MEETING SUMMARY

Cheryl L. Damberg and Maria DeYoreo
MEETING ATTENDEES

Technical Expert Panel Members

<table>
<thead>
<tr>
<th>NAME</th>
<th>POSITION</th>
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<tr>
<td>Arlene Ash, Ph.D.</td>
<td>Professor and Division Chief for Biostatistics and Health Services Research in the Department of Quantitative Health Services, University of Massachusetts Medical School</td>
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<td>Liza Assatourians, J.D.</td>
<td>Vice President of Federal Programs, America’s Health Insurance Plans (AHIP)</td>
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<td>Anne Burns, R.Ph.</td>
<td>American Pharmacists Association</td>
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<td>Kim Caldwell, R.Ph., B.S.</td>
<td>Principal, Texas Star Healthcare Consulting</td>
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<td>Lindsey Copeland, J.D.</td>
<td>Medicare Rights Center</td>
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<td>Darrell Gaskin, Ph.D.</td>
<td>Professor and Director of the Center for Health Disparities Solutions, Johns Hopkins University</td>
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<td>Emma Hoo, B.A.</td>
<td>Director, Pacific Business Group on Health</td>
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<td>Deborah Paone, Dr.PH., M.H.S.A.</td>
<td>Performance Evaluation Lead for Quality Measurement, Social Determinants of Health, and Care Innovation, Special Needs Plans (SNP) Alliance</td>
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<td>Professor of Medicine and Pediatrics, University of California Davis School of Medicine</td>
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<td>Debra Saliba, M.D., M.P.H., A.G.S.F.</td>
<td>University of California Los Angeles, RAND, Veterans Affairs Los Angeles HSR&amp;D Center of Innovation</td>
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<td>Senior Strategic Policy Advisor, American Association of Retired Persons</td>
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<td>Dolores Yanagihara, M.P.H.</td>
<td>Vice President of Analytics &amp; Performance Information, Integrated Healthcare Association (IHA)</td>
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RAND Staff
Cheryl Damberg, Project Director
Maria DeYoreo, Project Codirector
Marc Elliott, Principal Senior Statistician
Rachel Reid, Physician Policy Researcher
Melony Sorbero, Policy Researcher
Jessica Phillips, Project Manager
MEETING SUMMARY

Welcome and Introductions
- The RAND Corporation project director, Cheryl Damberg, began the meeting by welcoming attendees and reviewing housekeeping items.
- RAND introduced new TEP member Debra Saliba.

Potential Development of a Measure to Capture the Value-Based Care Arrangements Medicare Advantage (MA) Organizations Have with Their Contracted Providers and its Possible Inclusion in MA and Part D Contract Star Ratings
- RAND team member Rachel Reid presented slides about the measure concept, example framework for categorizing types of value-based arrangements, and descriptions of current measurement efforts.
- A TEP member asked for clarification regarding who is considered a “provider.” Does this refer to an individual provider or a physician organization or other provider group entity?
  - RAND responded the term provider refers broadly to include provider organizations. Health plans have contracts with varying entities (individual physicians, small and large groups of providers, and contracted entities [i.e., Tax Identification Numbers or TINs]).
- A TEP member asked if there are specific categories of payment arrangements of interest.
  - A representative from the Centers for Medicare and Medicaid Services (CMS) noted that they are in the very early stages of investigation and are interested in a wide range of arrangements.
- A TEP member commented that contracts will look different for provider groups that are owned by health plans versus those that are free-standing.
  - RAND noted that the health care delivery market is changing rapidly with more vertical consolidation of both provider practices into hospital and health systems and with insurers. The mix of independent versus owned practices has changed dramatically over the past decade.

Potential Impacts and Unintended Consequences
- RAND asked TEP members to consider whether measuring value-based plan-provider payment arrangements is likely to increase quality of care for MA patients. RAND also asked TEP members to consider whether measurement of value-based plan-provider payment arrangements would have unintended consequences or downsides.
- A TEP member commented that there is a lot of regional variation in provider acceptance of taking on financial risk. The TEP member shared concern that value-based arrangements tend to place greater focus on financial risk than on quality. Additionally, Special Needs Plans (SNPs) have specialized networks that may be integrated into health systems or operate separately. Patients with long-term care needs have diverse care needs and specialty care providers; these providers may or may not be well connected with value-based payment models. Provider attribution can be complex, particularly for the SNP patient population, so it may be more
challenging to structure value-based payment models. Given these considerations, SNPs may perform systematically worse on this potential type of measure.

- RAND posed a follow-up question: To what extent are specialty providers involved in value-based arrangements?
- TEP member responses: It is highly dependent on the region and size of the provider organization. Also, it depends on the providers' capacity for data collection and reporting.

- A TEP member commented that in alternative payment models, the payments made may encompass providers across multiple settings; this may create complexities in measuring value-based payment arrangements with providers.
- A TEP member shared that they have seen contracting arrangements between MA plans and pharmacies to address gaps in care. For example, wellness visits were taking place at pharmacies during the pandemic. Can the provider, in this case pharmacists, help health plans meet the performance measures for which they are accountable? We are seeing this happen more often in the commercial sector than in MA.
- A TEP member commented that the Integrated Healthcare Association has conducted analyses of performance by risk type (e.g., professional risk only, full risk, and no risk), and there is a clear correlation between more risk and better performance. However, it is unknown if tracking value-based arrangements improves performance.
- A TEP member noted that value-based contracting is a challenge in rural areas, especially during the coronavirus disease 2019 (COVID-19) pandemic, when health plans try to ensure that providers have the resources to perform well. There are also situations when providers may not want to pursue value-based contracts. Some factors are outside the control of the health plan.
- A TEP member commented that, from their own experience tracking health plan data, they have seen large increases in performance when providers care for a high volume of enrollees. When providers care for a smaller number of enrollees there is less focus on achieving high performance on the measures. Therefore, it would be important to capture information on practice size or the number of enrollees the provider has under the MA contract.
- A TEP member commented that in some cases the results from value-based arrangements have been disappointing. Some Center for Medicare and Medicaid Innovation initiatives have worked out, while others have not. The TEP member posed a series of questions to the group: How much is at jeopardy? How much influence does the health plan have in delivering care? Do they have the right levers and relationships with the providers to actually improve quality?
- Multiple TEP members expressed concern about the appearance of improvement that does not represent reality. The more that is measured, the more opportunities there are for well-financed plans to game the system. A lot of resources are spent to build the appearance of a high-quality plan.
- A TEP member noted that many electronic health records are built to automatically populate data elements needed to perform well on measures that might be part of value-based payment (VBP) arrangements.
- A TEP member reflected on the individual needs of patients recovering from hip and knee replacement. There are financial savings when patients are sent home with
The COVID-19 pandemic has increased the complexity of delivering home-based care.

- Relatedly, another TEP member expressed concern that providers will be punished for lack of capacity.

**Measure Construction**

- RAND asked panelists for input on (1) how to quantify value-based payment arrangement participation; (2) which providers should be included; and (3) how to account for varied categories of value-based contracts.
  - A TEP member noted that a physician organization may have subcontracts with other providers (e.g., post-acute care providers). How far down the chain should information about value-based care arrangements be captured?
  - A TEP member commented that multiple sites of care make it difficult to attribute care. Furthermore, medical records may not be integrated across sites.
  - The HCP-LAN framework includes four broad categories of value-based arrangements. Members of the TEP suggested starting with a high-level reporting structure similar to the HCP-LAN framework and then consider more-detailed reporting in future years.

**Data Collection**

- A TEP member recommended aligning future data collection efforts with any existing reporting to the extent possible to reduce burden.
- A TEP member noted that a better understanding of what data will be collected and reported is needed before discussing ways to audit the information.
- A TEP member asked if the group is knowledgeable about value-based payment reporting requirements across states.
  - RAND responded that reporting requirements and data collection tools differ by state. There is no national requirement at this time for collection of data on use of value-based payment arrangements to use as a quality measure. There are additional state examples included at the end of the presented slide deck.
  - A TEP member highlighted the issue of health plans that operate in multiple states: Do they report different information for each state?
- Adding to the complexity, TEP members noted that many measures are constructed using claims data, and aspects of VBP may not be captured in claims data. As the market moves to population-based health arrangements encouraged by value-based payments and alternative payment models, it is more likely that some important services will not be well-captured in claims data.
  - A TEP member made the distinction between claims data and encounter records. A claim is something that gets filed to be paid. Encounter records are different and are not tied to payment, which may result in less-complete documentation.
• RAND clarified that the potential data collection would be from the health plan using their knowledge of their own contracted arrangements with providers, and that data collection from providers was not envisioned.

• A TEP member commented that the timing of data collection is important to consider because it pertains to provider payment arrangements and what would be captured and counted in a given year. Health maintenance organizations (HMOs) participate in annual payment updates. Preferred Provider Organizations (PPOs) have annual payment updates, but payment is prospectively applied on a future rate. There is a lot of complexity across different types of payment arrangements regarding the timing of reporting cycles and when payments are actually made.

• A TEP member asked whether it would matter if there was not alignment between the metrics used in the plan-provider VBP arrangements and the measures CMS uses to assess quality in MA (i.e., would VBP arrangements need to explicitly include or align with any requirements as to performance metrics otherwise incentivized by CMS?).

• A TEP member noted that some payers may consider their payment arrangements with providers to be proprietary or confidential, and may be reluctant to disclose different payment arrangements.

Final Thoughts
• A TEP member shared that the Covered California initiative that collects information on the value-based payment arrangements plans have with their contracted providers has been successful partly because Covered California engages with the information collected and encourages health plans to improve products and lower rates based on the data captured. These data inform a negotiation process. The TEP member does not know whether CMS would have a similar mechanism to engage with plans to improve products. States have the ability to become active negotiators.

• A TEP member summarized that despite many concerns and issues raised during this meeting, they believe there to be viability in constructing a measure and the potential for positive results to improve quality of care and reduce costs. However, it will require providers to be involved and health plans to build new reporting systems, which will take a long time to develop and require making ongoing improvements.

• A couple of TEP members noted that the results from such a measure should be shared with beneficiaries.

• A TEP member noted the difficulty and resistance to the standardization of reporting templates and systems. One possible solution is to distribute free software that everyone must use.
  o Many TEP members noted that standardization is required for success.