH; episode-based or condition-specific like the oncology care model and BPCI[12]; and then finally, advanced primary care like CPC+[13] and Primary Care First.

Let's look at each of these categories to see how they compare with respect to the care transformation strategies, payment mechanisms, incentives around total cost of care, and finally, try to note each of their specific issues and considerations. Next slide.

Starting with the current population-based model, the typical care transformation strategy was shared accountability around quality and cost.

Various payment arrangements exist from fee-for-service to capitation, but most of them are keyed to a bonus payment when costs are below threshold. Incentives are based on these performance bonuses.

There have been challenges in these

12 Bundled Payments for Care Improvement
13 Comprehensive Primary Care Plus

models, including attribution, risk adjustment, benchmarking, issues related to safety net provider participation, provider consolidation, and whether or not to include or exclude drug coverage. Next slide.

Looking at the current episode-based or condition-specific models, like the population models, the care transformation strategy in these models is also based on shared accountability around quality and cost, but for further specific episodes or conditions.

The payment arrangement is typically tied to prospective payments that result in two-sided risk. This two-sided risk is benchmark-based, and there may be separate payments for care coordination.

Importantly, the key here is that these models can be nested within large population-based models. Next slide.

Insights from the current advanced primary care models demonstrate some differences from the other two models. The care transformation strategy for advanced

primary care is largely based on patient-centered medical homes. The payment mechanism is population-based and prospective.

The incentive is a positive performance-based adjustment based on a comparison with the benchmark. And the major issue here is that specialists and hospitals still operate on a largely fee-for-service system and are incentivized to delivery high-volume, high-cost care. Next slide.

We would be remiss if we didn't mention insights from selected Medicaid programs. Section 1115 waiver programs use a care transformation strategy for accountable entities that use a network of providers responsible for delivering all primary care and coordinating this across the full spectrum of services.

Payment mechanisms have included various payment arrangements, including episodes of care, bundled payments, shared savings, and capitation.

There have been mixed outcomes regarding cost savings, but there are

opportunities for multi-payer alignment and some of these ideas could be transferable to Medicare. Next slide.

There have been encouraging findings on the effectiveness of population-based approaches in improving quality and reducing total cost of care.

ACOs with greater financial accountability are more likely to deliver better coordinated and efficient care for Medicare patients.

Several evaluations of models that seek to reduce total cost of care have demonstrated the role these initiatives have played in reducing health care costs while still maintaining or improving quality of care.

Some of these programs have shown success targeting higher-risk, higher-cost beneficiaries where there is a greater potential for reducing expenditures and utilization. Next slide.

There have been challenges though. Let's look at the many challenges related to designing effective population-based total cost

of care models.

There's limited research exploring the relationship between total cost of care, care coordination, and health equity.

There continue to be disparities in savings associated with various approaches for reducing total cost of care that vary based on a range of factors, including geographic location, patient population. Provider readiness to participate in an APM varies across the spectrum.

Several evaluations of APMs that include approaches for reducing total cost of care have observed negative returns on investment. This may not be due to structural flaws, but may be due to the time necessary to generate these savings.

And finally, there continue to be questions regarding the impact of voluntary versus mandatory implementation of APMs under Medicare, with mandatory models obviously posing challenges for provider engagement. Next slide.

So, what are the potential

opportunities for improving multi-payer alignment? These include multi-layered accountability structures or established governance with multiple payer participation and representation, for example, nesting; leveraging state-specific models to build upon existing value-based models; providing technical assistance to ensure that commercial, Medicare Advantage, and Medicare provider payment reforms meet the standard for Medicaid APMs and therefore qualify for bonus payment incentives.

A key goal would be to bring providers' panels under one set of common initiatives to align incentives, reduce administrative burden, and increase the business case for provider engagement in a meaningful delivery system reform.

Some experts believe payer participation in multi-payer models can increase engagement in value-based payment models. Examples include the Maryland All-Payer Model, the Pennsylvania Rural Health Model, and the Vermont All-Payer Model. Next

slide.

Our last topic surrounds areas where additional information is needed. We need broader vision regarding the structural elements of future population-based models and how they would compare to current models and programs, such as whether their payment model would be based on a fee-for-service architecture with two-sided risk or capitation.

We need to define the services that are appropriate for including in future population-based models in order to optimize patient-centered care.

We need to investigate and define the relationship between broader population-based models and episode-based or condition-specific models which are nested within them.

And very importantly, we need to figure out how to enhance provider readiness and incentivize provider participation in payment models with two-sided risk through innovative physician payment model reform, particularly for the independent physician practices and safety net providers.

Finally, we need to investigate opportunities for addressing equity issues and incentivizing screening and referrals for social determinants of health.

That's my last slide. For those of you who want further information on the PTAC proposals we reviewed for this presentation, I'd refer you to the Appendix on Total Cost of Care. And I would also ask my other two colleagues, Chinni and Josh, if they have any additional thoughts?

DR. PULLURU: Thank you, Larry, none at this time.

DR. LIAO: I agree. Great review of our information.

DR. KOSINSKI: Back to you, Paul.

CHAIR CASALE: Great, thank you, Larry, and to the whole PCDT team, for a very comprehensive presentation.

So, we have a few minutes. I'd like to open it up to PTAC members. Any follow-up questions? That was a lot of information and really helpful. Any follow-up questions for the PCDT?

VICE CHAIR HARDIN: Larry, that was a tremendous presentation. Very well done. I just have a follow-on question. In the research and the review, one of the things that comes up as we look at equity and integration of social determinants of health in screening is actually the financing for the services to deliver, and so I'm curious if you had conversation about that or what themes came up related to that. It's wonderful to screen and refer, but on the other side of that, the financing of those services was so important.

DR. KOSINSKI: Well, we discussed it to a small extent, but if an entity is under total risk, then all of these other components can, in their own way, decrease the total cost of care. If you're not under a total risk-based model, it's difficult to include that.

DR. PULLURU: Lauran, the components that we also touched on, and to add to what Larry had said, was that is there a way to sub-stratify this risk and really make sure that vulnerable populations, you know, sort of have that compensation attributed to that

beneficiary, and how do we do that in a way that helps provider groups and systems fund that.

VICE CHAIR HARDIN: Thank you.

CHAIR CASALE: Other questions for the PCDT? You can either raise your hand in Webex or simply just raise your hand and ask a question.

Larry, on that slide of challenges, and I know each one of them seems daunting almost, but as the PCDT discussed the challenges, did one or two sort of rise to the top of the list in terms of maybe being the most difficult to overcome as we move towards this population-based lower cost of care?

DR. KOSINSKI: I think the most significant one is how to bring the specialists into value-based care. You know, PCPs have a long history of capitation and working in a value-based environment. Specialists are still paid discounted fee-for-service. So, how to bring them into the value-based space is going to be a major, major challenge. It has to be done though.

CHAIR CASALE: Agreed. Josh and Chinni, any additional comments on those challenges and thoughts?

DR. PULLURU: One of the things that we spoke about, Paul, was how, you know, sort of the negative return on investment initially and the time lag that it takes to generate savings and therefore, you know, most systems that run with very low margins, you know, how do you do that front-end investment, and so how do we solve for that in especially provider-based groups.

DR. LIAO: I'm just going to briefly add to the comment that Larry made, that I think, you know, how to integrate primary care and other clinicians, I think, is important.

Particularly when we're thinking about accountability, I think some of what we saw was, you know, communication and connection is one thing, but that doesn't itself, at least in my view, equal accountability.

So, that's where the kind of proverbial rubber meets the road with payment incentives and care delivery models, so I think

that's really the crux of the work.

CHAIR CASALE: Yeah, I would agree, and I would certainly agree with all of those comments, and I think understanding on who to identify as the accountable.

You know, there's often shared accountability, which can often in some ways, unfortunately, lead to no accountability because no one's quite said, you know, for a particular beneficiary, I am, you know, we will be the accountable or I will be the accountable, and so trying to navigate all of that, I think, can be particularly challenging. Other questions?

DR. LIN: Paul, I have a question.

CHAIR CASALE: Walter, go ahead. I'm sorry.

DR. LIN: Oh, great, thanks. Sorry, I was waiting to be recognized. So, first, Larry, Chinni, and Josh, thank you so much for that really great comprehensive review. Thanks also for the PTAC staff for all their assistance.

My question centers around kind of

whether you found any innovative physician payment models within the 10 PTAC proposals that you looked at for this presentation.

Were there any ways of aligning physician behavior to achieve those outcome measures that you described during the presentation?

DR. KOSINSKI: Well, you're going to hear of one later on this morning from me, but it's essential that providers get some type of support for this transition.

So many of the commercial models are based on a shared savings at the end of a time period, but there's no investment into helping the groups make the transition.

And so, I think it's critical that we have to invest in order to get a return here, and the current structures of practices are not designed to succeed in value-based care, but I'm going to present something later on this morning.

CHAIR CASALE: That's great. So, I want to once again thank you, Larry, Chinni, and Josh. This is really helpful background

for our discussions today.

So, at this time, we have a break until 11:15 Eastern Time, so please join us then. We have a great lineup of guests for our first listening session of the day.

(Whereupon, the above-entitled matter went off the record at 11:06 a.m. and resumed at 11:17 a.m.)

CHAIR CASALE: So, welcome back. I'm excited to welcome our first listening session on issues related to population-based total cost of care models.

Larry and the PCDT team helped us level-set with helpful background information, including how previous proposals submitted to PTAC incorporated relevant components.

*** Listening Session on Issues Related to Population-Based TCOC Models Day 1**

Now, we've invited four outside experts to give short presentations on their vision for population-based total cost of care models, based on their experience.

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

So, presenting first we have Dr. Michael Chernew, who joins us from Harvard Medical School. Michael, I'll turn it over to you.

DR. CHERNEW: Thank you. It is wonderful to be here. I wish I could actually be there. Maybe you all wish you all could actually be there.

But it is nice to see you, at least the subset of you I can see on my screen now. Thank you so much for having me.

I will emphasize as I go through this, that these thoughts are mine and mine alone. They don't reflect the views of MedPAC. So, understand I'm speaking in my role as a professor, not as my role of Chair of MedPAC. I may say that multiple times. Okay, next slide.

So, let me just lay out something I

think you all know, but I use it as a touchstone for me when I start talking. And that's sort of the broad theory of value-based payment, or, for that matter, Alternative Payment Models.

The main view, it was my view, is efficiency in the health care system requires flexibility in how inputs are used. That's actually true of any industry. Efficiency requires us to be able to substitute some inputs for other inputs, to get more output for less resource use.

In the case of health care, we should think of health care services -- hospital bays, imaging procedures, lab tests, drugs -- those services are inputs.

The output is actually health. So, our basic goal for efficiency is to produce more health with fewer inputs.

And the flexibility allows us to substitute those inputs to capture gains from efficiency, and that ends up being very important. So, next slide.

The challenge is that the fee-for-

service system doesn't really encourage that type of flexibility, because you basically get paid for which inputs you use, more so than the outputs you get, or anything like that.

So, our goals, as Alternative Payment Models, is to create incentives to save, to become more efficient.

And the key question related to a lot of the discussions we're going to have, I think, is who -- by that I mean what type of provider -- is best-suited to eliminate whatever waste you believe there is in the health care system.

We want to create incentives to promote access to care and quality and equity. Again, flexibility can help all of those goals. And we want to create incentives for organizations to participate in the models.

I'll emphasize that participation is not a goal in and of itself. But any program of Alternative Payment Models can't succeed without people participating in it.

So, in all these models there's always this question of how you induce or

mandate participation. How do you get people in while you meet your other goals? Next slide.

So, I'm going to make two main points today. In fact, when I'm done with this, maybe you'll hear some detail. But this is pretty much the conclusion in Slide 3.

The first point is, no payment model's an island. While we have environments that have models in them, they all interact because the delivery system is influenced by all the payment models that occur.

So, we often think about how well would a payment model perform against, say, nothing. But the real question is, how well would a payment model function in the environment to which it's introduced. And that environment is seldom nothing.

Which leads me to my second point, which is the APMs that we do have need to work together. We need to be aware of this sort of a broad portfolio of models. Next slide.

So, when a lot of this current journey was launched into payment reform, we

launched it under what I used to consider many flowers bloom test/test and diffuse paradigm.

So, the basic idea was you're going to have a lot of payment models, we're going to try a bunch of them by testing them. The ones that work you're going to let diffuse, and the ones that didn't work -- it was complicated because knowing what the control group is was hard because the environment was changing. You never knew if you participated in a model, whether that model was going to continue.

So, every model had an uncertain future, which discouraged participation, and it tended to disincentivize savings, because you don't want to make a big investment to succeed in a model that may get sunsetted.

If you have a lot of models occurring at the same time, the savings might get siphoned away. What I mean by that is, there's a certain amount of waste in the system.

And when we set up a portfolio of payment models, we're essentially assigning the waste to a delivery organization. And if they

can eliminate that waste, they get to share in some of the savings.

But if we have a broad model -- think population-based payment models -- where the waste is assigned, for example, to an organization of employees, the primary care physician, and then we take a portion of that waste and assign it to another model -- say, an episode model -- that removes the potential savings that the ACO could have had from trying to eliminate the same way.

Now, they might not have done it, but you're reassigning where the waste goes, and that discourages participation and disincentivizes savings.

So, for example, if you had a model that was assigned to, say, physicians to manage congestive heart failure, but you gave savings associated with anything post-hospitalization to, say, a hospital, as opposed to, say, the cardiologist -- just picking an example -- you discourage the cardiologist from participation, because you've taken a certain portion of waste in that stream and assigned it to some other

entity.

When you have a lot of models' participation, the model selection can be game. Some people might want to choose one model, other people might want to choose another model. If the models overlap in varying ways, they can game them because there are often parameter differences. How the benchmarks are set, for example, with quality measures there are.

And all of this leads to a situation where providers don't really commit to success, because there's a lot of time focused on, what model should I be in, what are the actual incentives in those models. So, go to the next slide.

So, the sort of environment overall, and maybe I should have led with this, is there's waste in the American health care system. I don't think that's surprising to anybody. And we should view that waste as an asset.

And when we set up these models, the different models, we're assigning that waste to

different organizations, and when we do that, we create a series of both conflicts -- like this slide illustrates the conflicts -- and also incentive issues. Next slide.

So, some very, very basic evidence that I'm going to breeze through very quickly. I'm happy to talk about it more. Next slide.

So, in the case of population-based payment, here's my summary of the evidence. Population-based payment models -- think ACOs -- reduce spending, albeit by a small amount. The savings are readmissions, a shift to outpatients, to office, as opposed to hospital outpatient departments, and there's a bunch of savings in post-acute care.

There's some evidence of reduced use of low-value care. Independent physician groups kind of do better, often do better. My joke about that, I'm not sure it's funny, but anyway, is if your goal is to reduce hospitalization, it helps if you're not a hospital.

The results tend to improve over time. They never get huge, they just get

bigger. And private sector models tend to do better. And part of the reason is in private sector models, there's a lot of variation in prices that doesn't exist in Medicare.

So, you can save in the private sector by how you steer patients, more than you can save, for example, in Medicare.

Medicare, you can still save by shifting sites, but it's not the same variations you would see in the commercial sector.

Importantly, and it shouldn't be surprising, but it seems to be surprising, in shared savings models, savings get shared.

I don't know why people don't pick up on the fact that you share savings in shared savings models, but it is odd.

One interesting thing to remind everybody of their days in kindergarten, or at least my days in kindergarten, is when you share something, you end up with less. That's the nature of sharing.

So, there are changes to behavior that require less utilization of care. Those

savings get shared. In most of these models, there's evidence that Medicare still saves some, but not as much as they would have, because they've shared some of the savings.

If you don't share the savings, there will not be incentives to create the savings that you want to share. I hope I never read the transcript on that sentence.

Anyway, it's hard to know what this does for quality or equity. They seem to be the same or better, but I wouldn't claim that we measure that well enough that I should really emphasize those points. Next slide.

There's also reasonable evidence on episode payments, and there is some savings in episodes. It very much depends on the episode. There's a lot of different types of episodes. And of course, it also depends on the design. Lower extremity joint episodes, for example, have seemed to have done well.

In Arkansas, they had a big model. They saved some on perinatal episodes. The savings are not uniform across episodes. I wouldn't expect it to be uniform across

episodes.

The savings potential, for example, varies across episodes, and where the savings are varies across episodes.

There's been a concern that there's going to be an increase in episode volume associated with this. In other words, you're not paying fee-for-service, you're paying fee-for-episode.

We haven't seen a lot of empirical evidence of that. So, actually, I'm less concerned that people are going to generate a lot of episodes. And again, we haven't seen a lot of evidence of how strong, because of its effects on quality.

So, I'm going to say the same thing I said about basically population-based payment models. It's hard to measure quality.

My personal view is the evidence is reasonable. If we have time, and you can send me emails, I would love if you think anything in this lit review misstated the facts. I spent a lot of time trying to make sure that I get the evidence right, but the evidence is

constantly evolving. So, I'm interested in any thoughts you may have on that. Next slide.

So, in thinking about episodes versus population-based payment models, here's my quick summary.

Both of them seem to lower spending, at least for some episodes and for some population-based models.

Episodes are narrower, so if your goal is to get per-member per-month savings, that's harder to do in episodes, because they're just influencing a smaller share of the spending.

But not all practices can support population-based payment models, and episodes do engage specialists better. So, if you think you need specialists involved to get the savings, you're not going to get savings if you don't get the neurologist, surgeon, cardiologist. You get whatever specialty you want, oncologist, involved.

By allocating some of the savings, some of that waste is an asset to some of the specialists, it's possible you can increase

the incentives for the specialists, and that might increase your savings overall.

And there's some evidence that in fact if you have both, you can have a bigger pie of savings. And neither have a particular clear impact on quality. So, the next slide.

So, let me give you a very brief model outline, and then I'll conclude. Next slide.

So, MedPAC had a recommendation. And again, I'm speaking as me as a professor. This is just a statement of a MedPAC recommendation.

The recommendation was, the Secretary should implement a more harmonized portfolio of fewer Alternative Payment Models that are designed to work together to support the strategic objectives of reducing spending and improving quality.

What that essentially means is, instead of just launching models sort of as they come across the transom, one should think strategically about the portfolio of models that are launched, make sure they're

harmonized.

So, you might not want three lower-extremity joint episodes, for example. You might be careful if you started launching episode-based payment on top of ACOs, because every time you do, you siphon some of the savings away from ACO toward the episode. Things like that.

So, there should broadly be fewer types of models, and they should be designed in recognition that the others exist. Next slide.

And so, a very, very brief version of an outline of what payment might look like in 2026 or whatever.

There would be a multi-track, population-based payment model. The amount of risk could vary by size, so think, for just the purposes of conversation, something like MSSP, where you have a sort of high-power track, a medium track, maybe a downside, an upside-only track or some version of that.

It should be designed in a way to avoid the ratchet and the benchmark. I wish I could spend more time talking about that. But

what I basically mean is, it becomes problematic if when you save in one performance period, that lowers your benchmark in future performance periods.

You basically just have lag penalization, so you're always competing against yourself. Eventually, that model will fail. And so, you need to design the payment models in a way to avoid that ratchet.

Once you have that multi-track population-based payment model, you want to add episodes because of the evidence that episodes can enhance the savings. But you have to do that carefully. You want to do it, for example, to avoid siphoning off too much of the savings.

So, for example, if you thought ACOs were making a lot of the savings and reducing post-acute care, which evidence is true, you have to be careful of giving up post-acute care savings potential to some other organization.

Now, if they can expand the savings, it might work. So, I'm not saying not to do it. I'm just saying be cognizant of how all

the models are interacting.

You want to focus on episode with clear triggers, in my opinion, and you want to focus on episode with limited ability, the primary care or the ACO, if you will, to influence the savings.

You don't want to, in my view, give the population-based savings to an episode, because you'll discourage the population-based savings participation from happening, and from participation of those organizations. So, there's a balance.

In some ways -- again, I'm speaking as me, but you'll see my connection where I say this at MedPAC a lot. MedPAC is not CMMI. So, Liz Fowler, for example, is a much, much -- and her policies at CMS -- have a much more difficult job than I do.

Because we say sort of conceptually, here's how you might think about things. But the rubber hits the road when you actually have to make all these principles work in practice. So, next slide, which I believe is just going to say end. Or just, be the end.

So, those are my comments. And I know you have two other outstanding speakers, both of whom are wonderful. So, I will stop now. I think you're going to go straight through before asking questions of me. So, I'm good with that.

CHAIR CASALE: Great. Thank you, Michael. Great presentation. Appreciate it. And yes, we're saving all questions from the Committee until end of all presentations.

So, now we have Dr. Cheryl Damberg, who joins us from RAND's Center of Excellence on Health System Performance. Dr. Damberg.

DR. DAMBERG: Thanks, Paul. Can you hear me?

CHAIR CASALE: Yes.

DR. DAMBERG: Okay, terrific. So, Mike is always a hard act to follow, but I'll do my best to fill in some of the gaps.

Thank you so much for the opportunity to speak here today. I'm going to share with you sort of a summary of what I've observed, both from my own research, as well as that of others, over the past couple of

decades, as we try to shift these payment models towards delivering more value in health care. So, next slide, please.

So, Mike had already shared with you some of what has been learned. Some of it is duplicative on this slide. And this is sort of covering a vast frontier of a lot of studies trying to make sense of what's been going on on the street.

So, overall, we've seen modest savings, although with time, the magnitude of savings has in some cases increased. As Mike noted, quality performance is either sort of improved or largely stayed the same.

But I would call out that even in the context of, say, the CMS ACOs performing relative to Medicare Advantage in many cases. So, there's still some distance to go there.

The other thing to note. So, the -- limited in lots of different settings, and these contextual factors really matter, in terms of both the settings and how they're structured.

And some of the work that I've been

doing here in California really underscores something that Mike noted in an article. ACOs, or these entities that are being held accountable, they have incentives to lower spending on care that they actually don't provide.

So, what we see here in California, is these large physician organizations, there are about 180 of them in the State of California, that are being held accountable for total cost of care, all of them accept financial risk for professionals, some of them accept global risk, but that tends to be a minority. But where they have looked to reduce spending, has really been on the inpatient side so it hasn't really affected their personal bottom line, if you will.

The other thing that we see in the marketplace is that the uptick of these models has varied. Many of the high-cost players are not yet at the table.

And I have to say, I'm looking at the list of entities that signed up for the Direct Contracting, the most recent CMMI

demonstration, I was actually kind of surprised at who I did not see at the table.

So, I think one of the things that various folks who understand what it's going to take to move this ball down the field needs to be doing, and it's talking to the players who did not come to the table, about why they're not coming to the table, and really understand that space. Because a lot of the risk-bearing entities who have a lot of experience in this space were not at the table for that demonstration. So, the question is, why are they sitting it out.

The other thing to note as we see a lot of these Alternative Payment Models are built on a fee-for-service chassis, so there's lot of -- for bleed-out, and sort of challenges that providers face in managing the total cost of care for the beneficiaries or patients assigned to them. Next slide.

So, this is just here as a reminder, as I move to the next slide, please. And I

know you're all familiar with the LAN[14] model.

So, my assessment, looking at the results from the latest survey, show that we still have a great distance to go to get to Category 4. And I assume that personally and the work that I've done conducting interviews with health systems.

And if you look at the results, we still see close to 62 percent are still in Categories 1 and 2 in that fee-for-service space. And even within the combined Categories 3 and 4, where there's kind of a greater push towards total cost of care, much of that is still built on a fee-for-service chassis.

So, again, we are still not in this space of population-based payments, as much as I think we'd all hoped we would be. Next slide.

-- which that my team has been doing over the past five years. We have been studying health systems in the United States

14 Learning and Action Network

and cataloguing what they're doing to try to drive performance improvements, and those performance improvements cover total cost of care, clinical quality, as well as reducing low-value care.

And we looked at large health systems. These are physician/hospital health systems that have 50 or more physicians, of which at least 10 are primary care physicians.

And when we looked at those who are participating in the Medicare ACOs, whether the one-sided or two-sided risk contracts, we find that a fairly small fraction of their beneficiaries are actually enrolled in these ACO arrangements.

So, the median, 50 percent of the entities had 18 percent or fewer of their beneficiaries in these ACO contracts.

And one of the things that we are seeing in our work is when we look at the correlation between -- beneficiaries who are in ACOs in these health systems, we are finding higher performance on clinical quality, and better performance on lower-value care.

So, trying to push those numbers upwards potentially can help drive the value part of the equation. So, we would call that out.

But the other thing I guess to note, and Mike referenced this, is that it is very hard to redirect --resources to population-based care delivery if only a small fraction of your patients are under these models.

And -- the organization different directions. Next slide, please.

So, we face some pretty strong headwinds. And this is because these health systems report that they're not able to advance the carry design as rapidly as they'd like, given the small total share of their book of business that these value-based payment models represent.

And when we queried them about what fraction of their total revenues were tied to these value-based payment arrangements, generally they would report five percent or less.

And these were very large

organizations, sophisticated organizations. Oftentimes, they were in markets where, at least on the commercial side, the commercial payers were not facing a lot of pressure from employers to shift toward those models.

So, they are kind of still operating in this fee-for-service space. And because they have so many different payment models that they face from Medicaid, Medicare, and the commercial side, they're trying to figure out how to balance all these different incentives.

So, what do they do? They play into the middle. And right now, that middle is skewed heavily to the left side of that LAN framework, toward fee-for-service delivery. Next slide, please.

So, this was a study that my colleagues and I recently published that describes sort of what the frontline physicians in these large health systems are facing.

And again, it's really still a fee-for-service world for the front line. The size of the incentives are very, very small for anything around total cost of care. In most

cases, that was missing from what they were held accountable for. The incentives tended to focus mostly on things like clinical quality, patient experience, and other types of things, including increasing the volume of patients moving through the system. So, again, these headwinds are pretty significant. Let's go on to the next slide.

So, one of the things that I think folks around this table are probably aware, is that we've seen a lot of restructuring in health care markets. And a lot of that's being prompted by these payment reforms.

And the different payment reforms that the ACA[15] kind of unleashed contributed to significant vertical consolidation in the market, with these hospital and health systems following up previously independent physician practices in their communities, as well as across communities.

And when we spoke to them, we asked them why this is happening. And most of them

15 Affordable Care Act

reported that they really needed to beef up their size, to be able to spread and manage financial risk, despite the fact that most of them were not actually taking on that much risk at this point in time.

They also talked about the need to offset loss of revenue that a lot of these total cost of care value-based contracts place on them to reduce spending and, lastly and importantly, to bring greater leverage and price negotiations with payers.

And a lot of this vertical -- management, it's happening also through these contractual relationships that are driving up prices in various markets. Next slide, please.

So, there are a number of proposed benefits of this type of vertical integration, whether it's lowering administrative costs, improving the care delivery infrastructure to try to deliver better quality at lower cost, and last but not least, working to improve clinical integration and the coordination of care across providers within a system.

And if we go to the next slide, our

work has found that it's an assumption that vertical integration is going to actually produce clinical integration.

And there are different forms of integration. And most organizations are coming together structurally through ownership or management of operating units.

The functional integration, which is evidenced by the extent to which the health system has more centralized control, versus others' autonomy of the entities within the system, some of that can be effectuated through centralized decision-making, or can be effectuated through softer incentives and branding kind of mechanisms.

And health systems really vary in terms of how much they're putting sort of that hard versus softer integration into play.

And then, last but not least, and I think what we're all trying to work toward, is better clinical integration, evidenced through the presence of organized processes, to control costs and improve quality.

And that can be through hardwired

clinical processes, standardized service lines, redesign in care delivery, formal protocols or processes.

And systems are really struggling with this. And the executives we spoke with told us that clinical integration is the building block for better performance.

But as we see from the next slide, so this clinical integration has been really hard for them to achieve. And most of them would admit that this has largely not been achieved, that they have not achieved standardization across their entities within their systems.

And this is a function of many things. Changing physician practice patterns is hard. They don't necessarily have the structures in place to do that coordination across different settings.

But I think of interest to this Committee, if you look to the right of this slide, they repeatedly reported that the pace of payment reform is too slow to be transformative to make the investments that

they need to transform care. Next slide, please.

So, I'm going to shift gears just quickly. So, as somebody who has spent time trying to evaluate these programs over the years, there's a mix of both quantitative and qualitative work that needs to be done.

But I think most folks who operate in the evaluation space know that a lot of these voluntary models have been very problematic to evaluate because of selection issues related to who chooses to participate, and that the entities who sign up are likely those who are going to be most likely to succeed, and the challenges of finding good comparison groups.

So, those are among the various challenges. But also -- that are really trying to advance many of the same types of end objectives.

It's very hard to isolate the effect of any single Alternative Payment Model being tested, when there are so many other reforms that are in play.

And despite the fact that the Office of the Actuary needs to understand kind of how much savings has been accrued, to decide whether a model continues and moves into real time, that has been a very challenging space to navigate for them.

But I would say this. If you think about how the real world operates, generally they learn by doing and adjusting. And so, I do think that there needs to be greater emphasis put on qualitative work to try to understand a lot of these contextual factors that affect results, but also can help spotlight how to improve the effectiveness of these different payment models moving forward. Next slide, please.

So, in terms of what's needed moving forward, I do think that it would be helpful to the providers on the street to narrow the payment options, to help bring greater focus.

When I talk to physician organizations and health systems, they're staring down more than 200 quality measures. And if they don't feel like they could ask

their frontline physicians to focus on any more than a handful -- again, they're really struggling with thinking through what share of the revenue is coming from which sources, and which incentive to pay attention to.

We also need to think about the incentives to reduce spending, and whether they're high enough to not only induce participation, but also cover the cost of participating and the types of investments that providers have to make to move to that next step.

I would encourage CMMI, as well as private payers, to emphasize testing of models that really start to shift toward true population-based payment.

I think we've seen very few of those models. And Direct Contracting is one such model. But I hope that there would be other such wholesale-type models tested in the future.

I would, again, encourage mandatory participation, to be able to -- some of these impacts, to understand what's happening, to

avoid those selection issues.

And as I noted on that last slide, we really need to beef up the qualitative work to understand these real-time learnings, to make adjustments as we go.

So, with that, I'm going to close. And thank you so much for the opportunity to share what we've been learning.

CHAIR CASALE: Thank you, Cheryl. Appreciate that. Great presentation. Next, we have Mike Adelberg, who joins us from Faegre Drinker Consulting. Mike, I'm going to turn it over to you.

MR. ADELBERG: Well, thank you. It's a pleasure getting a chance to speak with the panel. And certainly, I'm honored to get a chance to be in the company of Drs. Chernew and Damberg.

The focus of my slides is a little bit different in that I work primarily with health plans in the Medicare Advantage program. I'm going to talk to you a little bit about best practices, in terms of affordability and driving high-value care in that program, that

might be helpful to the Committee as it thinks about the evolution of total cost of care models. Next slide, please.

So, just a little bit about me, because I may not be known to the Committee. I've been in and around the Medicare program for the last 25 years. Includes 15 years of CMS, different senior positions. Also spent a number of years at a health plan.

And I currently lead or co-lead a consortia of provider-owned health plans focused on improving their benefits packages and improving their provider network administration. Next slide, please.

Okay, so a couple of assumptions going in. We're going to look at the levers that are available to plans, and assume that these levers raise and lower utilization, and can impact the activity of members.

And of course, when we think about ACOs and directing contracting entities, again some of these levers in this toolbox may be available today, and some of these levers and tools in the toolbox may be available in future

models.

But the assumption here is that by promoting high-value utilization, we can improve outcomes, we can drive down waste, and all of that frees up money that can be paid to create more generous benefit packages and sort of create a positive cycle going forward. Next slide, please.

So, we know a number of things about the Medicare beneficiary population. We know that it is a cost-sensitive population, and that Medicare beneficiaries, when they feel price pressure, will underutilize.

Certainly, it's well-documented activities, particularly with drugs, but also other services, with respect to pill-splitting and under-dosing when people feel price pressure.

We also know that health literacy is limited. So, there have been tests, for example, looking at a $20 copay versus 10 percent coinsurance, and people presume that 10 percent coinsurance is better coverage than a $20 copay. And of course, that is rarely the

case.

And they're underlying all of this as whether they be Direct Contracting Entities or succeeding models, the economics that drive an MA plan in a capitated environment and full risk, more and more providers are going to experience similar, if not the same, dynamics.

And so, we're going to look then specifically at some of the tools available to health plans. Next slide, please.

Okay, so how can plans encourage high-value care? Certainly, cost-sharing is a big piece of that. In recent years, we've seen more and more Medicare Advantage plans that make zero-dollar primary care available, make zero-dollar generic drugs available.

We're seeing more and more plans experimenting with different types of reward programs. For example, gift cards, you got your flu shot, targeted OTC[16] supplies, et cetera.

We're seeing more and more

16 Over the counter

condition-specific benefits. The idea here is if you have someone, let's say with kidney failure who needs to get dialysis three times a week, make it easy for them by putting them in a car to get to their dialysis facility.

We're also seeing a lot being done with healthy groceries now, again to help people more successfully manage their primary conditions.

Flexibility that CMS created in 2018, but has had relatively low uptake, but I think may be particularly interesting to the Committee, is the high-value provider flexibility.

This allows the plan to measure its network providers, and, based on that measure, whether it be a set of HEDIS[17] scores or low admission rates, or whatever else the plan selects, to then lower cost-sharing or create an additional supplemental benefit that will encourage members to utilize that subset of the provider network.

17 Health Effectiveness Data and Information Set

So, if you add 10 primary care docs but four of them are helping you get to the key star rating, you can have a set of benefits and services that incent your health plan members to utilize those four primary care docs, rather than all 10.

There's also a lever that's coming online next year, was tentatively introduced this year, which are the real-time benefit tools specific to Part D.

These are tools that will be available to all members next year, whereby the drug formulary is ingested into a tool -- a smartphone app for example -- and that tool, when a script gets written, will understand the least expensive, clinically appropriate, drug, and stimulate a conversation between the provider and the member, as to whether a lower-cost script can be written.

We know that if the lower-cost script is written, the member saves money on cost-sharing, the plan saves money on its costs, and we know medication adherence goes up because a drug is more affordable. Next slide,

please.

We also know that plans have a toolbox for discouraging low-value utilization. And this again includes cost-sharing. It can also include using deductibles.

Using deductibles is, of course, a controversial practice, in that yes, you might be discouraging low-value utilization. But along the way, you may be discouraging quite a bit of high-value utilization.

And then there are the utilization management tools, which include prior auth, and we know that CMS, in original Medicare, is using more and more prior auth, most recently the national expansion of RSNAT[18], and step therapies, particularly with respect to drug utilization.

In both cases, and I suspect everyone on the Committee has their own opinions about these utilization management tools and how they're often implemented, there are legitimate concerns about how these tools

18 Repetitive, Scheduled Non-Emergency Ambulance Transport

have been implemented.

There was a concerning study, for example, in Health Affairs published last year, which showed that in the study, the majority of step therapy protocols are not synched up to clinical guidelines.

So, I don't want to suggest that these utilization management tools are without their flaws. But they are used because they do disincent and discourage low-value care. Next slide, please.

Medicare Advantage plans are increasingly interested in addressing social needs and the social determinants of health. A great many plans now, in one way or another, contract with a social service referral platform.

There are a number of these that exist and the idea is, as the health plan becomes aware that a member is struggling to pay rent, is struggling with their bills, is struggling to get reliable transportation, the health plan plugs that member into the social safety net programs that exist at the community

level.

Now, obviously our fraying and under-resourced social safety net cannot always meet the needs of these individuals, but in many cases, it can.

And then, the plans are experimenting. And more and more plans are offering some form of healthy food assistance, some form of transportation assistance, in-home supports, friendly visiting, and light house chores, socialization activities, and even mild home modifications, from air conditioning to putting in home safety devices, and mild home modifications like, for example, grip bars in a shower, stairwells in a hallway, swapping out draw pulls so that people don't fall when they are attempting to open a drawer or medicine chest in need of repair.

The book on these, these are all very new. How many of these produce the efficiencies that we're all looking for, we have to learn that. We know that these are worthwhile experiments, but we don't have a rich body of evidence yet on most of these

activities, with respect to whether they do ultimately prove to be self-financing in the form of relatively low investment in the activity, cost-avoided as a result of the activity. Next slide, please.

The Medicare Advantage plans also are in a competitive marketplace, and they are seeking to acquire members.

So, while perhaps in a perfect world every penny invested in additional services by an MA plan would solely be focused on improving high-value care, improving health outcomes, we know that marketing value is one of the reasons why plans invest in these benefits.

And there are certain benefits that I suspect do not significantly add to high-value utilization. That includes the Part B premium buy-down, which is marketed aggressively during MA enrollment season, and arguably, it also includes the very popular gym benefits that most plans include, but we know utilization is very low.

I don't mean to criticize fitness benefits that are well-utilized, but not all of

them are well-utilized. Next slide, please.

So, all of this is powered by the actuarial exercise of cost-offsetting. Actuaries have worked with cost-offsetting for many years.

We know, for example, that when actuaries have grown comfortable with the idea that when you lower cost-sharing for a drug, adherence is going to increase. And there's comfort, at least with certain more predictable chronic diseases, that with increased adherence comes a slower progression of that disease, and savings resulting from that.

What the actuarial profession is still gaining comfort with is the cost-offsetting from these non-traditional and non-medical investments.

Here, the idea that transporting someone to a dialysis facility should result in less missed dialysis appointments. With less missed dialysis appointments, we would have fewer hospital-based emergency dialysis episodes of care.

So, it makes sense that there would

be some cost-offsetting associated with the cost of transportation. But this is all fairly new, and the actuarial profession is still coming to grips with this other type of cost-offsetting exercise.

Ultimately, whether it be a health plan, or whether it be a provider in a full-risk environment, the incentives would be the same. What are you going to invest in up-front that ultimately proves self-financing because of the costs avoided when you make this investment?

And together, we're all going to have to get better at this. The body of literature is going to have to improve. We're going to have to develop forums for sharing successful practices.

But ultimately, to me, it's a very exciting place to be. And certainly, it's very rewarding for me to get a chance to work with some plans on that type of modeling. Next slide, please.

And so, with that, those are my remarks together. And I'm very happy to stay

around for Q&A later. Thank you.

CHAIR CASALE: Great. Thanks, Mike. Great presentation. And so, for our last listening session, I'm going to turn to Chris DeMars, who joins us from the Oregon Health Authority. Chris, turning it over to you.

MS. DeMARS: Thank you so much. Hi everyone. And, as Paul just said, Chris DeMars, Oregon Health Authority, and I am Director, Delivery Systems Innovation and the Transformation Center Director. And I don't see the slides yet.

MS. AMERSON: One second. They're coming up.

MS. DeMARS: Sure thing. So, while we're waiting, today I'm obviously kind of taking a different tact as well. I'm providing the perspective or experience that Oregon has been on through our health system reform journey.

I will just be focusing on part of it, but I'm going to try to kind of get through a number of years of history, and also our vision, within the next 10 minutes or so. So,

next slide.

So, first I'll start with an overview of our coordinated care organizational model, which is focused on Medicaid, and then talk about our vision for a multi-payer reform, focusing on three specific initiatives: our health care cost growth target work; spreading value-based payment, which is a term we use for APMs across all payers and providers; and a regional multi-payer global budget pilot that's currently under development. Next slide.

So, Oregon's CCOs, Coordinated Care Organizations, were established in 2012, so about 10 years in. These are community-governed organizations that bring together physical, behavioral, and dental health providers to create care for a Medicaid plan which we call the Oregon Health Plan. It's about 25 percent of the state. And about 90 percent of Medicaid members receive care through a CCO.

And distinguishing aspects of the model, CCOs receive a fixed monthly, blended budget from the state to coordinate this care

for the members, and it grows at 3.4 percent a year, and we have an 1115 waiver for this model. I should have mentioned that.

They receive financial incentives via metrics that they need to achieve benchmarks for improvement targets on. And it's kind of pay-for-performance, the point of the model.

They receive a blended budget that I already mentioned. That gives them flexibility to address their members' health needs, or kind of social needs, beyond traditional medical services, and we call these health-related services.

And some examples are short-term housing, or cooking classes, et cetera, mental health programs within schools. And the model is designed to improve member care and to reduce cost. So, next slide.

So, we've seen significant progress in both quality and cost. And the data here is a little bit old, but, generally, we're still seeing these outcomes. And so, with regard to the incentive metrics that I touched upon, you

see the performance on adolescent well-care visits and depression screening, our emergency department visits are down, and it's just going in the right direction with regard to quality, and while also lowering costs. And we've saved well over, now, $2 billion.

We haven't tracked for a number of years, but we know, compared to the cost growth that we were on at 5.4 percent when CCOs were put in place, and the agreement we have through our 1115 waiver, was, as I said, to limit that to 3.4 percent, we save a lot of money. And also, about 94 percent of people in Oregon are insured.

So, all of that being said, it's going in the right direction. We know we still have quite a bit to do related to cost and VBP[19], social determinants of health or health-related social needs and health inequities. So, next slide.

So, kind of stepping back and providing some context for our vision. And

19 Value-based payment

many of you probably know this as well, that countries with high-performing systems share four attributes: affordable, universal coverage; high value in primary care; investing in social services; and decreased administrative burden. So, next slide.

And we have been making some progress in these areas. With regard to affordable care, we expanded under the ACA, launched the statewide cost-growth target, which I'll be touching upon, with regard to social determinants of health. I already mentioned the health-related services, and CCOs are working with community-based organizations, and they have lots of demonstrated examples of that.

High value in primary care, we have pieces of a medical home model that we call the Patient-Centered Primary Care Home Program, that's been very, very effective. We have a prioritized list of health services that promotes high-value care. And we're kind of taking the CCO model and we're starting or have started to spread some components of that to

our public employee plans.

And then, in administrative simplicity, we have a statewide committee that is trying to identify metrics to be adopted by all payers in the state. I'll be talking a little bit about spreading value-based payments.

And then, also the Oregon Health Authority has health programs, the public health programs, all in one agency, which happened a few years ago and has really helped around administrative simplicity as well. So, next slide.

And one other kind of component, or context setting, is that in 2020 Oregon established a 10-year goal. The Oregon Health Authorities established a 10-year goal to eliminate health inequities. Yes, it's very bold, but we thought we would set the bar high. And the rest of this slide provides our definition of health equity. I won't read that, but you can reference that if you're interested. So, next slide.

So then, looking forward, we know to

achieve this goal, the health equity goal, we need to create a simpler system that's focused on equity.

So, what you see here is our vision that everyone, not just the Medicaid members, is insured and has access to affordable care. Everyone has access to high-value benefits and culturally responsive care that promotes equity, primary care, and prevention, that the entire health system uses a fixed total cost of care global budget, and has a flexibility to address social needs, and that plans are designed -- plan designs, contracts, are aligned with common expectations for equity, quality access, and cost containment. So, next slide, please.

So, our initiatives to achieve this vision. We're kind of knitting a number of different initiatives together. So, first is to achieve virtually universal coverage.

We're striving toward 98 percent. You've seen the previous slide, we're about at 94 percent. I'm not going to be talking about those initiatives today, but just know that

that's kind of a backdrop here.

Implementing the statewide cost-growth target, and then delivery system and market reforms around value-based payment and aligning across markets, and piloting our regional multi-payer global budget. And I'll be talking about those in the next slide. So, next slide, please.

So, first is this statewide cost-growth target that was established through legislation in 2019. It set a cost-growth target for the entire state, starting in 2021 for 10 years. And that target is at the 3.4 percent, which you might remember I mentioned that that's where CCOs had started out. And then kind of moving it out further, starting in 2026, to 3.3 percent. And we've just done the projections for the first five years, and we're projected to save $16 billion over that time. Next slide.

So, the Cost-Growth Target Committee that was established through the legislation I mentioned, they recommended principles to adopt advanced value-based payment as their kind of

first strategy to put in place to help meet this cost-growth target statewide.

And as a result of that, we have recently put in place last year statewide what we call a value-based payment compact, which has goals around, or targets, for all payers and providers in the state. Next slide, please.

So, to provide just a little more context setting for this VBP compact, CCOs have requirements around value-based payment that began with their five-year contract starting in 2020.

And I won't go into detail on this, but the bottom line is CCOs have targets they need to achieve that start with LAN category 2C, so pay-for-performance on up, and to have 70 percent of their global budget be paid out to their contracted providers, in the form of a value-based payment, by 2024.

And there are also some PMPM[20] requirements for them to pay their patient-

20 Per-member per-month

centered medical home clinics. And then they need to develop that value-based payment, and one of five what we call care-delivery areas, to give them more experience in VBP. So, next slide.

So then, now going back to the VBP compact that we just put in place, these are voluntary targets, but -- and I'll get into the adoption so far in the next slide -- but they are also more aggressive than the CCO requirements.

So, I mentioned the CCO requirements starting with pay-for-performance, so LAN 2C. For the VBP compact, the targets start at, for all payments, start at Category 3A, shared savings. And we're striving toward, as you see, 70 percent by 2024.

And for primary care and hospitals, their targets are focused on shared risks. So, LAN 3B at kind of this region, also 70 percent by 2024. Next slide.

So, I mentioned the compact was put in place last year. And the end of last year, we had a wonderful adoption of this voluntary

compact. Well, we'll be tracking that obviously for the next number of years, to see if it's actually successful.

But we have all major payers that have signed on and this accounts for almost three-quarters of all lives in Oregon, the self-insured kind of lives is the biggest chunk that's missing. Next slide.

So, moving toward kind of our vision that I, kind of like moving forward. So, the VBP compact was our first step at true alignment across all payers and providers toward our vision. And so, now we're going to further align across markets.

And this slide shows lives that are under the state, and we really want to focus on getting the state lives kind of aligned, or the state programs, the state lines of business aligned, and then move forward.

So, you see here it's about a third of the lives that were, again, are under either Medicaid, or public employees, or educators, or the health insurance marketplace. Next slide.

So, the alignment across markets,

we're looking to align total cost of care. We've already talked about the value-based payments and global budgets, accountability toward equity, quality. These would be tracked through metrics, and outcomes, including addressing social needs, and then also really promoting community voice.

In the alignment, we are looking to engage communities and the health system design and accountability. Next slide.

And kind of more the initiative that's underway to kind of play out this vision is, in 2020 at our legislative session, the legislature passed a bill to require the Oregon Health Authority to design a plan for a pilot of a multi-payer global budget.

So, as you see here, we have the state lines of business, the three umbrellas on the left, and our hope, our goal, is to bring in Medicare -- and we had some initial conversations with CMMI about this -- and also bring in commercial payers.

And so, the preliminary plan is that we would -- and we just started working on this

over the last few months -- is we'd start with a budget for payers in a defined geographic region, to cover the total cost of care for their members, and then pair this budget with aligned expectations for promoting equity, quality, community engagement, the VBP compact requirements -- I mean targets -- and actually have them become requirements, as opposed to voluntary.

All purchasers would pay their payers a global budget that would grow at the same fixed rate, and then we'd trend this forward at an annual fixed rate.

So, the results that we're looking for is this. Is more equitable access to quality care for people across all insurance plans, improved access to preventative and health-related social needs, and cost containment and smarter spending.

So, that's our vision in Oregon. Thanks for letting me share what we're striving for.

CHAIR CASALE: That's great. Thank you so much, Chris. And thank you to all our

panelists for sharing your insights and experiences with us today. Really covered a lot of ground.

So, I'd like to now open up the discussion to our Committee members for questions.

DR. SINOPOLI: Yeah, this is Angelo. I'd like to make a comment and pose a question. So, again, just great. Congratulations to Chris and the Oregon model. It's just very impressive work.

And throughout the presentations, I think several highlights were made which have been my experience as I worked with other networks. And that is that there is a lack of enough patients with any given network to really accommodate their willingness to redirect their care model. So, that's a big issue across networks that I've dealt with.

And there's, on top of that, not a clearly successful care model that's implementable at a primary care level or a smaller network that's not an Oregon-type model, that's kind of state-supported.

And so, since that care model didn't clear them and there's not enough upside on most of the contracts to cover the cost of implementing something that there are questions about, those two things combined create the hesitancy for most networks to want to really get into value-based care where there's significant global risk associated with that.

And so, that was well-outlined in the discussions. But my question to you all is, so what do you think recommendations to PTAC and CMMI would be to get past those two things as an all-payer model?

Is it standardizing the care model best practice? How do you see getting past those so we can get more value-based care implemented across the country? And I'll pose that to any one of the presenters.

DR. CHERNEW: That's a big question, I'll say very quickly, that I'll leave to the other presenters.

First, I agree that that's a large problem. In fact, in many ways it becomes a bigger problem as Medicare Advantage grows,

because there are fewer people in fee-for-service, and we think about ACOs. Most of these models are only there.

I think that that's one motivation for having fewer, more harmonized models, so you aren't dividing what you have across different types of models.

I think there's some merit in doing things in states like Oregon, where they're trying to bring them together. I think it is going to be hard for CMS and CMMI to do multi-state models.

So, I think collaborating when possible with states that are doing it is actually a good thing.

It's hard to push them into it. It's easy to participate when they want to do that. And hopefully, there can be models that have more incentives to participate, and the providers will work with their payers to try and move synchronization of the incentives that they face.

But that is, of course, challenging, because when the providers are not integrated,

and Cheryl talked about the integration, you have a problem.

For example, in an ACO model that's based on say an independent physician organization, how are you paying the hospitals? And they tend to be still paying some fee-for-service basis. So, how you engage them matters.

So, I think there's a lot of work to be done in those spaces. And I think I would expect going forward, that we're going to make progress incrementally, as opposed to revolutionary, in a big revolutionary way.

It's hard to move that many contracts with that many payers and that many ways simultaneously.

So, I think starting with a strong vision of where we're going, and a set of models that work, and hoping that much of the other system, including the state-based payers, can work around that, is probably the best I could do. And I somehow feel that wasn't very good.

DR. SINOPOLI: Thank you.

CHAIR CASALE: Any comments from the other presenters on that question? You're on mute, Cheryl. You're still on mute.

DR. DAMBERG: Can you hear me now?

CHAIR CASALE: That's great. Yeah.

DR. DAMBERG: Okay. So, it's really strange, because I'm calling in through my phone.

So, I would agree with what Mike said. But I do think that the extent to which Oregon is able to make some inroads on this front by bringing together the different payers to agree on some common standards for how they're going to proceed, I've seen the value of that in California.

And most of the time I don't see all the different payers in the marketplace, including Medicaid and Medicare, come into the table with the private payers, to decide sort of how everything should play out.

So, whether that's alignment on measures, or kind of how providers are paid and what they're incentivizing, I think there's still an opportunity for greater collaboration

and coordination than currently exists, because there's just so much noise in the marketplace.

And personally, I don't know how providers kind of manage it all. I mean I think for the most part, they're not. So, we're not getting the results that we want.

CHAIR CASALE: Great. Thanks, Cheryl. Other questions from Committee members?

DR. KOSINSKI: I have a question. Can you hear me? Because I'm talking through my phone.

CHAIR CASALE: Yes, we can hear you, Larry.

DR. KOSINSKI: Okay. All right. So, our session these two days was around the definition of total cost of care. The four presentations provoked a lot of thought, but I don't have a clear definition from each of you on total cost of care.

I wonder if we could come up with some concise statement from each of you as what you view as total cost of care.

DR. CHERNEW: If we're going in

order, I'll say something that might be straightforward. Others can correct me. It's good to go first and get corrected.

I view it as the total, essentially, per-member per-month, that's paid on behalf of a beneficiary, either by their plan or by the beneficiary themselves, or by any supplemental coverage or any other coverage.

So, you take a beneficiary, say, Larry, you look at all the money that is paid on his behalf to a provider. That's a total cost of care.

And I would do it for all services. I would do it for a period of time -- a month, a year, some version of that. Others can tell me, you can tell me, what am I missing?

DR. KOSINSKI: And you include pharmaceuticals?

DR. CHERNEW: I would include pharmaceuticals. That's why it's total.

DR. KOSINSKI: Okay.

DR. DAMBERG: It's total spend.

MR. ADELBERG: Well, I would certainly agree with that. But I'd also note

that as we think more about closing health equity gaps and social determinants of health, increasingly, we're tempted to make investments outside of a medical service in the interests of making the medical spend more efficient.

And as we think about this holistically, I'd encourage us to whatever definition we land on, to accommodate the possibility that diverting some amount of funds from the medical spend in the interest of helping the medical spend is a concept that we should be working with.

DR. DAMBERG: I think that providers that are paid under these kind of global budget models -- for example, let's take the most extreme case, Kaiser. They can choose how to allocate resources, whether it's towards their doctors or medications or, you know, buying food for seniors.

DR. CHERNEW: And I agree with that. I don't think we could increase the budgets of these models to include extra for all the other things that people buy -- housing, food, et cetera.

But if you want to reallocate in a target, that's fine. I think, Larry, the point you're raising about drugs is right. I would define drugs as part of total cost of care.

But, for example, in Medicare, when you're paying through that separately through Part D, the models aren't really true total cost of care models.

don't worry a ton about that, by the way, in the grand scheme of things. But there's a slight difference between what I define as total cost of care and how I would put these, say, population-based payment models, in place in practice, because they do tend to have some nuances based on the way coverage plays out.

So, if you carve out mental health. Mental health I would clearly put under total cost of care. But if you carve it out, it's going to be hard for a payer to have a total cost of care contract if they aren't responsible in the grand scheme of things for total cost of care.

In Kaiser's case, if they're

responsible for everything and nothing carved out, then you can get to a truer total cost of care model.

MS. DeMARS: And I'll just say in Oregon, we're seeing, as I mentioned, health-related services. And CCOs have the ability to pay for needs beyond the traditional medical care. And we're seeing costs go down.

And what we're hearing is they're focusing on their high-cost patients and providing them the care and supports they need. The care coordination, we have community health workers, et cetera.

And so, providing that flexibility really helps you get at both the quality increase and cost decrease.

VICE CHAIR HARDIN: I'm just going to add a follow-on question to all that. So, Mike, you talked about the tremendous investment on Medicare Advantage into social determinant of health platforms and referrals.

I'm curious what each of you are seeing as the highest value investments to impact equity and social determinants. So,

what I see around the country, there's a big movement towards housing as health care, and some really interesting outcomes related to that.

But I'm curious from each of you what you would see as best recommendations for where to invest if we start to look at in total cost of care, social needs.

MR. ADELBERG: Well, I'll take a shot, but I'm sure my co-panelists will have additional, and perhaps ultimately more valuable, responses.

I liken this to, it's a 5,000-piece jigsaw puzzle, and we've put about 20 pieces in so far.

And so, there are these little use cases. I do think there's some good actuarial study and there’s some peer-reviewed articles around transportation for kidney failure.

There's recently been a handful of studies related to Medicaid programs to short-term housing support. Support of housing short-term.

And there are a couple of things

related too, but there are all these very use-case-specific scenarios.

Now, I'm not aware of any type of meta understanding of when to do this. We're still very young in all of this.

I would note that all of this is confounded by the diversity of our social service safety net. So, what would work in one state because the social service safety net is so different in another state, there's this added layer of complexity that what might work in Oregon can't automatically be transferred to Kansas.

DR. CHERNEW: If I could add two things, and I agree with what Mike said. The first one is, what evidence we have is growing, and it needs to grow not just in volume, but in rigor in some ways. The Camden Coalition experience is one that I would point to, where the randomized trial didn't give you some of the results that you got in the earlier reports.

By the way, I'm a fan of the Camden Coalition work. It's just understanding the

evaluation point is difficult because of a bunch of selection and other issues.

The second thing I would say is, if your goal is to save money, or even improve quality, the targeting is crucial. It's not that transportation or housing works. It's all about who you target to get it and how you get it to them and how you engage them.

So, the operationalization of these things matters crucially. And I guess the third thing I'll say is, it really shouldn't be all about saving money.

We often evaluate these things and say they save money. We don't think about the same for example, oncology care, a bunch of other care.

We have a health care system to make people better off. And so, I don't think we should abandon things that improve people's well-being but don't necessarily save money.

That said, there are fiscal constraints and there’s complicated questions about whether the health care system, for example, should be responsible for these

things, or whether other aspects of the social safety net should, and how do you have the health care system wraparound would exist, or with what exists.

These are all very complicated questions, because you can envision expanding our payment models into areas that are well outside of the area of expertise of the organizations that are managing these.

So, the flexibility to do them the way Mike emphasized, I think is important. But I think it's clear that certain places -- Oregon, I'm sure Kaiser, other places -- a lot of MA plans are doing that.

I would be cautious about how we try to institutionalize that as a fundamental role for the health care system. I'm afraid we'll create the wrong metrics of success, so we will turn over the responsibility to organizations that might historically not have been focused and sort of set up to meet those goals.

DR. DAMBERG: I'm going to add two things to what has already been said.

I think generally we're not

necessarily meeting people where they're at. And by that, I mean for the people who are the hardest to reach often cannot, you know, receive care in an 8:00 to 5:00 space of time.

And I think health systems that have demonstrated more flexibility in terms of offering primary care services after hours, into the evening, walk-ins, have been more successful in getting people in for needed services.

So, it would spotlight that space, and how are the incentivizing that type of flexibility and care delivery?

The second thing I would flag is that in various communities around the United States, we have what I refer to as ambulatory care deserts. And so, individuals who want to obtain primary care, and even specialty care, have to go great distances outside their communities, and oftentimes have a very difficult time accessing providers who can assist them.

And I think that's largely a function of payment rates to individuals in

those communities, such as in Medicaid, are so low that providers don't have any interest in serving those communities.

And so, I think we have to think carefully about sort of the structural racism that's been built in based on our payment policies.

CHAIR CASALE: Great.

MS. DeMARS: If I could just add a few there.

CHAIR CASALE: Okay, yeah. Great. Please.

MS. DeMARS: I couldn't get off mute. So, with regard to the kind of partnerships between the health care system and the social services, or community-based, organization system, what we're seeing is there are cultural issues. Bringing these entities together requires capacity building, and maybe some convening, that needs to happen.

And then, there also needs to be kind of, the data piece is really important. So, in Oregon, we just developed a social needs screening metric that we're hoping to put in

place soon.

And so, that would be kind of screening patients in providers' offices, and then referring them to get their needs met around housing, transportation, and food.

And in order to do that well, we're hoping to build kind of a statewide -- this is happening in pockets -- but a statewide community information exchange between the health care system and the CBO.[21]

So, that's one other point. And then, the last point I'll mention here is I think we should think about social risk adjustment. That's an area that we've looked into, and the data are not there to kind of indicate what model to adopt. But it's something that I think is really important to put in place when you have a payment model, to make sure that providers are receiving adequate payments for members that have kind of high needs, to be able to address their social needs.

21 Community-based organization

VICE CHAIR HARDIN: Very valuable comments. Thank you so much.

CHAIR CASALE: Thank you. Other questions from the Committee?

DR. DAMBERG: Yeah. Can I just follow on that last comment?

CHAIR CASALE: Oh, right. Yeah.

DR. DAMBERG: You know, I'm not trying to spotlight my own work, but we have looked at trying to do what I call some post-adjustments to payment related to social risk factors.

Because the underlying concern is, particularly around pay-for-performance or some of these value-based payments, is they tend to reward the kind of more affluent groups who often have lower percentages of people of color, people of low SES[22] backgrounds, and so on.

So, I do think that both private and public payers need to be thinking about some of these back-end adjustments, since they can

22 Socioeconomic status

occur, related to these value-based payment approaches.

DR. CHERNEW: And REACH does do a version of that, by the way. If you look at the new REACH model, they tried to separate the utilization from the amount of money. You can discuss how, but they are trying to do that.

DR. DAMBERG: Yeah.

CHAIR CASALE: Great. Thank you for that. Other questions?

DR. PULLURU: One question I'd like to ask Mike, as well as the rest of the panelists, is -- You guys touched upon this.

When you think about harmonizing APM models and trying to engage specialists, besides having a shared sort of profitability pool like an integrated system, some of the challenges are, if you do episodic care and you nest it inside an ACO, how do you think about poly-conditions? Right? How do you think about people with multiple conditions and the true risk for that?

So, I'd love to hear some thoughts on what you've seen as best practices, or what

your thoughts are on how to solve for that.

DR. CHERNEW: Yeah. So, first of all, it's always hard to get on a panel where there are two Mikes. I wish my mother would have known that at the time.

I'm going to take from context that I was the Mike you were talking to. But if not, tug at your ear, and I'll just shut up.

So, I don't have a good answer to this question. It's a very, very challenging question. It is one reason why I tend to think it's important to have a foundational population-based payment model.

Because I worry that if you try and build a bunch of episode models, you will begin to run into this issue that you arise, that there are multiple people treated by multiple specialists with multiple conditions, and getting the coordination right becomes very, very hard.

The solution that I would put forward, although I understand it is vague, is I would err on the side of having fewer models, and have models with very clear triggers,

procedure-type models in places where you think you can add new things. And I would spend less time trying to come up with models to deal with important places to engage specialists, and hope that they get engaged by the ACO in a more organic, as opposed to formulaic, way.

So, if I'm an ACO, I know a lot of my spending is going to be people with multiple chronic conditions. I understand that I have to engage with a specialist on that. And I believe that type of engagement is going to be very, very context-specific.

On the plus side, in situations where you have large integrated systems -- Cheryl noted is in an increasing number of places -- a lot of the times the primary care doc and the specialist, and a lot of other parts of this care delivery infrastructure, are under the same roof, and that gives some more flexibility for you to build out the internal compensation, internal reward, and management structures, to address your issues.

And I would try and keep payment policy writ-large as much out of that as you

could, as a general point. That's not always possible.

So, I would lean to, personally, relatively fewer episodes, in relatively more targeted ways, and hope that the population-based payment models find ways to work around the challenges that you raise.

But in our complicated fragmented system where a lot of the money, and frankly, a lot of the health decrement, is occurring for people with multiple chronic conditions, it's very hard to sort that out through a bunch of episode models, given the complicated sets of overlap.

DR. DAMBERG: I would agree with that. And I think that the organizations that are managing global risk rather than just professional risk tend to be better positioned to be able to manage whatever variety of issue confronts them, to try to do that efficiently.

I think what I've observed, at least among the groups that are only taking professional risk, beyond sort of saving on the hospital side, which doesn't affect their

bottom line, they have shifted to trying to capitate specialists, again, to try to control utilization.

But, you know, that may affect utilization, but it doesn't necessarily address coordination of care for people with multiple chronic conditions. So, it's kind of a quick fix, but it doesn't necessarily address what I would call optimizing the quality of care for individuals with multiple conditions.

CHAIR CASALE: I guess, maybe adding on and addressing the other Mike on this topic of coordinating specialists and PCPs, is there something we can learn from the MA plans related to how they build their provider networks and use payment structures to align incentives of individual providers, i.e., specialists, with primary care clinicians?

MR. ADELBERG: My general response is I think this is an area where the health plans can get better. They have analytics platforms, and they look at referral patterns. They look at, within the network, which providers are ultimately creating the best

outcomes, whether they be particular quality measures for SARS[23], or whether they be things like avoidable readmissions.

But I don't think the plans are, by any means, at their climax level of maturity in terms of network steerage and network leakage. I think this is a place where they are getting better. The data is getting better. The contracting and incentives have only just started to get better.

CHAIR CASALE: I know we're actually over sort of our time. I don't know if there is any, before we close out with our panelists, and move on to Larry's presentation. Any other questions from the Committee? I mean, we'd really like this to go a long time because we'd love to continue this conversation, but we know we have some time limits. Any last minute questions from the Committee?

DR. LIN: Paul, I do have just one quick question for Mike Chernew, because I appreciated your summary of the evidence around

23 Severe acute respiratory syndrome

population-based versus episode-based payment models. And I understand kind of where you're landing on that.

Looking forward to our June PTAC meeting, we're going to be talking about care delivery model innovations that support the overall population-based total cost of care objectives.

And I'm wondering if there's any evidence whether episode-based or disease-specific-based payment models will support increased care delivery innovations around that specific disease or episode.

And I think, from a care delivery perspective, they would be much easier to focus on.

DR. CHERNEW: Yeah. So, I think the short answer is, yes, there is. It's episode-dependent. So, lower-extremity joints is going to do better than sort of other areas. But sometimes the episode models haven't been exactly optimized in a bunch of ways.

So, there's always this concern that you look at what's happened in the past and you

say, that's what's going to happen in the future, in these models.

But of course, I think what you think a lot about, what others think a lot about, is, well, did you get disappointing results in -- I don't know, I'll pick an area -- gastro? I'm not saying there are disappointing results, but I'm just picking an area that's not joint.

Do you get disappointing results because it will not work in that clinical area? Or did you get disappointing results because you didn’t design the model in some way?

So, with a lot of places -- oncology, for example -- attribution is a huge problem. So, is the issue there that we don’t have the attribution models right to the episodes, or is the issue that it's just hard to work in oncology?

It's hard to know. The question becomes, if you keep experimenting and you layer it through different settings, so the ability for any of those models to achieve success depends on, are they put in the context

of an ACO model? Are they put in the context of an ACO model where the organization includes the specialist?

So much of the right reactions, or the reactions you're going to get, are context-specific, environment-specific, that it's really hard to generalize.

I think there is clear evidence that episodes can work. And frankly, that clear evidence that, for a bunch of reasons, in certain cases, if you add episodes on top of an ACO, you will grow the pie of savings.

But there is also evidence that is not uniform. And the question is, how do you figure out where it works and how these things don't bump into each other?

Again, I feel like that was a little bit of a general answer. But maybe it was helpful.

DR. LIN: Thanks.

CHAIR CASALE: Great. We have time for one more question. Chinni?

DR. PULLURU: Yeah. I wanted to actually address Chris and also the other Mike,

Adelberg. Because one thing we haven't focused on is sort of what you guys touched on with patient literacy and their knowledge of the health care system.

And particularly, in Medicaid, Chris. I know that it's very hard to engage patients. It sounds like you guys have cracked the nut on it.

I'd like to hear from you guys on some best practices there, as well as ACO's swing a lot and that's a challenge for when there's not assignment for a health system. So, how do we solve for that when we design a payment model?

MS. DeMARS: So, I can't address the last one around attribution, which is I think what you're getting at.

But the former, with regard to patient engagement, the CCOs have a requirement that each of them needs to have, and this is in legislation, a community advisory council that is comprised of at least 51 percent Medicaid members, and then other representatives from the community and community-based

organizations.

And this model, while not perfect, has certainly gone a long way with regard to kind of engaging members in the design of the CCO model, and especially where the CCOs invest in those health-related social needs, and also addressing more system-wide social determinants of health.

So, that's a model that I would say you can look at, and look at spreading. I mean, it's kind of somewhere to the FQHC[24]'s requirement of the Patient and Family Advisory Council, the PFAC. But it's at the system-wide.

And, actually, the last thing I'll say about CACs, is their kind of directive is to --- it’s to advise the CCO on the health, not just of the CCO's numbers, but of the whole community.

And they are tapped with developing a community health improvement plan for the community, based on the community health

24 Federally Qualified Health Center

assessment. So, the CCOs have a quite large role. And it's been relatively successful.

MR. ADELBERG: And just building on Chris's very good comments, because health care is so expensive, relative to ancillary services you can build on top of it, there are a number of plans in Medicaid and MA that are investing in various types of concierge programs.

So, whether it's a community health worker, whether it's a pop-up pal, a national rent-a-grandkid platform, the idea that you are going to deploy someone who will assist and nudge a subset of your membership, people with high needs, to navigate the system more successfully and to be a resource in navigating the system more successfully, these interventions are very inexpensive relative to the cost of health care.

And if they do lead to gap closures, I suspect their ROI[25] is pretty good, as well as outcome improvements. To Mike's comment, it shouldn't only be about money.

25 Return on investment

DR. DAMBERG: Can I just add one final comment on this patient engagement piece?

CHAIR CASALE: Sure.

DR. DAMBERG: So, I'm going to share my own direct experience, as well as the people around me who allegedly have been enrolled in ACOs.

The communication between the ACO entities, so the plan and the physician organization to the member, very cryptic, not easy to understand what it is you're in.

But additionally, we've seen no evidence of any change in care delivery or access. So, I think a lot of this is not clear to the consumer, the patient, the beneficiary, that they are in anything different, and that their care experience will be anything but the usual.

So, I think that we clearly need to better understand what it is we're trying to engage patients in, and how that interaction with the care delivery will be different. But I think right now it's very opaque.

CHAIR CASALE: So, I've been texted

we actually have a few more minutes. And we hate to have this panel go if we have some additional questions from the Committee.

VICE CHAIR HARDIN: I have sort of a tangential question. So, what I've seen working a lot in the underserved population space, is a massive proliferation of venture capital-backed risk-based models. And I was curious what each of you think about those and what lessons we might be able to take from those as we look at the next phase of total cost of care model design?

DR. DAMBERG: Well, we're -- and private equity, getting into buying up practices. Mike, you may have more evidence on this. I know MedPAC's been looking this.

But I think there's this other issue that your question sort of prompts for me, that I've been hearing from providers in that with this vertical integration that I was speaking about -- for the independent physicians who remain in the community, who serve a lot of these disadvantaged patient populations.

And it's making it so they don't

have the cross-subsidies from the commercial side that they used to have. And so, they're finding their kind of risk position to be pretty bleak.

And not sure how they're going to continue to serve the patients and their communities.

So, again, I think kind of in this larger look at payment models, I think we have to figure out how we get to greater equity across these different payment platforms, with the commercial insurers paying large amounts more than Medicare, and Medicaid sort of struggling to provide services and provide access to people.

DR. CHERNEW: I agree with that. I wish I had better insights.

One of the challenges here is that broadly speaking, as the delivery system changes -- I'll say this differently.

The core value in the health care system is coming from the delivery system. Like, financing matters. But what you really want is a good doctor, you want a good

hospital, you want a good nurse, you want a good post-acute-care setting, you want the right technology applied in the right time, whether you're going to get there.

It's all about how we deliver care. A health care system, the goal is to promote health. Financing can facilitate or become a barrier to that.

As the health care delivery system changes for all these reasons that we're talking about, the overall environment that we're overlaying this financing on changes.

That has ramifications. Because our financing is fragmented, it is difficult to provide a consistent message, if you will, to this underlying delivery system. And the underlying delivery system is sort of -- I'm going to call it the golden egg.

I don't mean that given maybe, I don't know, got some issues with it. But the point is, it is the core source of value, is the delivery system.

And how we facilitate its health and its ability to innovate and produce care

efficiently, is the core that we need to accomplish in these payment models.

Fee-for-service I think inherently doesn't do that. But moving into an Alternative Payment Model in a fragmented way, as was pointed out -- I think the very first question was, they don't have enough patients in that model anyway. They're not going to be able to change. I think Cheryl said that in one of her slides.

So, I think there's some notion that that's where you have a problem. And when you have other things going on in that system -- fragmentation, consolidation, different types of organizations buying up other organizations, exploiting the loophole in every rule you put in place, it becomes even more challenging.

And I don't know how much longer we have, but I hope we don't end on that depressing note.

VICE CHAIR HARDIN: Mike, I think you have a comment.

MR. ADELBERG: I'll be brief. I don't think private equity of itself is

something we should seek to exclude from the health care system. But to the degree that private investment seeks the most profitable niches, and then leaves the least profitable niches for legacy entities, that's a public policy problem, and we should be worried about that.

VICE CHAIR HARDIN: And, Chris, I'm wondering if you see a different proliferation of VC[26]-backed models in Oregon because of what you have in your structure.

MS. DeMARS: That's a good question. I don't have line of sight into that. We're pretty locally based. Many of our health plans are based in Oregon, so I don't think so. But I don't know.

VICE CHAIR HARDIN: Thank you all so much.

DR. CHERNEW: But private equity can occur in the delivery system, and it can be terrific. You can see you know, a bunch of new primary care organizations functioning, a lot

26 Venture capital

is going on in telehealth, a ton's going on in mental health, which is an area of unbelievable need. I'm sure there'll be a lot going on in social determinants. And private equity can also get involved in the financing side in a whole range of ways.

Again, doing very innovative things to be consumer-centric in engaging patients and solving some of the problems we've mentioned, there's a lot of ACOs and organizations that have been private-equity-financed that enable and support delivery system transformation, and some maybe not as valuable.

I'm not trying to make judgment, but private equity, like many things, can be both good and bad.

VICE CHAIR HARDIN: I think the big trend, huge change the last six months especially related to Cali -- so a Medicaid redesign in California -- has been approached by so many different companies looking at taking on the homeless population as a total cost of care model, or the criminal justice population, justice involved as a total cost of

care model.

Because this made me think differently about where what kinds of competencies and things we need to be thinking about. We're building a really just and integrated system for the next phase.

CHAIR CASALE: That's great. So, with that, I want to thank everyone, the presenters, excellent presentations, excellent discussion.

You're certainly all welcome to stay and listen to the remainder of our meeting. We'd certainly love to have you stay on if you can.

*** PTAC Member Listening Session on Issues Related to Population-Based TCOC Models**

But we're going to move to the PTAC member listening session. Larry Kosinski, who is one of our PTAC members, will be presenting on how specialty models fit in a total cost of care context.

And please have questions ready for Larry after his presentation. So, Larry, I'm

going to turn it over to you.

DR. KOSINSKI: All right, thanks, Paul.

Okay. Well, as Paul said, my task is to discuss the role of specialty models in reducing total cost of care.

I'd like to thank the PTAC for giving me the opportunity to speak today about my experience, and taking an idea that started from a clinical observation, to then become a project that was presented to PTAC for consideration and recommended back in 2017, and has since resulted in a successful commercial venture.

I'm talking about Project Sonar, which was the first PTAC recommended physician-focused payment model, back in 2017. We will use it as an example of the role of specialty models in reducing total cost of care. Next slide.

Our agenda today is shown on this slide. We will begin with a review of Project Sonar, starting with its early development, how it came to be, and the reasons for its

existence.

We'll then summarize our presentation to PTAC back in 2017, and what happened following the meeting.

I will then spend some time on SonarMD, the company that I formed to commercialize this project, and we'll discuss its payment model, and its performance in the commercial space.

This will lead to a discussion around total cost of care, where we will discuss the multiple commercial definitions of total cost of care, using the elephant view as a model.

I'll then discuss how the definition of total cost of care affects patient care, and finally, try to draw some conclusions.

Next slide.

So, how did this all get started? We have to go back 10 years to 2012, when I was asked to be the chairman of the Practice Management and Economics Committee, for the American Gastroenterological Association.

This would be a three-year

appointment, and I wanted to accomplish something memorable, while in this position.

Gastroenterologists, like many specialists, have a very poorly, poorly diversified revenue stream. In fact, a great majority of the income realized by a gastroenterologist today comes from performing colonoscopy. One procedure.

And most of these colonoscopies are performed for preventative reasons; screening for colon cancer; or, surveying patients who have a history of colon polyps.

Over 60 percent of the revenue of a GI[27] practice comes from just this one service. Not a very, very diversified revenue stream, and one that is vulnerable to less expensive technological advances for colon cancer screening.

I, therefore, sought to help diversify the revenue stream of gastroenterology, and hopefully encourage my colleagues to enter value-based care

27 Gastrointestinal

arrangements in the process.

The major significant disorders treated by a gastroenterologists are the inflammatory bowel diseases, Crohn's disease, and ulcerative colitis. Very expensive conditions. $40k per capita annually, with over two-thirds of the per capita costs as disease-specific costs.

I decided that these diseases would be the basis of my investigation, was fortunate to convince a major payer to provide me with claims-level data on patients with Crohn's disease.

They provided me a commercial database of 21,000 patients with the disease, claims over a two-year period.

And these are the patients, these patients can become very seriously ill. I already talked about their cost, but they had a 17 percent hospitalization rate.

The investigative physician in me wondered, what happened to those patients before each of these hospitalizations. I asked myself, could some of them have been avoided?

When I researched each admission for what happened in the preceding 30 days, I had my first ah-ha moment. In over two-thirds of the patients, there was not a single CPT[28] code in the 30 days before their hospital admission.

Not an office visit, not a lab test, no imaging. I thought that was quite strange, and represented a potential opportunity to build on.

We interviewed patients from the data set that were from our practice, and heard the same refrains over and over again: I have this all the time, doc; I didn't think it was important; I thought I had the flu; I wanted to call the doctor but I didn't have time, you know, with work and family and all.

It was clear that patients with this type of symptomatic chronic disease were going over the cliff without realizing it. They weren't Crohn's patients, they were human beings with lives who just happened to have the disease.

28 Current Procedural Terminology

I determined I needed a communication system, a sonar system. A way to ping these patients in between their face-to-face visits, so a medical professional could decide if they needed intervention.

Because if we waited for the patient to realize they needed help, most often it would be too late.

I created a crude communication system using the patient portal, where I sent out some questions from the Crohn's disease activity index to patients. We sent them out monthly.

It was cumbersome because everything had to be calculated by hand. But in the calendar year 2013, we had only a 5 percent hospitalization rate, which was significantly lower than the 17 percent from the previous claim set.

So, I went back to the health plan, they were impressed enough to make us their first intensive medical home, they had ever done with a specialty group.

It was launched in December of 2014.

The structure was that every patient had to be touched in some way, every month. We used a tech-enabled platform that we had developed to facilitate this level of engagement, but there was a strong human component to it. This was not just an app.

Our practice received perspective care management payments, to help build a value-based infrastructure. Something very critical that I believe in these days.

Finally, quarterly claims were available to the practice, which is also essential, so we could really see what was happening to our patients.

The figure on the right side of the slide shows our first year's performance. We lowered hospital admissions by 57 percent. ED visits by 53 percent. Total cost of care, which included drugs, by almost 10 percent.

We presented this at Digestive Disease Week, our major GI conference, in 2016. The physician-focused payment model was launched later that year. And we immediately filed an application so that we could bring

this to the public space, and potentially garner a 5 percent bonus from Medicare.

Our proposal went through the usual four-month process. It was presented to PTAC in April of 2017. It was approved by PTAC and recommended to the Secretary, for limited scale testing.

The Secretary though, decided not to pursue our model since it was using a proprietary technology, but stated that it would consider input from this proposal when developing potential models in this area.

We were disappointed, but understood. A commercial venture was now in our focus.

Next slide.

Sonar was formed in February of 2018 as a venture capital-backed company. We are a tech-enabled care coordination solution, for patients with symptomatic complex chronic diseases.

We're currently deployed as a solution for multiple GI illnesses, but only GI, and are contracted in multiple states.

The way our solution works is shown in the clinical wheel on the right. We receive an attributed population of patients from a health plan. Patients who have inflammatory bowel disease, and now several other diseases.

The disease-specific cost as I said, of IBD[29], is two-thirds of total cost of care. So, a specialist's work is very important here.

An important point is that a gastroenterologist on the average, only realizes $400 a year, when taking care of a Crohn's patient. A patient with a $40,000 per capita cost.

We have to get, work to get those gastroenterologists out of their GI labs where they're performing colonoscopies on healthy patients, and focused on the care of these ill patients. Which means program design.

So, we enroll patients in the program performing a three-pronged risk assessment disease severity, based on disease-specific metrics, but patient engageability

29 Inflammatory bowel disease

assessments. Placing patients in cohorts of engagement, so that we can communicate with them in the way they prefer to be communicated with.

And finally, using a claims-based assessment of existing doctor-patient interaction. And we're building this over time now, with machine learning.

The patients are then engaged using our platform on a monthly basis. Care coordination is performed by a human being. By a member of our staff. If symptoms scores exceed benchmarks, we then alert the practices to their potential deteriorating patient using a structured format.

Our goal is to work as an extension of the practice, and not disintermediate the doctor-patient relationship. Intervention taken by that practice is then fed back to us, so we can continue to improve our data-driven risk assessment.

Next slide.

This is probably the most important slide. It demonstrates our payment model, and

I have to say, it has significantly matured since our PTAC presentation in 2017.

SonarMD occupies a position between the commercial health plan and the specialty provider. We provide flexible, value-based arrangements for the health plan, where we guarantee them a minimal savings above which we share equally with them.

They do provide us an advance performance payment, which we're on the hook for, but which we use to both fund our operations and share with the practices, so that they can help, we can help them build a value-based infrastructure.

As I said earlier, this is critical if the practices do not have an existing structure for value-based care. Many of these practices don't even hire a nurse.

Risk is aggregated amongst the practices for each health plan, so we get some benefit from the larger numbers. There's no downside risk at this time, for the practices. That's an aspirational goal of ours for the future. Sonar bears the downside risk.

Next slide.

We continue to show the same success we demonstrated early on. This slide shows a difference of differences study, against a propensity matched control group a couple, a few years ago.

We demonstrated again, a 15 percent savings in total cost of care, including drugs. Both on the medical claims, as well as on the pharmaceutical claims.

This was driven by declines in in-patient admissions, ED visits, and non-ER[30] out-patient expenditures.

The savings, on those components, is much higher than 15 percent, but the total cost of care declines 15 percent.

We recently had a reconciliation from one of our large plans, and their savings was again, demonstrated in 2020.

Next slide.

So, using the elephant analysis. Total cost of care depends on your view. Like

30 Emergency room

the example of the elephant, it all has to do with how it looks to you.

Most health plans today, commercial health plans, focus on medical costs. This may or may not include provider administered drugs like biologics, since in most cases, two-thirds of the patients are self, are funded by self-funded employers, and PBMs[31] may be different than that of the health plan.

The PBMs of course, are focused on these costs. Provider focus is specialty-dependent. If you ask any of my GI colleagues, what's the most expensive component of GI care, they will all say colon cancer screening. Because that's their focus.

ACO is mostly focused on medical costs, but not pharma costs.

The patient is concerned about their out-of-pocket expenses. Their co-pays, their deductibles. What's coming out of their pockets. Employers who don't bear risk are concerned with insurance rates, whereas self-

31 Pharmacy benefit managers

funded employers are truly concerned with total cost, similar to CMS.

Next slide.

So how you define total cost of care can affect patient care. Business model conflicts can arise. Is the juice worth the squeeze? What percentage of your total revenue was represented by the Alternative Payment Model? If not enough is at risk in the value-based arrangement, there is no incentive to change.

Fee-for-service revenue versus value-based care revenue, must be changed out of the balance it's in right now, and put into a balance that favors value-based care, or we're not going to get buy-in from the providers.

Should fee-for-service rates be frozen, making value-based revenue the only driver of additional EBITDA[32] for practices?

There are potential direct patient care effects. Site of service drivers for

32 Earnings before interest, taxes, depreciation, and amortization

outpatient services can push patients to specific sites. These may or not be, may or may not be desirable for the patient.

Route of drug administration. Part B versus Part D. If I'm not on the hook for Part D drugs, I can play that system, and push patients off Part B drugs onto Part D drugs. If total cost of care is not the metric, then this can be played by the providers.

There are infrastructure issues. Does the institution have the infrastructure to manage the care? Is the institution large enough to manage the risk? Whose responsibility is it to decide this?

Next slide.

Total cost of care needs to be defined so that risks can be managed; accountable entities can be defined appropriately for managing the risk; care can be optimized for value from a patient focus.

Skeletal infrastructure must be defined. Risk should not just be transferred. Who has the obligation to the beneficiary, that the transfer entity can handle the care?

Skeletal substructures need development for specialists' participation. Can we build nested solutions? Can we limit carve-outs?

We don't want to be creating a structure like the condo building shown in this, in this slide in Florida, that collapsed last year because the responsible party for maintaining its structure was incapable of making the necessary decisions to maintain it.

My final comment is, can PTAC's review of proposed physician-focused payment models become a vehicle for evaluating stakeholder submitted approaches, that have the potential for deployment as nested solutions in population-based risk entities?

Thank you.

CHAIR CASALE: Great, thanks, Larry. That's a terrific presentation.

So, we're going to open it up now for questions and discussion, from our Committee members.

So, certainly you can raise your hand in the Webex, or just go ahead and ask a

question.

MR. STEINWALD: This is Bruce. I did raise my hand. And I have a question for Larry.

I'm sort of thinking back to the previous panel, and I think it was Michael Chernew, in particular, who expressed some concern about the proliferation of episode- or disease-specific models.

And I think he went on to say that he thought that programs like yours, Larry, that have been shown to be successful, could be integrated more organically, I think is the word he used, as opposed to, I'm not sure what the opposite was.

But I'd like to get your reaction to that. Do you think that's feasible?

DR. KOSINSKI: I do think it's feasible, and we are pursuing this. If you look at the GI space, over 20 percent of the total cost of care is represented by patients who carry GI disease diagnoses.

Now, that doesn't mean that the GI disease is the dominant reason for the cost in

some of these populations. But we have studied with actuaries, the GI population.

And inflammatory bowel disease is responsible for over 50 percent of the variable costs of that space. So, we're already half-way there.

And our goal is to be able to say to an entity like an ACO, or other large population-based, total cost of care entity, that we can handle this GI component. And we're willing to work at-risk.

It's too small to say we're going to take care of your inflammatory bowel disease patients. I remember from our PTAC presentation back in 2017, IBD is one percent of the patient population, but 2.5 percent of CMS's overall expenses. Still, too small.

It happens to work for us because most of the costs are disease-specific, and the primary care doctors are not typically taking care of these patients.

There's a firewall there that you can do. But when you get into other conditions, like acid reflux, or irritable

bowel syndrome, or diverticular disease, you have to be able to decide what components of those illnesses' costs, are driven by the GI decision. And the GI doctors should be at-risk for those.

I'm a big believer in the fact that we need to either freeze fee-for-service reimbursements at their current level, and allow only growth to occur in a value-based arrangement.

But we have to move this in the right direction, and encourage providers to accept controlled risk. And I really do believe that's going to come from putting episodes together, nested in larger entities.

MR. STEINWALD: Thanks.

CHAIR CASALE: Other questions?

Larry, I'm curious how you think about sub-specialty within your thinking. Certainly, in many GI practices, there are one or two gastroenterologists who focus on inflammatory bowel disease, yet they may be in a much larger group.

Similar to in other specialties,

certainly in my specialty, in cardiology, I feel in some ways this sub-specialization almost works against us, as we're trying to move towards this total cost of care.

I'm just reflecting on that, and your experience. How do we try to manage that within the context of this move towards sub-specialization?

DR. KOSINSKI: That's a great question; very pertinent.

I want my best colonoscopist, if I'm running a GI practice, and I did, I ran the large, I participated in running the largest GI practice in Illinois.

I want my best colonoscopist in that GI lab, doing colonoscopies. I also want doctors who are focused on IBD, to be taking care of the IBD patients.

And maybe the value-based revenue that's coming from an agreement like this, goes only to the doctors who are actually taking care of the IBD patient.

We have the same issue with hepatology, because it isn't compensated as

well as the procedural services.

So, I think the payment models have to be structured, but structured with the patient's best interest in mind. You don't want every gastroenterologist taking care of IBD. You don't want that.

If this is too serious of an illness, with too much potential for morbidity and cost, to have every doctor feel like he's an expert, he or she is an expert, in taking care of it.

I think we need sub-specialization. We just need to adjust our payment models within our practices, so that we compensate appropriately.

CHAIR CASALE: Great, thank you.

Other questions for Larry?

DR. PULLURU: Larry, one, great presentation. One of the questions I had was how do you in this model, navigate the drug cost besides, you know, obviously managing through the physicians that can prescribe the drugs?

But, you know, for example, site of

service with where their infusions are done. How do you navigate some of those challenges that lend itself to high cost?

DR. KOSINSKI: Well, that's what I was referring to in my, one of my bullets where the risk-bearing entity will control where the patient is having their services provided.

So, if someone's part of a hospital-based ACO, they're going to get their infusions in an expensive hospital outpatient department.

Whereas if it's a provider-based ACO, in all likelihood, that patient's getting it in an office-based setting, where the cost between these two are miles apart.

So, we have to, I think it all comes down again to the model. And how you're compensating for certain things. And, you know, having sat on a hospital board, I know how important it is to the hospitals, you know, to have those revenue streams.

One thing I think I have to say, is that my presentation of Sonar here, was my presentation. This isn't a PTAC endorsement of Sonar, or a PTAC-driven presentation.

This was just my ability to present from the provider's point of view, what it was like to go through the PTAC process, and what happens after that.

CHAIR CASALE: Other questions for Larry?

DR. KOSINSKI: See, I told you we'd get it in time, Paul.

(Laughter.)

CHAIR CASALE: Well, Larry, as you've heard from other specialties, and we're thinking about models and look to your model around the country, do you see this, your type of structure as something that can be reproduced for other specialists, specialty models?

DR. KOSINSKI: Yes, yes. With these following criteria. I published a paper in Gastroenterology a couple of years ago, raising something I called the high beta concept.

We're all familiar that in a stock portfolio, you have high beta stocks, and low beta stocks. And you can make the same analogy for a family of diseases.

So, if we look at the GI space, there are some conditions in gastroenterology that are high beta. IBD is one of them. It has high variability in cost, and as opposed to others, which are very low.

They exist in other specialties, as well. In cardiology, congestive heart failure would definitely be one. In pulmonology, asthma, COPD[33], are definitely high beta conditions.

The metabolic conditions. Inflammatory diseases like rheumatoid arthritis, and the lupus and that. They would fall into it.

The key here for what we're doing, is they have to be symptomatic. They have to be conditions where patients' symptoms can be used to help you decide when patients need intervention.

And we're not doing anything really sophisticated here. We're just getting patients to care earlier in the course of the

33 Chronic obstructive pulmonary disease

deterioration of their illness.

And when you work off the concept that most symptomatic chronic diseases are going to fall into that kind of category, if you find the ones that are high cost, high variable cost that are symptomatic, they should benefit from this type of a structure as well.

CHAIR CASALE: Great. Just adding on to that, and this is somewhat anecdotal. Because you mention COPD, when we did a pilot around COPD, and it turned out that a lot of the cost was actually driven not so much by the COPD, but by SDOH, and behavioral health issues, and such.

Do you find in your population, that those also are cost drivers that you need to address?

DR. KOSINSKI: Yes. We just published an abstract that's going to be at this May's Digestive Disease Week, looking at the difference in total cost of care of patients who answer a PHQ[34]-2 evaluation at

34 Patient Health Questionnaire

enrollment, positively.

There was a statistically significant increase in cost, not from the patients who had a history of mental health disorders, but in the patients who answered that PHQ-2 positively.

They have active problems, not, they may not be carrying a diagnosis or not, or if they have a diagnosis, it might be under control. But we're finding evidence of active psychological motivation in the, and that's affecting their cost of care.

So, the answer is yes, very definitely yes.

CHAIR CASALE: Great.

VICE CHAIR HARDIN: Just to follow on a comment for that Larry, I think clinically I've seen that across the country. The association between domestic violence and trauma, especially with GI and IBS. So, it's just really curious if that maps for you.

DR. KOSINSKI: We can talk about that for a long time. Definitely.

CHAIR CASALE: Okay, great. Well,

we're at time at 1:30. Thanks, Larry, can't thank you enough. Great presentation, and great discussion.

So we're going to take a break until 2:00 o'clock, then we'll come back. We'll discuss what we've heard, and then we'll be done for the day.

So, we'll see everyone back at 2:00 o'clock.

(Whereupon, the above-entitled matter went off the record at 1:31 p.m. and resumed at 2:01 p.m.)

CHAIR CASALE: So, thanks for coming back. Now the Committee members and I are going to discuss what we've learned throughout the day, from the various presentations and Q&A sessions.

We still have one, we still have more presenters in a panel discussion tomorrow, but I want us to reflect on what we heard today.

After we conclude this series in September, as I mentioned earlier, we will submit a report to the Secretary of Health and

Human Services, on population-based total cost of care models.

Our reflections at these meetings will help shape our findings in that report.

* **Committee Discussion**

So, to the Committee members, I'm going to ask you to find the potential topics for a deliberation document, in the binder.

And then either use the hand raise feature in Webex, or simply raise your hand as we begin our discussion.

We have the slide up currently for those participating in the public meeting that identifies some of the potential topics for the Committee's deliberation during this March public meeting.

So, I'll just run through them and then we'll take them down.

So, potential topics include: defining and structuring population-based total cost of care models; challenges in developing and implementing population-based total cost of care models for physician practices; equity implications of population-based total cost of

care models; payer variation in population-based total cost of care models; and, then promising approaches related to care delivery, payment, and performance measurement.

So, you can go ahead and take this slide down, and so we can see all the Committee members. And we'll just open it up for comments and questions about what we've heard so far today, and any other comments you may have.

VICE CHAIR HARDIN: I thought it was a very good discussion today, with a lot of really important themes being pulled out.

One thing I'm struck by is the opportunity to really look to states like Oregon and Vermont, who already are creating, or on the path to integrated all-payer models.

And pulling out the themes of success, and the (audio interference) out of that, and that being really important patterns to look at, as we look at total cost of care.

DR. SINOPOLI: Yes, this is Angelo. I would agree with that. I thought the presentations were exceptionally well done

today, and covered very important topics. And what struck me is that it, this is achievable at a state level, and an all-payer level.

And, hopefully, we can develop some models to kind of track an all-payer model, to create that scale that the providers need, to really engage in this. That was good to hear.

CHAIR CASALE: Other thoughts?

Lee, as you think about your work in Oklahoma, I'm just curious on what you heard today, how this resonates or, any particular challenges you think about when you heard the conversation today?

DR. MILLS: Appreciate that, Paul.

Yes, my thoughts actually were going two different places, which I experienced and we're working in, but both of which remain murky. And which is, one, I'm fascinated by that, you know, kind of the clear, evocative description of a nesting of, you know, baseline, broad population-based, total cost of care model. Then, with other focused population or episode models, you know, kind of under that umbrella.

And we heard from Dr. Fowler, potentially dialysis could be an episode model. That makes good sense. We heard from multiple speakers about lower limb joint replacement. I think that makes good sense.

My brain also would include perhaps hospice populations.

So, I guess I was wondering what, if that model is a working construct, what other most tightly defined, you know, episode or specific populations, would we want to have a separate nested model out, and pull your potential exceptionally high-cost, high-risk people out of a population-based model.

So, that was the first thing, and I'll let the Committee kind of reflect on that. And then I was going to go towards risk adjustment next.

CHAIR CASALE: Thoughts on that from other Committee members?

DR. SINOPOLI: I like those models. I think that that's necessary to figure out how to nest those things, within a total cost of care for all the population model.

VICE CHAIR HARDIN: I agree, Lee and Angelo. And I think I was referencing in some of the comments, there's also the social determinant sort of aspect of that.

So, there's this emergence of equity-backed total cost of care population approaches, to homeless populations. Or justice involved populations, which is a very different way of thinking of it, rather than fees-oriented standpoint.

But it does make sense when you look at the experience of the population, and offers some real interesting opportunities for integrated care.

DR. LIAO: This is Josh. I just kind of reacted a little bit to Lee's comment and actually, many of the ones that were said this morning. I've been kind of processing and noodling on these. So much good information there.

And I think one of the comments that struck me was this idea that, you know, X intervention or Y solution, doesn't work all the time. There has to be some targeting, you

know, in that way. You have to deliver to the right population.

And to just draw a rough panel of, that to me is what when we're talking about nested or coordinated models, that's what episodes are, right.

One of the challenges of that broad population is you can go after one of any N areas. And so, I really don't like that idea.

I think more like the proverbial rubber meets the road for me, is as I look at models in the past, little things, like multiple models will have SNF[35] waivers, but they'll vary just enough they don't plug right.

There's no USB so to speak, we can plug these in. And I think if we're going to go forward here, we'll need something to where, in my opinion, it would be beneficial to think about a set of things, whether it's risk adjustment, or benchmarking, or you know, we could think of a few things that someone could say within my population-based model, I would

35 Skilled nursing facility

like to plug in these two of your episodes, right?

Because it's not also just what is most fruitful from a, you know, national perspective. I think a few people mentioned this idea that you may not have enough patients for your population right. So, that flexibility to be able to target is important.

But I can't make everybody target everything. And so, to me, like, we're not going to be able to do that unless we have some standard set of payment features, which maybe we'll talk about in the next few meetings here, to let us do that.

I think short of that, that will remain an idea.

CHAIR CASALE: Thanks, Josh. Other thoughts on?

MR. STEINWALD: Yes, this is Bruce.

Actually, the space bar is not working for me to get off mute. I don't know if anyone else has that problem.

I agree with others. I thought that the presentations were very good, and they were

meaty, which was nice.

I did notice that the actuaries were made reference to a few times. And, earlier this morning, I mentioned maybe having actuaries represented.

By the way, the actuaries, as you know, are people who are pretty good with numbers but don't have the personality to be an accountant, right?

(Laughter.)

MR. STEINWALD: Are there any actuaries in our group? I'm sorry.

But just to get a sense of how they look at it, that they're looking at all of these issues related to total cost of care as we are.

And I think it might tee up some good discussions about methodology, which may be focused on in the September meeting. But I think we need a lead into those discussions in the June meeting.

So, I'm going to reiterate my suggestion, that to have the actuaries represented at that meeting, seems sensible to

me.

And it makes even more sense to me having heard the presentations that we just did.

VICE CHAIR HARDIN: Bruce, tomorrow Torrie Fields is part of the presenters, and she's an actuary.

MR. STEINWALD: Oh, boy.

VICE CHAIR HARDIN: And is articulate about this. So, it will be really interesting to ask her a few follow-on questions tomorrow.

MR. STEINWALD: Right. And I sure am glad I didn't make my joke tomorrow, instead of today.

(Laughter.)

CHAIR CASALE: Thanks for that, Bruce.

Other thoughts?

DR. PULLURU: A couple of things that --

(Simultaneous speaking.)

DR. KOSINSKI: I think we did --

CHAIR CASALE: Oh, sorry.

DR. KOSINSKI: I'm sorry, go ahead.

DR. PULLURU: No, go ahead, sorry.

DR. KOSINSKI: I think we, I'm coming away from this morning with a definition of total cost of care. In fact, it's more inclusive than I might have thought, even before the meeting started.

So, I mean, that's our major goal of these two days, is to define what that is, so that then we can look at models and programs, and, you know, make some structure.

But they had a very inclusive concept of total cost of care.

DR. PULLURU: Yes, and I was, that's almost exactly what I was going to say, Larry.

A couple things that struck out, you know, basically just stood out anyway, at me, were one, that their definition of total cost of care was very inclusive, and that seemed pretty uniform.

That the thought that if you included everything, you actually led to more innovation, seems to be the message.

Two, the social risk adjustment, I

thought was a great way to think about how you embed social equity, or health equity into programs.

And then the third message that I took away was the concept of harmonizing the APMs and then as alluded to earlier, nesting within the APMs. And I think that, you know, that needs some modeling to really see how that would play out.

But I thought that was a great message, as well.

DR. SINOPOLI: This is Angelo. I liked the conversations around total cost of care, but I just want to point out that my opinion, smaller particularly physician-only ACOs, are going to have a really difficult time taking risk for pharmaceuticals in those type of ACOs.

And so, we will have to make some exceptions to the definition, you know, based on the application.

DR. KOSINSKI: Yes, Angelo, the expensive drugs are either in or they're all out, whether they're in the medical claims or

in the pharma claims. This siloed approach where, you know, I look at my space and Infliximab and Vedolizumab are in medical costs, but Stelara and Humira are not because they're self-injectable. And I've always taken the position that either include them all, or you don't include any of them. But to have half of them in and half of them out makes no sense. And that just allows people to play those markets, and patients suffer in the long term.

DR. SINOPOLI: Yes.

DR. LIAO: With this idea of the nested models a little bit, too, you know, I just want to also just kind of surface this idea that, you know, if you talk to ACOs around the country, it's not that none of them are targeting. I mean, I think a lot of them do that already. They implement programs to target specific populations.

And so one could ask, you know, a systematic, episode-based model overlaid or kind of as one track or one component of a population-based model. There's pluses,

there's also minuses to that, right?

And I very much -- I trust the group knows this, from my perspective, we very much value evidence and using that to inform our decisions. However, we also don't penalize ACOs for, I think, the programs they do now that work, or don't work, right? We don't legislate that and say, well, you shouldn't go after your hospice population, or your CHF[36], or your multi-morbidity patients. We give that flexibility.

So, I just want to call out that if we nest and lay these tracks down, we are losing some of that flexibility. Just have to grapple with whether that's good or bad.

VICE CHAIR HARDIN: I think another interesting theme that came out, and this is related to Larry's presentation, but also looking at total cost of care type of models with (audio interference), which is based on any models where you're holding all costs of care for a certain rate.

36 Congestive heart failure

But that the importance of anticipatory management of conditions, and experiences, and then a pathway for addressing that before it becomes a crisis, is still an important design of the system.

So, the perpetuation of that in total cost of care models in all directions, is critical.

CHAIR CASALE: Other thoughts and comments?

I was wondering: we heard a little bit about MA today, and I'm wondering whether, based on some of the discussion today, is it worth learning more around the MA programs, and how they try to, again, create their networks and identify how specialists interact, or if that would be helpful in our thinking?

DR. PULLURU: I think there's a lot to be learned from them, Paul. It's a great idea.

Now, in the June meeting, I think we have scheduled a couple of sort of provider facing organizations that largely deal with MA, and that might be a good way to develop that

thought process.

DR. LIAO: I think it's a great idea to actually, just kind of list out all the things that we could learn from them, and things that won't translate, just to have that distinction.

For example, certain things like networks that just won't be, for a number of different reasons.

But other ways in terms of beneficiary engagement, I think great. So, yes, I agree with that idea.

CHAIR CASALE: Other thoughts? I know, and Lauran, you may have a comment on this, that we talked a bit around social determinants of health, and whether, you know, the best way to implement that is should it be medical systems providing the social benefits, or should it be the collaboration with social service systems?

I know you think about this a lot, so I'm curious what you have thoughts on that.

VICE CHAIR HARDIN: I thought there was great discussion about that. So, you know,

I spend so much time in that space, I have a very biased opinion, the need to invest in our social delivery systems.

Screening isn't enough. What we see around the country is a lot of screening and navigation to nowhere. Services don't exist, and they're not financed to meet the need.

If we don't include that in our total cost of care purview and discussions, we're going to end up just creating another cost source, and how will that be addressed?

So, the most successful and interesting models I'm seeing across the country are integrating that. I also think that partnership to that is really important.

I see people reinventing the wheel, and starting services when they already exist in the market. They're (audio interference) to the culture.

But I'm curious what others thought on the call. We heard some really great comments about that, and I think it will continue to be a really big area of discussion, and something that we're going to struggle with

as a country, about where are we going to invest, and where are the dollars going to go.

DR. PULLURU: Yes, I mean the challenge is going to be that it increases. It's not a budget neutral proposition in a lot of situations, right, so you're covering additional care.

And so then it goes back to how you define total cost of care. If it's just Part A and Part B, that's not something that is easily amenable to being budget neutral, to include social determinants of health.

But if you do a global fee, or total cost of care that encompasses everything, then you'll allow for people to be able to spend their money as they see fit. Which oftentimes, contributes to being able to spend money on social determinants.

(Simultaneous speaking.)

DR. LIN: Yes, just a follow-up on that. I think linking Mike Chernew's idea of flexibility, and creating efficiencies, you know, total cost of care if we, for example, include Part A, Part B, plus/minus Part D

costs, as a total cost of care, that would be the total cost of care.

But how the organization allocates those dollars, including to social determinants of health resources like transportation needs for dialysis patients, could be up to the organization, but that doesn't really add on to their total cost of care.

That total cost of care, should be the total cost of their health care expenses. But how you allocate those dollars, can be more flexible, I think.

DR. KOSINSKI: And one thing I've been struck with on this, is the length of time to assess success or failure of these programs.

And it may take longer to realize a return on investment when you're building SDOH services in. They may not pay off at the same rate. But that doesn't mean you don't do them.

CHAIR CASALE: Lee, I think you had a comment?

DR. MILLS: Yes, I think this circles back around to risk adjustment. I do operate a high-quality, help operate a high-

quality MA plan, and this concept of social determinants being so critical, I love the comment that it's necessary to do the screening, but it's not sufficient.

It's what you do with that information that makes the difference in members' lives. And, you know, the best risk adjustment models now, only elastically kind of counter-predict about 50 percent of the variants, give or take.

And none of them really account for social determinant findings, that seem way overweighted in what happens with a person's health care costs.

So, from the health plan's side, as I'm gathering all this data and systematically building care teams to react to it, I'd like my revenue to reflect the appropriate risk of the population, and the things we're knowing and finding, and taking on.

And then my provider operator brain is saying, and for the provider teams, they need payment that fully, fully reflects the severity of their patient population, which

really just was never recognized.

And so I think there is -- I'm a pragmatist, in part, but I think there's a lot of academic work and statistics to be done, about modeling what, how risk adjustment models reflect social determinant work. And that can't take a decade to do. We need to figure it out pretty quickly.

CHAIR CASALE: Yes, thanks for those comments. Other thoughts?

VICE CHAIR HARDIN: I guess a merging related to that is some really interesting AI-driven utilization (audio interference) related health needs, and social determinants of health, and really tiering populations.

And predictive models based on that. Just like we've kind of done with disease management, really looking at those social factors and being able to tier that out.

So, I have great a hope that that's coming forward.

CHAIR CASALE: Other comments?

DR. MILLS: Another thing that

struck me, Paul, that really didn't come up today, but in our total cost of care construct, we had nobody today that mentioned anything about, you know, proven clinical, or other service outcomes, quality metrics, pay-for-performance, et cetera.

And, to some degree, that's perverse and everybody's used to pushing on quality metrics and substitute endpoints.

But really in a total cost of care model, there's still going to have to be some, some breakers or some weigh points that assume, you know, some standard minimal level of quality is met for the total cost to construct to be valid.

And I think there's more thinking to be done there, too.

CHAIR CASALE: Yes, I agree. And at what level does the attribution on those quality measures, you know, the whole, all the usual concerns around all of that.

DR. MILLS: Right.

CHAIR CASALE: Yes, it's a good point. Very good point.

DR. MILLS: And that then parlays into essentially an all, some kind of coordinated all-payer mechanism.

As long as you're picking at it, one payer, one program at a time, you'll never have the volume to change practice.

CHAIR CASALE: No.

On the topic, I don't know why, maybe because I'm a specialist. I'm always focused back on the specialty within the total cost of care.

Any other thoughts around, many, you've already mentioned some important points, and, you know, and as Walter said, Mike Chernew mentioned about flexibility, and not being too prescriptive, and not trying to drive everything policy-wide because people can often look for ways, you know, to either pick populations, or do things differently.

But is there a sense that most of the specialty care would be, sort of sorted out within whatever entity is taking on the total cost of care, as opposed to prescriptive episodes, other than some of the ones that have

already been mentioned?

Is that the sense, or do I have that wrong?

MR. STEINWALD: I think you have it right. I also like Larry's construct, of how you identify what kinds of chronic illnesses are appropriate for nesting within a broad-based ACO-like operation.

In fact, you said it was published, right, Larry?

DR. KOSINSKI: Yes.

MR. STEINWALD: So, maybe we can get --

(Simultaneous speaking.)

DR. KOSINSKI: I'll send it to you.

MR. STEINWALD: Okay.

DR. KOSINSKI: I'll send it to you. I know where it is, they would have to look.

MR. STEINWALD: Okay, all right.

DR. KOSINSKI: No, it's like we deal with specialties, and patients have characteristics that go across specialties.

And there may be a different science around creating which patient populations we

should promote the development of nesting solutions to.

Because if we, and I'm speaking as CMS, if we're on the hook for providing the total cost of care for these patients, it might not fit into specialty categories. Or type of physician categories.

We may have to start with it from a patient characteristic point of view.

(Simultaneous speaking.)

VICE CHAIR HARDIN: I think that --

DR. KOSINSKI: It's what Lauran was speaking about earlier.

DR. SINOPOLI: Yes, my belief is, it's the ACO's responsibility to create service line-like entities across the ACO, that brings those multiple specialties together, that focus on certain disease areas. That to your point, may not be purely cardiology, or purely pulmonary.

It takes primary care at the table, and rheumatology at the table, and others at the table, as you're driving these care models, and looking at those outcomes.

VICE CHAIR HARDIN: And then having worked deeply with all the sub-populations who are complex. There are certain sub-groups where they really identify their primary care, for example, in sickle cell, is their hematologist. Or particularly with COPD with their pulmonologist, because they're spending so much time there.

So, who holds that role, and how does that nest, as well as the people who need the truly integrated specialty care, where they have multiple specialists and a primary care really sitting at the table.

Very important question, I think, for the future, from the patient perspective. Who they see as their quarterback of their care may be different than how we have designed the system.

DR. LIAO: I really like this conversation, but I think -- and this may be something that we can flesh out in future sessions, too -- but some of what we are articulating here, that flexibility exists today, right.

So, I just want to say, like, when we're talking about nesting a model in a model, you know, and each model has its analogous structures, maybe this conversation has kind of expressed it more elegantly than I could have. But that's the trade-off, right, to Angelo's point about those service lines.

If you create a model, like it creates restrictions around that. And we could ask how is what we're describing now different than what could, potentially, exist today in a larger, broad-based ACO?

(Simultaneous speaking.)

VICE CHAIR HARDIN: (audio interference)-- really relevant with the serious persistent mental illness population. So, who do people anchor to the most, and spend the most of their time?

CHAIR CASALE: That's great. We just have a couple minutes left. And want to be sure we capture everyone's comments and thoughts.

Of course, we'll be back tomorrow for more, but, you know, I thought the

presentation, all the presentations and the panelists, and then from the PCDT, and Larry did double duty doing the project.

So, I mean, it's just really terrific, and the conversation with the panelists I thought was really, really helpful.

VICE CHAIR HARDIN: Larry, you get the MVP award today.

CHAIR CASALE: Yes.

DR. KOSINSKI: Well, if you want to learn how to swim, you've got to jump in the pool. So, I figured I may as well do it. Thank you.

*** Closing Remarks**

CHAIR CASALE: So, I want to thank everyone for participating today: CMS leadership, our expert presenters, my PTAC colleagues, and those listening in.

There's a lot more to cover related to population-based payment and total cost of care models. So, we'll be back tomorrow morning at 11:00 a.m. Eastern Time. We'll feature another listening session and a roundtable panel discussion. So, I hope to see

everyone back then.

*** Adjourn**

Thank you. This ends our meeting for today, and we'll see everyone back tomorrow at 11:00 a.m.

(Whereupon, the above-entitled matter went off the record at 2:29 p.m.)

C E R T I F I C A T E

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Before: PTAC

Date: 03-07-22

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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