Specialty Care Strategy Listening Session
December 1, 2022

>>Meghan O'Connell, CMS: Good afternoon, everyone, and welcome to the CMS Innovation Center Specialty Care Strategy Listening Session. We are so excited to have everyone here. My name is Megan O'Connell and I'm from the CMS Innovation Centers' Division of Specialty Payment Models. Next slide, please.

Before we get started, there are a few administrative items to address. First, I want to let everyone know that this session is being recorded. After this session concludes, the recording and slides will be available on the CMS Innovation Centers' website under the Strategic Direction page. The link to that page is being shared in the chat now. Second, closed captioning is available for the event. To get closed captioning, please click on the CC button at the bottom of the screen. Third, I want to point out that we have a Q&A function available to use during this meeting, and I encourage everyone to use it. Due to the size of the event, we might not be able to respond to everyone's questions, but we'll be monitoring the Q&A closely and capturing any follow-ups there. Lastly, if there is any press on this call, please submit questions through the CMS Media Inquiries Portal, and that link is being shared now. Next slide, please.

Again. I'd like to warmly welcome you to today's listening session. Following my overview of today's session, my colleague Purva Rawal, the Chief Strategy Officer at the CMS Innovation Center will provide a few opening remarks on the Center's specialty care integration in models. After those remarks, I'll walk through the Center's Specialty Care Strategy, each element of the strategy, and we'll call upon experts in the field to provide their comments along the way. Finally, I'll summarize and close out the session. With that overview of the agenda, I'd like to open the floor to Dr. Purva Rawal. Next slide, please.

>>Purva Rawal, CMS: Thank you, Meghan. I'm really excited to be here with you all today and thank you all for joining us.

As many of you know, the CMS Innovation Center has been holding listening sessions and roundtables since the release of our Strategic Refresh last fall. We're excited for this continued engagement, with today's focus on specialty care. Before diving into the details of our Specialty Care Strategy, I'd like to point out why the Innovation Center is focusing on specialty care integration. Next slide, please.

As many of you know, Congress provided CMS the authority, through the Innovation Center, to test innovative models as part of the Affordable Care Act. The goal of the models is to preserve or enhance the quality of care for beneficiaries in Medicare, Medicaid, and the Children's Health Insurance Program while spending the same or less. On a practical level, this means that the Innovation Center can, for instance, change the way services are paid for and then evaluate whether that change improves quality or reduces costs.

Our strategy for the Innovation Center's second decade was released in October 2021, and it outlines our focus in some key areas, including our focus on equity and everything we do, paying for healthcare based on value to the patient instead of the volume of services provided, and delivering accountable, person-centered care that meets people where they are. Just a few weeks ago, we released a report which outlines our progress in the implementation of this new strategy for the past year. The report also describes areas of focus for the coming year, one of which is the implementation of our Specialty Care

Strategy, and begins the process of measuring our progress against the five objectives listed here, listed on the next slide.

The five strategic objectives are: guiding the implementation of the Innovation Center's renewed vision to drive accountable care, to advance health equity, to support innovation, to address affordability, and to partner to achieve system transformation. Next slide.

I'm sorry, can you go up two slides? That was my error. No, go up, go back up to the start. Can you go back up one more? Thank you.

You may already be familiar with the objectives, so I won't go into too much detail on each of these but discuss the importance of increasing access to high-quality specialty care to achieving this vision. In the last year, our team has conducted interviews with experts and gathered lessons learned to develop the comprehensive Specialty Strategy that Meghan is going to discuss with our panelists today.

The first objective is to drive accountable care by increasing the number of beneficiaries in a care relationship with accountability for quality and total cost of care. To bring accountable care to more beneficiaries, we want to develop models that aim to ensure those with chronic or serious conditions receive coordinated care. We're also focusing on strategies to drive better integration of specialty and primary care in our model design.

Our second objective aims to embed equity in every aspect of our models. This means that we want equitable access to high-quality specialty care that reduces disparity in care and outcomes. To achieve that objective, we're focusing on increasing safety net participation in our models, reducing disparities in care and outcomes through payment incentives, quality measures, beneficiary data collection on demographic characteristics, and the identification and resolution of social needs.

The third objective is to support care innovations to enable integrated person-centered care. One of the things Meghan will be discussing is the role the Innovation Center can play in providing data and promoting transparency to support high-value specialty referrals and better management of episodic care by ACOs.

The fourth objective is to improve access by addressing affordability through strategies that address healthcare prices, affordability, and the reduction of waste. As part of our specialty work, we'll continue to examine ways to reduce low-value care across both primary and specialty care.

And then the fifth and final objective is to partner to achieve system transformation by aligning priorities and policies across CMS and engaging payers, purchaser, states, and beneficiaries. This also requires us working across CMS with our partners and the federal government. We'll continue working with the Learning and Action Network as well to gather feedback, to gather beneficiary input on the design and implementation of the various parts of our specialty strategy, and to consider opportunities to support transformation and specialty care across payers.

Now I'd like to hand it back over to Megan to go through the Innovation Center's Specialty, Care Strategy in greater detail. Next slide, please.

>>Meghan O'Connell, CMS: Sorry about that. Fabulous, thanks Purva. Within the strategy that Purva just outlined, we feel very strongly that achieving our goals requires addressing the full range of patients' needs, including care for chronic conditions and episodic or other specialized care and needs,

given much of this is provided by specialty physicians, such as orthopedic surgeons and cardiologists. This is especially true given that over the last few decades Medicare beneficiaries have been faced with both greater clinical and system complexity. A majority of beneficiaries have one or more chronic conditions, and the number of providers they are seeing each year is increasing, which means increasing demands on primary care providers in terms of the number of providers they need to coordinate with. We also know there are opportunities to impact health care spending given specialty care plays a large role in overall medical spending. So, we know that we can't improve quality or reduce costs for people without designing models and tools that put beneficiary needs at the center of specialty care with the right incentives to support access and better outcomes. Next slide, please.

There are four main elements to our strategy that really set a foundation for integrating specialty care in a way that can drive broader system transformation for patients. First, we've heard from many stakeholders and model participants about the critical need for data to drive quality and integration. So, we're really considering the role of data and other supports that can provide increased access to high-quality specialty care, and really enable better communication across primary and specialty care.

The second critical element is maintaining momentum with our acute care episodes. Episode payment models like CJR, which is the Comprehensive Care for Joint Replacement Model, and BPCI-A which is the Bundle Payment for Care Improvement Advanced Model, which many of you are familiar with, have really driven transformational changes in the delivery of care across transitions between hospitals and post-acute care and to the community. So, we're actively exploring policy options for those potential successor models to these initiatives.

And then the last two elements, the third and fourth building blocks are related to supporting better engagement between specialists and our primary care models and ACOs. Data is one component of this. But we've heard from stakeholders, primary care focused ACOs, and advanced primary care models how challenging it is for them to reach past the point of referral for ambulatory conditions. And we've also heard from specialists that they feel left out of models. So, we know that we need to solve, for both of these challenges, bring specialists to the table, and we're looking at different types of incentives and structures within our models that can make that possible.

To discuss these elements, we have invited a few speakers, experts in their fields to provide their perspective on each element of the strategy. These speakers include, first, Aisha Pittman, Senior Vice President of Government Affairs at the National Association of ACOs. Second, we'll hear from Lili Brillstein, Founder and CEO of the BCollaborative. Third, we'll hear from Frank McStay, Assistant Research Director of the Duke Margolis Center for Health Policy. And lastly, from Michelle Mirkovic, Program Director Regulatory and Value-Based Care of the UT Southwestern Accountable Care Network. We look forward to hearing each speaker's input on supporting value-based specialty care within our models. Next slide, please.

So first I'll discuss element one of the Specialty Care Strategy. This involves increasing transparency with specialist performance data. Part one of this element on enhancing specialty care performance data and dashboards involves two types of data. The first is beneficiary-level data packaged in a way that will give population-based model participants the ability to compare quality and costs of procedural or acute episodes of care. And we've referred to this in the recent specialty care blog as shadow bundles. And this is intended to assist ACOs in better managing their value-based care strategies. The second type of data on specialists is on specialist performance, which is more aggregate measures that will allow ACOs

to identify the highest value specialists in the marketplace, meaning the highest, the highest quality at the lowest cost. And this is intended to facilitate a shift in the market from referrals driven by prior relationships really to more referrals driven by value. We will need time to construct dashboards and data feedback tools, but we really believe that any data that is thought fully presented can go a long way to enabling more high value choices in the health care industry.

Also, under the umbrella of performance transparency, is creating an industry standard definition of upstream condition and short-stay acute episodes of care. We expect this will support accountability and contracting around conditions in the market and doesn't necessarily require an Innovation Center model. It's more about creating a standard definition of a condition beyond just a single diagnosis. It will ideally create a standard unit for quality and payment that can be used to contract for condition management, for example, within an ACO. I also want to mention that defining episodes under these, this strategy directly feeds into the strategies three and four and we'll be getting to those. Next slide, please.

With that, our first panelist is Aisha Pittman from the National Association of ACOs. Aisha, our question for you is: How can increasing transparency on specialty care performance data enable a better experience for patients? And I'll give you the floor.

>>Aisha Pittman, National Association of ACOs: Thanks, Megan, and thanks to the entire CMS and CMMI team for having me today. Just for a little bit of background, the National Association of ACOs represents more than four hundred ACOs that are in the Medicare Shared Savings Program, Direct Contracting, and soon to be ACO REACH. And these ACOs are also engaged in other CMMI models and doing shared savings and episodic arrangements with other payers as well. So overall, we're really committed to the administration's goal of moving all Medicare beneficiaries in an accountable care route, to an accountable relationship that's responsible for total cost of care and quality by 2030. We just think this specialty engagement strategy really thoughtfully considers how to engage specialists to meet that goal and to address a lot of the challenges that we've seen today.

We've had ten years of testing innovation payment models, and we've learned a lot, and that there are some challenges created, particularly when we've had these specialty specific bundle payment programs. In the ACOs, that sometimes leads to a model overlap and some conflicting challenges that just ultimately results in the providers having to manage to the model rather than thinking about how they're partnering together to improve care across the continuum. So just want to say a huge thank you to CMS for all of your, and the CMMI team, for all of your work on this Specialty Strategy.

In terms of the short-term goal of additional data on specialist performance from the perspective of ACOs, this is really greatly appreciated. I think ACOs really vary in their ability to conduct this type of analysis themselves. For the ones who are able to conduct this type of analysis, they're just limited to what you can see within the ACO and don't have much sense of specialty care and performance outside of their ACO. So, I think this effort to increase transparency, and especially performance data, would really help the ACOs engage in a number of ways designing, you know, engaging with the specialists and sub-contracts to do shadow bundles or quality for performance bonuses or things like that. But then also supporting the beneficiaries with identifying the most optimal specialist for what's needed.

In the strategy blog, CMS notes needing to work with stakeholders to identify the best metrics, so we appreciate that you recognize that piece. You talk a little bit about perhaps using the MIPS cost

measures as a starting point. We would also say to look at the episodes that have been tested in BPCI. These both have sort of different strengths and weaknesses. The MIPS measures are very targeted to provide information about the care only that the specialist is providing. But then the BPCI episodes are where ACOs are currently looking to think about how they might engage specialists in subcontracting efforts as well. So, rather than sort of defining one approach, we encourage you all to pilot test a few different approaches before full launch and get stakeholder feedback on those different potential approaches. Some of the approaches really get to, for what purpose are you using the data. I think we also have to think about what data is most meaningful to patients. I know one of the uses for this is really to help beneficiaries help with beneficiary navigating the healthcare system and selecting specialists so as their main doctor or PCP is consulting with them. What you use for quality, and what is used for a payment model might not be the exact same elements that a patient wants to know about as they're selecting a particular specialist.

In terms of the long-term goal of creating industry-standard definitions for episodes, I think this will really accelerate the concept of shadow or nested bundles and help us ultimately within ACOs move away from the underlying fee-for-service chassis and get to new payment models. Some challenges there that I think we need to think about from a data transparency perspective. One is just the small numbers. So ACOs that are already engaging specialists in some contracts around the shadow or nested bundles have a real challenge with insufficient volume. When you are thinking about a small number of cases for a procedural or an episode, any one high-cost case could make it very difficult for that specialist to meet their quality or financial benchmarks. And so, I think, having standard definitions that are across Medicare models, but then also thinking about alignment with other payers would allow specialists to pool risk across multiple ACO or plan contracts. I think, additionally, a sample size is just critical for accurate measurement. And in any approach with providing more data, really thinking about is the data sufficient to provide accurate results and is it can it be reliably used.

I think another piece from the long-term, the goal that should be considered is, what type of episodes you're looking at, whether they're procedural or chronic. We've had a lot of experience with looking at procedural episodes within BPCI-A, there's a lot of learning there. I think there's a desire to also think about some chronic condition episodes, where we have tested that less, and it's a little bit more difficult. In a procedural episode you can very clearly target the facility or specialists providing the care. But if we think about something like a chronic condition episode for diabetes, who takes responsibility for the quality of cost? Is it the PCP, is it the endocrinologist, is it a combination of both? I think, within the context of total cost of care model this is the place to really test some of those shared attribution and accountability, and that we should be doing that as part of this effort as well. And I think we could really look to some of the ACOs that are currently in the Direct Contracting REACH program doing total capitation to really understand what some of their approaches for looking at some chronic episodes might be.

I think, to summarize here, as I've said, we're really pleased with this overall strategy. Some additional things to consider across both the short and long-term goals is one: What is the purpose of the data? There's a few different stated purposes throughout this. One is understanding the quality performance. Designing payment approaches within total cost of care or separate bundle payment programs. And then finally giving patients more information. Each of these might have varying data approaches but trying to understand what's common across all of them.

Another piece is really balancing customization versus standardization. I think ACOs and plans and other entities all want to be able to design the best approaches. But we've also, in thinking about quality measurement, have learned that when everyone designs their own approach, it just leads to duplication of efforts and burden on the provider. So, I really like that CMS is thinking about creating standardized definitions, but there should be some flexibility within there that remains. One piece of flexibility is allowing the total cost of care entity to decide which, or what data that they want to use. It's great to have a standardized definition, but you might want to in a particular year only target certain areas of care and not want to use the other ones. So, uh, as an example of if an ACO is doing sub-capitation arrangements that should be their choice, and not having to go with a CMS defined set. I think the other place where there should be flexibility, is it is great to have a standardized set of episode definitions, but you might want to have flexibility on what you define is the target price as well.

Timeliness of data is another consideration. I think the retrospective data is really great for understanding overall trends and setting targets for outcomes or financial benchmarks. But we also need to consider real time is data. I know that's a little bit part in a later part of your strategy. But how does the real time data connect back to the overall trends and making sure that some of those elements are similar.

And then, I think, just transparency of data across the board. It's great to get more data in the hands of those doing the total cost of care arrangements but making sure that the specialists themselves also have access to that. And then also giving consideration to what information that is out there and available for consumers, as I know that there's a real opportunity here for the main doctor or PCP to help consumers with navigating the overall health care system. But if that information is not also publicly available, it's a little bit hard to do that as well.

So, thanks for your time today, and thanks for all your work on the strategy. Really look forward to partnering with you on this in the future.

>>Meghan O'Connell, CMS: Thank you so much for those comments, Aisha. I just want to highlight some of the points that you noted that we are really thinking about in our day to day; challenges around contracting for value in the context of insufficient volume, and the discussion around procedural versus chronic conditions given some of the challenges you mentioned with shared attribution, identifying sufficient starts or triggers for chronic episodes. And then I really like what you said around customization versus standardization providing some of that structure while also allowing for flexibility. You really hit the nail on the head in terms of the balance that we're trying to strike as we provide this this data. And then, of course, real time data, always a challenge, but something that we're thinking of as we move through this element of the strategy. Thank you so much for your response on that. Next slide, please.

The second element of our strategy involves maintaining momentum on acute episode-based bundled payment models. What we have repeatedly heard as we developed a strategy, was that participants in bundled payment models like CJR and BPCI-A want to maintain momentum in value-based care, and continue to be rewarded for their investments and care redesign to date. So, to that end, we plan to extend the voluntary BPCI-A model for an additional two years, while we simultaneously develop the next iteration of a bundled payment model. In terms of a new model, we're exploring stakeholder feedback on a shorter episode duration, and other design elements that we'll better complement the overarching ACO framework.

The launch of a new model focusing on beneficiaries with cancer, the Enhancing Oncology Model is also a part of this element. The Enhancing Oncology Model, or EOM, was announced in June of this year, and is expected to begin in 2023. Next slide, please.

Before I move to the next section and speaker, I want to take a quick poll from the audience. So, the poll question here is: What are two top considerations for providers and patients in testing a mandatory acute episode payment, episode-based model? So please write your response in the Q&A. And we'll give you a few minutes here.

Again, you can please submit your answers to the poll via the Q&A function. I can see responses coming in. That's really fantastic. We'll just give people a few minutes to think about the poll question and submit their responses.

It looks like responses are still coming in. I want to thank everyone for participating, providing us with your feedback. In addition to hearing from our expert panelists, your feedback is an important component of this listening session. I also want to note that we'll be soliciting broader feedback on the design of our bundle payment models through an RFI next year and want to encourage you to continue to provide us with that feedback. We won't be able to summarize the responses in real time, so I think we'll move on to our second speaker. But again, thank you for your feedback. We'll be summarizing it as part of the wrap up for this session. Next slide, please.

Our second panelist is Lili Brillstein from BCollaborative. Lili, our question for you is: What are the key issues to consider in testing an acute, mandatory, bundled payment model that would aim to improve patient outcomes, care transitions, and transition back to primary care. I'll now give you the floor,

>>Lili Brillstein, BCollaborative: Thank you so much, Meghan, and thank you to all of CMMI for inviting me to do this. There's nothing I love more than talking about this stuff. I know I have also been given a hard stop at 1:34, so I'll be quick.

Just quickly, my background, I spent many years on the commercial health plan side, building episodes of care models. And I work now, I have a company called BCollaborative. I work with groups, particularly in specialty care, around figuring out their strategies for engaging in these sorts of models with payers and other stakeholders. So, I really appreciate having the opportunity to comment on this.

Number one is, I absolutely love the glide path. I think we are, you know, at the beginning of this whole evolution to value-based care, there was a lot of thinking that we could go right from fee-for-service to risk-based models. And I think we've seen that really there needs to be time for individuals to figure out: What does the data show? What are the opportunities? What are the potential interventions that we can do to address the drivers of inconsistent outcomes? And then some time for it to sort of play itself out. So, I love that there is sort of a thought about creating a glide path.

The number one, the thing that I would say, and this is what I would always say, is engaging the physicians in the discussion right up front, right from the beginning. So as there is this two-year period where you continue to offer the, as you call them, voluntary models. During that period, to engage not only the PCPs who are at the ACOs, but the specialists themselves. The experience is different, the care they render is different. And to bring them to the table, in my experience, having the docs come to the table, or the clinicians, is incredibly useful. They're the clinical experts that we want to partner with, right. And so, in contemplating things like what is quality, what are the outcomes, it's the docs who

understand that. They understand, you know, what is it that we're trying to get to. And as I think of value-based care, it's always starting with the outcomes first, and then working backwards to figure out, how do we actually address that. So, bringing the docs in to talk about both the clinical workflows and the operational workflows that can be affected.

And I would say, not just bringing them in at the beginning, but bring them in to design the model, and then continue to bring them in. Continue to have discussions on a regular basis. What's working? What's not working from CMMI's perspective? What's trending in the episode? What's happening from the physicians' and participants' perspective? What's working? What's not working? Do you have the data that you need? Is it timely enough?

And back to the issue of data that Aisha was talking about, I think it's it is critically important that there be data shared. And the question that I hear often, when we're talking about ACOs is, what data do the PCPs need. And I think that is critically important, but I would beg you to please not forget that the specialists need data from the PCPs as well, and they need to understand sort of the whole of the individual in these models. I'm talking about right now for the acute models, the specialists may only have the individual for a very short period of time, and so sharing information between the PCPs and the specialists, I think, becomes very important to be able to provide the comprehensive care that you're looking to do.

But the other thing is payment models that incentivize specialists, that actually carve out or integrate the payment so that they're actually rewarded for the outcomes that they're achieving. In my experience, a lot of ACOs are, they're attributed based on primary care, and there often is a lot of confusion and misunderstanding about what the specialty care spend is, and how to manage it.

So, a couple of other quick things. One is, you know, the continuous re-baselining very, very difficult for providers. I think you know, in in my view I am a big proponent of sort of starting in models that don't have any risk upfront, that allow the playing field to be somewhat level, so providers can come in and work in this sort of new model construct that's being put forward. So, I would say the continuous baselining sort of miss-levels that playing field again.

And then, lastly, I would say, please stop calling it mandatory. The word is just so offensive, and it implies, I know nobody means it that way, but it really has this implication of power and/or lack thereof power. And I think these models are really about partnership, collaboration, building teams to provide comprehensive care. And I think the language we use to express them really matters, and it really it makes a difference. You know nobody calls fee-for-service a mandatory model, right? That's the standard payment mechanism that we use. We're now evolving into what will become a new standard mechanism. I think it will, as silly as it might sound, I think changing the language really changes the sort of spirit of the way people will participate.

I think I should stop because it's 1:35. So thank you for having me.

>>Meghan O'Connell, CMS: Thank you so much, Lili, for those comments. I really appreciate your insight, and especially your comments on how we talk about our models really shapes the narrative and shapes the climate of participation. So, thank you for that.

Just one quick follow up question. You mentioned the importance of engaging specialists, which we really agree is a core component of this strategy. You mentioned bringing them in from the beginning.

Are there other ways, I guess best practices you have found in terms of bringing specialists to the table to discuss the key components that you mentioned on quality measurement, how outcome, how we reward for outcomes, benchmarking approaches, et cetera?

>>Lili Brillstein, BCollaborative: Other ways, other than bringing them physically in?

>>Meghan O'Connell, CMS: I guess the question is around venues for engagement. What could that look like ideally?

>>Lili Brillstein, BCollaborative: So, before we were into the Zoom world, we either met in person or by phone. You know, there were, certainly when I was on the commercial side on the commercial payer side, we used to do that quite a lot, set up virtual meetings with specialists. And we would typically, I would typically host them around a particular specialty, for example, and this worked really beautifully. Doesn't work so well in fee-for-service, right, payers don't like to bring lots of specialists, lots of doctors of any kind in at one time, because it's too scary, they say mean things to the payers. But in the value-based models, it's different. And so, bringing, for example, all of the orthopedic surgeons, or participants who are in the orthopedic models together once or twice a year can be done successfully, virtually.

And really, I think if there is information that gets shared by CMMI and information that is shared by the physician specialists it actually works really well. I mean, we know we have to continue to revise and refine these models. We can't build it and walk away from it. But I think that I do have lots of ideas about how to do that, I would say it's always really interesting to bring groups in, and you have the opportunity to do it really from around the country. The clinicians begin to talk to each other and begin to share sort of best practices and what they're experiencing and provide ideas that we couldn't possibly have without them. And the same for bringing in their analysts and their business people, like everybody, hears it differently, depending on their perspective. So yeah, maybe sort of small groups.

>>Meghan O'Connell, CMS: Fabulous, thank you so much for your insight and experience on that issue. Next slide, please.

The third element in our strategy is about incentivizing primary care physicians and specialists to communicate and coordinate better on behalf of their shared patients. We really know that the financial proposition for specialists to stay in fee-for-service is strong. So, the aim here is to better engage specialists, to Lili's comments, in value-based care arrangements.

The first component aims to do that by incentivizing better communication and collaboration through tools like e-consults and enhanced referrals in our advanced primary care models. The second component, on establishing financial targets for a high-volume, high-cost specialty care within population-based models will be longer term and we'll explore establishing, for example, capitated payments or targets for certain conditions. And this will also relate to and depend on what we learn in the first element of the strategy around data elements that we've already discussed. Next slide, please.

Before I move on to the next section and speaker, I want to take another quick poll from the audience. The poll here is: In your opinion, what should be the focus of service delivery and payment approaches aimed at improving the experience of specialty services for beneficiaries? I'll give you just a few minutes to review and answer the poll question.

Fantastic, thank you so much for participating and providing us with your feedback. The poll will close shortly, and here we have the results. So, it looks like a majority of responses are increasing communication and coordination between primary current specialists, which is really the foundation of a lot of the elements of our strategy. So, I think great to see both a spectrum of responses for each answer but also some consensus around the first two elements as the most important components. Thank you so much for your feedback there, and again we'll be summarizing this as part of the wrap-up for the webinar. Next slide, please.

Our third panelist is Frank McStay from the Duke-Margolis Center for Health Policy. Frank, our question for you is: What types of incentives could support specialists engaging with primary care providers to deliver accountable care? Over to you.

>>Frank McStay, Duke-Margolis Center for Health Policy: Great thanks, Meghan, and I appreciate the opportunity to have this important discussion today on CMS's new Specialty Care Strategy and specialty care coordination and engagement with accountable care models and primary care overall.

CMS, as was said in the beginning, is that really ambitious goal to have all Medicare beneficiaries, and the vast majority of Medicaid in accountable care relations by 2030, most of which are going to come through advanced primary care or ACO models. But given that specialists comprise most of the physician workforce and oversee a vast majority of the healthcare spending, to achieve this objective specialist engagement in alternative payment models and these incentives we're talking about for accountability for quality and total cost of care like we see in ACOs is critical. Historically, most the incentives have been on the primary care side of accountable care. So, payments for expanded care management, and bundle codes that aim to decrease specialist care costs by reducing admissions, procedures, and tests. While these have made tremendous progress, it's only one part of the equation.

To more directly engage specialists in primary care value-based payment models, they're going to require short and long-term steps and incentives that create an aligned incentive architecture across both primary care and specialty that aim towards longitudinal models of care. A multitude of incentives could support meaningful primary care and specialty care engagement that align the support mechanisms for delivery of accountable care.

Some of the more short-term innovative incentives include exploring valuations and financial support for e-consults and other curbside console models that encourage conversation and communication between specialists and primary care physicians, as we noted previously in the discussion. Implementation of limited specialist care coordination payments for certain complex patients and fee-for-service, I'll note, might have unintended consequences in terms of raising spending. But, implementing these types of payments in the short-term, especially for specialists that are already engaged in ACOs, expanding that would have opportunities to improve complex care manager for these patients.

Another opportunity might be for expanding or implementing care coordination for primary care, or is sorry, implementing care coordination for primary care and behavioral health specialists similar to like what we've done for collaborative care management codes. While these might again be more costly and less effective when you in general fee-for-service, by expanding them to muscular skeletal or cardiology and other specialties who are already engaged in ACOs, we'll be able to better, more appropriately manage the care for complex patients. This nested approach also aligns with longer-term options which

we'll get to later in the next presentation about nesting these types of payments in value-based payment models.

Another opportunity to develop an incentive is what we talked about in terms of data, especially developing, standardized, and especially developing, standardizing, and releasing performance measures that support data that are me meaningfully measuring the value that specialists bring to longitudinal and accountable care models. It's important to distinguish here that we're talking about, we're not necessarily talking about data related to acute procedures and events, but more so longitudinal condition measures, especially those that are tied to meaningful patient outcomes. These data and data dashboards that are outlined in CMS's strategy could include condition-level measures for quality that better measure meaningful outcomes for patients, the patient experience as well as spending measures and utilization measures related to total cost of care. For example, orthopedics groups could receive a report showing the rate of joint replacements that he or she performs relative to all attributed patients versus the number of referrals and participation of their patients in physical therapy or other potentially pain, appropriate pain management programs.

Sharing the same data with ACOs and primary care physicians, as others have said, is critically important as well, especially physician-led primary care teams. This will help them overcome data administrative burdens, but also help them identify high-value specialists that they may want to refer to. Indeed, such data incentives can help provide and form referrals, but also in link to specially care payments, either through MIPS or some other meaningful, nested condition-based payment can help align financial support to engage specialists in primary care as well as improve patient outcomes.

Much of this work is described further in a recent work released by Duke-Margolis, Strengthening Specialist Participation in Comprehensive Care through Condition-Based Payments. Ultimately, though what we're building towards is more comprehensive, longitudinal models of care that might be nested, that would be nested, into ACOs. And to that end, I'm happy to give the floor back to Meghan and to answer any questions.

>> Meghan O'Connell, CMS: Excellent, thanks so much Frank, for your insight. I really like how you framed it as an aligned incentive architecture. And I think a lot of your comments on exploring care, coordination payments, the application of collaborative care management codes, a lot of those components are very much aligned with the areas that we're thinking as we move through this strategy. Thank you so much for your comments. Next slide, please.

The fourth and final element is about creating financial incentives for specialists to affiliate with ACOs and move to value-based care. This will be a longer-term effort and, again, it depends on what we learn from the components that we've already discussed, especially sharing data with ACOs. But we're considering a few different levers here, including a targeted set of ACO financial incentives to actively manage specialty care. And we know that beneficiary alignment algorithms and quality measures are both important here, and we'll explore changes to these that have the potential to strengthen incentives for specialists. And we know that the math of ACOs is different for integrated delivery systems and hospital led ACOs, and that we need tailored approaches and incentives for working with different types of participants. So, we will be working over the next few years to just further design the components of this element, so please stay tuned for that. Next slide, please.

Our fourth and final panelist is Michelle Mirkovic from UT Southwestern Accountable Care Network. Michelle, our question for you is: What are promising approaches to engaging specialists in value-based care and affiliating with ACOs? Over to you.

>>Michelle Mirkovic, UT Southwestern Accountable Care Network: Thank you so much and thank you for inviting me to join today. I'm glad to be here.

Just a little background, UT Southwestern Accountable Care Network is part of Southwestern Health Resources. We have over 7,000 providers in our network, and about 1,200 to 1,300 of those are specialists. So, in Texas, we call that herding cats, right? That is not an easy thing to do with regards to that many specialists. So, we really looked at taking our data and figuring out what's going to work best for the specialists that we have. We have some excellent specialists that came into our organization that asked to be part of the solution. And so, wanted to just talk about some approaches that we've been looking at, and then how we can work with CMMI on getting the data to move this forward.

So, you know, it's hard to look at your entire patient population and your entire group of specialists and figure out an approach. You have to be more targeted. And so, looking at, and we've talked a lot about orthopedics and cardiac, and so we've looked at some specifics with regards to what are the outcomes that we want to incentivize. And so, we, working with our spine surgeons and joint replacement specialists to figure out, you know, historically, what do those outcomes look like? And while it's true that a lot of times you don't know the outcome until years later after joint replacement. But there are some things that we know occur almost immediately. Readmissions, we can find that from our claims data, and infection rates and revision rates, and utilization of post-acute care.

When we're talking about incentivizing a specialist for the quality of care, you've got to also look at the utilization of what happens after that patient leaves the hospital or the ASC. And so, looking, it's helping the providers, the specialists, understand what that total cost of care looks like for their specialty. And for orthopedics, for joint replacements, that cost of care also includes the next level of care. So, we have providers that have historically referred patients to in-patient rehab after a joint replacement and helping the providers understand that that may not be necessary and look at alternatives. We are looking at alternatives, maybe using the Part B Cost-Sharing Benefit Enhancement for outpatient therapy as opposed to home health or skilled nursing. So again, helping that specialist understand that it's not just about the readmissions or the infection rate, it's also about the care that that patient receives after they leave the facility.

We're also looking at some alternatives again with our providers to do a pre-hab or a pre-operative class so that the patients are better educated up-front about what their alternatives are, and then building that incentive with those providers around the outcomes and the total cost of care. And a lot of times when we're talking to the specialists, and we've been talking to the PCPs about this for a long time, but this is new to our specialists. And so, they don't really understand, especially our surgeons, you know, only have the patient for a short period of time but helping them understand that they drive that that care beyond the hospital and beyond the OR.

And so, we're getting a lot of feedback from our providers that they want to be part of this. They want to be part of the solution. They want to understand the differences in the different levels of care and post-acute, and they also want to see their own outcomes. They want to see the difference between when I send my patient to in-patient rehab versus skilled nursing versus home help or outpatient

therapy, and we can show them that in the data. It would be nice if we had a nice dashboard from CMMI to really pull that together instead of just our claims and data. But that's what we have today, and that's what we're using.

And that's for joint placement and for spine surgeries. And for spine surgery, you know, a lot of times we were looking at, of course, infection rates, readmissions. But we're also looking at utilization of pain management after surgery, and asking the spine surgeons, you know, if the patient still having to utilize pain management after surgery, why couldn't we reverse that, and do pain management first, and see if that manages the symptoms better. So, just having those conversations, but then incentivizing the providers too with those outcomes after the education. You can't give them the incentive without explaining the how and the why. So, starting with why, and then going on to how.

And for our cardiac, we are really looking at just narrowing a focus with our cardiologists only looking at heart failure with reduced ejection fraction patients without other underlying conditions. And really helping them understand the goal-directed or guideline-directed medication management and making sure that they understand those processes in those medications. They're only, you know, and the fee-for-service, they're only paid for the services they're providing. And so how do we help them with remote patient monitoring? How do we subsidize that to make sure that the patients not just getting a scale but hemodynamic monitoring, so that we know what their hemodynamic status is. We know what their one lead EKG looks like, their blood pressure. So, but supplementing what they're doing to have better outcomes. And so, if they're working with us on the GMT medication process, then we can help supplement with the remote patient monitoring, health coaching and things like that. And then incentivizing those cardiologists for improvements in their measures, and improvement in blood work, improvement in reducing acute admissions or acute exacerbations of that heart failure and, you know, reducing ED utilization.

So, it's about the quality of care being provided to that patient with understanding that, having the right care and the right place at the right time is very important. So that's just some of the things we're looking at. Having the data and the ability to have a little bit broader brush would be really helpful in those efforts, because the specialists are engaged, and they do want to be part of the conversation.

>>Meghan O'Connell, CMS: Fantastic, thank you so much for your insight, Michelle. I think really resonates your comments on taking a broader perspective, but then really needing to have tailored, targeted approaches, depending on the specialty in order to focus on the outcomes that we want to incentivize. Thanks so much for your comments. Thank you. Next slide, please.

Sorry about that. The last component here is really around how the solutions fit together. CMMI, in the past ten years has built and is continuing to refine a strong foundation of accountability across a number of key specialties and conditions. We did this alongside, but separately from our model tests of advanced primary care and ACOs. So as the Strategic Refresh terms, it's focused towards improving specialty care. We expect these accountability structures to coordinate with or fully integrate specialty care to deliver whole-person care. So, there's a really strong emphasis on centering equitable access to high-quality specialty care as part of the accountable care in that patient journey. The lens through which we're approaching model development, and our specialty strategy work, is really with the accountable entity at the center. And that's what we've meant to depict with this graphic. Next slide, please.

In closing, while we worked on improvements to value-based payment models and to restructure payment, our goal remains, ensuring every beneficiary gets the best possible care while advancing equity, promoting affordability, and expanding access to whole-person care. We intend to address Medicaid and partnership with states to improve access.

I want to say a big thank you to the panelists for your feedback. And we encourage feedback from those of you listening today as well. We'll also have a more formal request for feedback coming soon, as I said, through an RFI on our bundle payment models. So, thank you so much for your participation today. Next slide, please.

I think this was a really productive conversation. We look forward to future dialogue. CMMI will be synthesizing today's conversation to carry key insights and feedback. As I said earlier, the recording and slides will be available on the CMS Innovation Center website under the Strategic Direction page. And please participate in the survey for today's events by clicking on the link in the chat window that link is being shared now. You can send any additional input on today's session or concepts to CMMIStrategy@cms.hhs.gov with subject line Specialty Care Strategy Listening Session.

Please also take note of the following actions to continue engagement and learn more. If you haven't already, you can read the recent specialty care blog that provides further details on today's discussion. The link is being shared in the chat. And visit the CMS Innovation Strategic Direction webpage. You can sign up to receive CMMI email updates, including upcoming events and model participation opportunities. And lastly, you can follow us on Twitter @CMSinnovates. Next slide, please.

This concludes today's listening session. Thank you for joining, and I hope you have a good rest of your day. Thanks everyone, so much.

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