[00:00:01.290] Announcer:

Welcome to APG on American Healthcare, the official podcast of America's Physician Groups where we discuss current issues in the healthcare value movement. APG members are at the forefront of national healthcare reform, practicing at risk-based prospective payment and other population-based payment models, the very models described by federal legislation for the entire nation. And now for an inspiring and educational look at the transformation of America's healthcare delivery system, here's your host, APG President and CEO Don Crane.

[00:00:36.600] Don Crane:

I sat down with Mark McClellan the other day to discuss a couple of interesting issues that are arising on our healthcare scene. As you all know, Mark hardly needs any introduction, the former head of CMS, former head of FDA, current co-chair of the LAN. All of that important, but perhaps more important is, I really think, the widespread recognition that Mark is one of the most respected voices in healthcare policy in the country and has now for years and years been a chief proponent, an architect really, of the value movement.

[00:01:12.640]

So really a good opportunity to talk to Mark about two items that are surfacing right now. The first is this, but interesting silver lining within this God-awful COVID pandemic we're experiencing...hard to even want to talk about a silver lining as we move in now to probably a dark, very, very dark December and January in our country's history.

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But the silver lining being the recognition that fee-for-service has failed us utterly and that budget-based payment models are infinitely preferable. So, I want to discuss that with Mark. And then the second one is this rising chorus that there be a public option in the Biden Administration that will expand coverage. Yes, that's a large goal.

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But the interesting twist to it now that people are calling for is that it be exclusively capitated, a fascinating development, both of which I wanted to get Mark's comments on. He's so attuned to political winds also that I thought this would be a good opportunity. So, with that, take a listen.

[00:02:25.030]

Mark McClellan, good morning. It is a pleasure to welcome you to our APG podcast. We start with a short introduction. Mark, you hardly need one, certainly for our listenership.

[00:02:38.100]

If there's such a word, you're the Director and Robert J. Margolis Professor of Business, Medicine, and Policy at the Margolis Center for Health Policy at Duke University. You're the former administrator of CMS, former Commissioner of the US Food and Drug Administration. Holy smokes. Does that put you close to the hottest issues in American healthcare today? My gosh. You're also a co-chair of the guiding committee of the Health Care Payment and Learning and Action Network within CMS and many, many other things.

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And a friend to APG and a friend of mine. So, it's really...looking forward to talking to you this morning.

[00:03:20.220] Mark McClellan, MD:

Hey, Don.

[00:03:21.030]

Good to be on with you. And again, just thanks to APG for all of its ongoing efforts to deliver better care, do it less expensively and help the country get more accessible and affordable care. Boy, we need that now more than ever. Thank you for that.

[00:03:37.600] Don Crane:

We are trying hard. As you know, Mark, our goal is to proliferate our model of this model of risk-based, integrated, coordinated care across the country. If we could get it done yesterday by three p.m., we would have. So that's what we're working on. And so many of us are. I guess I'll make a quick little speech. One quick note and you can react to this is that it is, here we are in December of ‘20. As I think back, oh, 10 years ago, five anyways, certainly 15 and 20, we were in a very different place.

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We were still trying to tell people the difference between fee-for-service and capitation. No longer is that the case. It's I think, you know, an accepted conventional wisdom that fee-for-service is bad and anything other than fee-for-service is better. So, we're in a better environment in many ways, but it's not like there aren’t some clouds on the horizon. And we'll get to talk a little bit about that. I mean, do you agree with that observation that we're in a better climate now for purposes of transformation?

[00:04:41.070] Mark McClellan, MD:

Yeah, I think so. And Don, I expect we'll get into this…but, you know, boy, what a year. I'm about ready for it to be over and looking forward to a better 2021 from a health standpoint, economic standpoint, from

this country, for this country and everything else. But I think if there is a silver lining to all this, it's that the capitation movement, as you said, have been there for decades, and it's for people who have experience with it.

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I mean, patients in particular, the public has generally been a good experience, at least with established systems that know what they're doing and proven that they can be competitive when people can choose and get better care at a lower cost. I think we've seen the pandemic is that it would have been great to have these models more widely available. And so, there's a real opportunity to engage the public, I think, that we haven't had before around the value of care models that are centered on them and that are flexible enough to deliver the best care that they need to stay well and improve their well-being.

[00:05:49.350]

And it's getting beyond the capitation label to the actual experience that these models can deliver where I think we have an unprecedented opportunity right now.

[00:05:59.760] Don Crane:

So, let me pick up on that. I'm going off script a little bit. Our mutual friend, Mark Smith, your former co-chair of the LAN. Yeah, we did a podcast with him and he repeated something he said and maintained here, I think for years, which is pretty much your point, which is to make this movement really happen and happen effectively and fast. Somehow we've got to get the public…patients to somehow care about the movement value. And as I interpret that, it's making them, getting them to understand the virtues of, basically, prospective payment of their providers.

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So, the question I guess I would ask you, Mark, is do we really think that the public cares how their doctors are paid, particularly when some third party, like an insurance company, is paying the bill? And for those that do care, would they actually prefer fee-for-service? In other words, more (is) better…why should I care? Insurance companies pay. I want 19 different tests. Do we think that we ever really will get the public to understand and care?

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And is that important?

[00:07:12.810] Mark McClellan, MD:

It's very important.

[00:07:14.130]

And I think we can. And you start talking with the public about things like prospective payment and at best their eyes glaze over. And at worst, they have memories of, you know, understandably so, of the managed care in the 1990s, which was really more about managing costs and utilization and not really the way that many people are doing it, centering on how do we get the best outcomes and avoid unnecessary costs by engaging people effectively in their care and improving their health.

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And that's where I think people have seen that it can be different. It's less the name and more the experience. If you look at many of your organizations, Don, and APG, some of the most successful capitated models out there, whether in Medicare Advantage or increasingly direct contracting arrangements with employers, or even in commercial and other settings, they do really well, things like net promoter scores…where insurers typically do badly. And it's when they are able to truly align the experience of care that people typically get through their healthcare providers with the financing in a way that people can see it's better that the money that's being spent on their behalf

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is, for a change, going to something that they want. You know, convenient access to the care that they need. Assistance with understanding how to navigate the healthcare system and what they need to do to stay well, especially when they're in a pandemic. And I don't think we've really, you know, people can see the experience now. I'm not sure we've really gotten there to Mark Smith's point of how to articulate that in a way that can make it convincing and understandable because it's based on reality for people who haven't directly experienced it. So, I found that just telling the stories of what care is like for people in some of these capitated models, and why, is often the easiest way to really make it meaningful to like normal human beings who have lots of other things to think and worry about.

[00:09:32.490] Don Crane:

So, you know, at APG, we do tell those stories and we've got a couple of them in our back pockets and so on. And we use them depending upon the audience and we have given amount of reach and so on. Our members do the same thing with some amount of good effect, I think. But when you think about the other payers around the land, let's just think about carriers. I don't see a lot in the way of major carriers advertising the virtues of prospectively-paid products. You catch that a little bit in Medicare Advantage on TV during open enrollment, but there's not a lot of that.

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And they might, I think, defend themselves by saying, Don, there's all these marketing rules that prohibit us to do that. And so, I wonder if we should ask carriers to do a better job of that. I'm wondering, Mark, if thinking Medicare, ACO program…thinking Medicare, Medicare Advantage…should CMS get into the…in

order to boost this transformation…get to the goal we all want, should CMS itself take on this role of, you know, at least illuminating the differences, if not promoting the advantages of prospectively-paid coordinated care.

[00:10:55.350] Mark McClellan, MD:

Yeah, CMS does take some steps to let people know when they're in the open enrollment period, as you say, let them know what their options are in a way that makes sense to individuals. That's letting them know what they can expect to pay for the drugs they're using, for the care that they need, what premiums will be and some expectations about out-of-pocket costs.

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I agree, we can definitely get better about communicating that information to people around the issues that matter to most of them. What does this mean in terms of the care I can get, the quality of care I can get and the costs that I'm going to…that I should expect for me and my loved ones...if I'm trying to make a decision for my mom? And there is a lot of inertia and choice because I think it's just not as easy as it could be to get a handle on quality of care that matters and to get beyond just relying on the reputation of the physician or something like that.

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So, we definitely need to make more progress there.

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But I'd say, Don, relatively speaking, the evidence is by people's actual choices that in Medicare and Medicare Advantage in particular, that shift is occurring. We've seen steady growth in the Medicare Advantage program since we implemented it back when I was at CMS in 2004, 2005. And that's been through Republican and Democratic administrations. It's a program that has, I think is to the extent this is possible these days, solid bipartisan support.

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And I think it's going to keep growing. I think the inertia there is probably a reflection of the fact that it's just hard to communicate exactly what people can get in a way that they can have confidence in when they make a big decision, like switching care plans. So, if they're doing OK in Medicare, even if they're paying a good deal of money out of pocket, even if they're kind of missing out on what could be better care, you understand why people might be reluctant.

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So, I think Medicare can and should keep doing a better job of clarity about what people can expect in those open enrollment choices. We keep telling the stories. I think where the bigger challenges are…is outside of Medicare. And you were mentioning commercial plans, other parts of the healthcare market where we haven't seen as much movement into capitated…both capitated plans and also just more person centered, more, you know, capitated, non-fee-for-service delivery models.

[00:13:33.770] Don Crane:

Well, I would suggest that we lean on these commercial plans somehow, whether it's through regulation or legislation, because I think your observations are entirely right. I think about open enrollment. My own company, you know, you go to the webpage and you basically see spreadsheets. OK, HMO products have these features in terms of co-payments and co-insurance and the like, and these PPO…but there's no discussion of, wow, with HMO you actually may have a primary care doctor serving as your concierge, coordinating the care, helping you navigate through a difficult system.

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And if you've got multiple co-morbidities, you've got somebody who's got your back. By contrast, PPO, you know, maybe the premiums the same or lower, but there's no guidance to the consumers as to which might be better. And I, you know, you can react to this. I don't know why a health plan would want to do that. They make money on either choice and maybe more on the one than the other. And that's debatable.

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But at the end of the day, they're happy to sell HMO. They're happy to sell PPO. What's the difference? And so, what do we do with that situation, Mark?

[00:14:44.790] Mark McClellan, MD:

Well, I think we can keep asking the plans. I'm talking with a lot of these plans.

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They do talk about how they want to move more quickly into models of care like the ones you're describing with more reliance on providers who are willing to take on risk themselves because then they get more flexibility and more upfront payments they can use to do preventive care, virtual care models, deal with social factors and other things that can influence health, just better care models. But the plans will then point the finger at the employers and say, well, that's not what employers and their employees seem to want.

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And in this, it's important to remember that health insurance plans in the commercial space, for the most part…at least for large, middle, and large employers…aren't providing insurance. They're providing claims processing, administrative services, or, as you say, the competition is around, well, can you do it off of a four percent margin or a five percent margin or something like that? And if we really want to change that system, I do think we need to engage the employers more.

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I think it's starting to happen.

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But the way that these employer contracts typically work is they'll rely on a broker or benefits consultant who mean well, but they typically have those spreadsheets, Don, like all the fee-for-service prices for all the providers and will try to get you behind an option that is based off some percentage mark-up over a Medicare fee schedule, a completely fee-for-service based. What's needed is a model for employer contracting with the health plans that's based on total cost of care and important outcomes for that covered population.

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That sounds simple, but it's turned out to be hard to implement in practice. Many employers are really busy and they don't have a whole lot of time to come up with these new models on their own that they rely on the brokers or the consultants. And as you said, that's a well-established business model. I do think that's changing.

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I think there's some kind of outside-the-box brokers out there that are making it easier to contract with insurers that want to focus on total cost of care. There are employers who are moving towards direct contracting. These things have not happened at scale before it could probably think for large employers, probably, Don, in the single digits, the ones that have, you know, real networks that are focused on quality outcomes, total cost, and not just preferred providers based on their willingness to take a lower rate.

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But this is an area where I think the pandemic is going to make change or a lot of large employers like Disney. Others have been really hard hit, but they're also committed to providing a good employee health insurance experience that at least seem to be taking steps now to move out of that traditional model of preferred providers based on percent of fee-for-service discounts and into something that really is about,

you know, more comprehensive primary care accountability for total cost of care and maybe even more direct contracting.

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And I think that's what it's going to take to create an environment where the plans that say they want to move in this direction but aren't really getting support from their employers. That it's going to take that kind of change to really make for more progress in the way the payments work and the way the capitated plans get support.

[00:18:43.050] Don Crane:

So, I agree with you completely. We have mutual friends in the employer world and some of those with whom I speak, they're quite explicit these days about a frustration they have with some of the carriers that aren't accomplishing the transformation to value as quickly as these employers would like. So, I think there's…I'm optimistic that the employer sector is moving in the right direction. But one thing they say…and this brings me to a real issue I think we have, and that is whether the quote-unquote incumbents are going to adopt value, get us there, make this happen so you and I have some friends from very, very senior respected policy experts that have opined publicly that they don't count on the incumbents. They're not going to get it done. And they define incumbents as health plans and hospitals and even physician groups that are not sufficiently wedded to the value movement, that they are steadfast in their view now that we're X number of years into this movement, that the incumbents are not getting the job done.

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And that kind of is a reverberating echo with the conversation we've had with employers. So, multiple questions. Do I just start with asking, do you share that opinion, Mark?

[00:20:12.450] Mark McClellan, MD:

Well, I certainly would like to see more competition that encourages incumbents to use all the resources they have. And these are now very large insurers, as you're saying, who have a lot of capital invested in programs to do…maybe look at their business plans…population health management, data analytics, preferred networks based on value. I mean, all those elements are in there. But you're right, that one can certainly imagine faster progress happening.

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So, some more competition would help. That could come from the approaches we were just talking about. You know, more employers insisting on contracts that are based on total cost of care and the insurer going at risk if you're outside of a, you know, a corridor around an expected benchmark cost. And same, by the way, for meaningful measures of care, experience and outcomes that matter to the patients that

are covered. That would help some of these steps that employers are taking towards direct contracting. Finding a care system, provider base maybe, or doing selective contracting with one of the new up-and-coming, outside-the-box insurers that are trying to implement these models.

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But it is hard. I mean, this is a, you know, we've got a three trillion dollar, four trillion-dollar healthcare system with a lot of people who are reluctant to face…to have rapid change in something that matters as much to them as their relationship with their providers and the way they get care. So, getting more of a critical mass approach going here, Don, seems like what would also be helpful and there have been some efforts at CMS to support multi-payer approaches.

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You mentioned employer contractors. You know, the Pacific Business Group on Health, PBGH has tried to bring…it's trying right now to bring employers together to turn these kinds of intent and real anger at the pace of change into action. It is hard for any one of these segments to do it alone. So, I do think more efforts to get the reforms aligned across Medicare, Medicare Advantage, state health plans and employers would be…or state-run health plans like Medicaid and the exchanges…and employers would be really helpful.

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That sounds complicated, but there are some examples of progress taking place.

[00:23:05.760] Don Crane:

So, that that there is and I think that's hopeful.

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But I'm wondering if it's enough. So, alignment across programs and products and the like makes sense. But, you know, clearly we have a lot of friends in the health plan business and they are good people. Their current model is working well for them. It is not broken. In fact, I think there are all reporting record profits. Now some of that is a function of the pandemic and the decrease in utilization and so forth, so it may be fairly transitory, but even more generally, over time, I look at the picture, put myself in the shoes of health plans and I say, why try and fix something which is not broke?

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Our margins are good. Our volume is good. Why would we want to turn that upside down and move into some very different model of prospective payment? And that would be reasonable, worthy to say that out loud. I don't know that they're doing that publicly, but I think that I agree with some of our friends that are

calling for, quote-unquote, forcing actions in the nature probably of really long-toothed or teeth incentives, positive and negative. Upside and downside. And maybe even some mandates. Competition would be good. We can talk about the public option in a minute.

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But I mean, would you agree with me that legislated incentives would help these plans and maybe other incumbents to make this move?

[00:24:43.080] Mark McClellan, MD:

Yeah, I think it would help, Don. And we can see how the way you set up competition matters if you just look at the differential experience of the use of capitated plans and for that matter, non-fee-for-service. You know, more capitated or population payment-based providers. In the Medicare Advantage program, you mentioned that I helped lead the CMS CMMI-sponsored Healthcare Payment Learning and Action Network. It tracks what's going on with payment reforms around the country in the direction of all-in population-based models like capitation and not only are Medicare Advantage plans paid on a capitated-risk basis, but because they are, have put more of a push into working with providers and selectively contracting with providers that are willing to move in that same direction as well, so they can deliver models of care that really are person centered and less expensive.

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We've seen some movement in that direction in the traditional Medicare program through CMMI efforts like accountable care organizations and now some direct contracting options.

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So those in the traditional Medicare program, there have been some continued growth in ACOs and other arrangements, and particularly in the last couple of years, growth in providers taking on significant downside risk. And, you know, Don, another word for downside risk is more flexibility, but also more accountability for costs and outcomes and your payments, which facilitates a lot of these new models of care and, again, have been really helpful to be in those kinds of payment models in the midst of the pandemic and the response to the pandemic.

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There are more steps that CMMI is trying to take now. They just announced what's called geographic version of direct contracting. The way I think of that is working with an intermediary could be a plan, could be a healthcare organization of other types that aims to get the remaining fee-for-service beneficiaries and the providers they're working with moving into these alternative payment arrangements. So, there's a lot happening in Medicare. It could be more. Where there's less of that happening is we've already talked about the employer context, where the, you know, the contracts are typically focused year to year on

increases or relative rates against a Medicare-based fee schedule, and that's a sort of a ‘win the battle, lose the war’ proposition.

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And you might get the best rates relative to some other plan if you choose a plan that has negotiated somewhat lower fee-for-service rates this year. But those rates are increasingly diverging from the Medicare rates and employers are not getting reforms and care in the direction that we want. So, for employers we really need to make that switch over towards contracting with the plans based on capitation-type models. It's definitely doable. It's just like you said, it's a big shift.

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It's not easy for the employers. But these other trends in the market, maybe it helps. And then I do worry about the short-term contracts, both in many exchange…you know, ACA exchanges where many people in the plans are not necessarily there for that long. They might be between jobs or the like. And California is kind of an exception to this. But many of those markets are set up really to focus on short-term premium competition based on narrow networks, based on fee-for-service utilization, not based on getting these new models of care in. An all-in capitation, especially with an eye toward supporting plans that can make investments now.

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It may take a year or two to pay off in terms of really restructuring care. This doesn't happen overnight. And in Medicaid too, a lot of temptation for states to want to get the most savings possible for their budgets this year. Totally appreciate it. You know, they're facing huge projected deficits because of the economic impact of the pandemic. So, to go to them and say, well, what you really should be doing is entering into a three-year capitated contract with a Medicaid plan that's tied to putting the plan at risk for increases in total costs and improvements in outcomes. And if they actually do end up saving money this year, well, don't just go in and take it away.

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Let them keep it. Really encourage the longer-term investments in this direction. So, some states are starting to do things like that. But as you can see, we really haven't structured our markets and the payments that influence the behavior of our markets in a way across the board that encourages the kinds of models that we've talked about.

[00:29:58.780] Don Crane:

Yeah, well, I completely agree. Don't you suppose we're going to need federal legislation to make that happen?

[00:30:03.760] Mark McClellan, MD:

Yeah, federal legislation certainly could help. I missed putting on my political hat for a minute, and we just came through a really divisive election, have a closely divided Senate, maybe Democratic, maybe Republican and a pandemic and major recession, if not depression, to deal with if we're not careful. So, first order of business for the next Congress is going to be getting us out of the pandemic. Don, I'd like to see part of that be by moving our healthcare system in a direction of resilience.

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So, there have been a lot of payments going out to healthcare providers that are likely to be more. Let's not just do those payments in a way that encourages providers to fill the holes in their fee-for-service revenue from the pandemic. But let's do it in a way that encourages them to make the investments needed to prevent what happened in the spring in terms of providers losing their revenues and not being able to focus on keeping their patients safe, from a public health standpoint, let's make sure that never happens again.

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But we're going to have to deal with that first before we get to any major healthcare coverage reforms. And then I think there is going to be a question. I mean, I can see some bipartisanship emerging around on the one hand, Democrats who are understandably concerned about access to care and the high rate of un-insurance still in the United States that haven't expanded Medicaid and some of the gaps and challenges in the ACA exchanges. And then, on the other hand, Republicans who would like to see move toward more capitation, more accountability.

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And there are some proposals along those lines that you've been involved with some of them.

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I would just encourage people to recognize that we've got to deal with the pandemic first, hopefully in a way that tees up this movement towards more capitated value-based care and then find some bipartisan space, hopefully with leadership from the president-elect, to get to these better payment and care and coverage models.

[00:32:25.600] Don Crane:

Well, one of my favorite subjects, which is let's not prop up systems we don't want for the future. Let's not bring relief payments to fee-for-service model. Let's instead put our thumb on the scale. This is a good opportunity to do so. And let's go ahead and bring relief and funding and the like to the kind of models we

want prospectively paid ones. And I know that you and others have put together a resiliency proposal for that very thing.

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And so, thank you very, very much for that.

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You're, I think, also alluding to yet another. We had lots of forks in the fire here, but there is this other interesting movement underway just now, which is a call by some pretty senior people for basically, look, if we're going to have a public option, President Biden, it is a part of your platform, then let's make it exclusively capitated.

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So, this is an exciting development, literally days and weeks old, I think. What odds, what's your perspective on that and what sort of odds would you give that for succeeding?

[00:33:37.180] Mark McClellan, MD:

Yeah, well, it's first of all, it's interesting to see this come together.

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And if you look at some of the supporters, Don, they kind of span the political spectrum from, you know, people who are saying are kind of liberal Democrats who have focused on wanting to get to coverage expansions and more affordability in coverage, but also at least moderate Republicans who I think believe in a model with more accountability for total costs and more flexibility in the private sector for delivering it.

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It's a big lift, though, and in any significant coverage expansion is going to have significant budgetary implications, I understand that getting more people into coverage leads to better ways of spending the money. They are going to be healthier and they're going to enable a shift away from sort of downstream costs and complications. And that's all good for value.

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But this coming year, the budgets are going to be tight. Like I said, Congress is evenly divided. And so, a public option expansion is going to be a pretty big lift. And you have to see just how much the administration, number one, prioritizes that issue. Again, first steps are COVID response and economic recovery. That is unquestionably the big legislative package challenge right now here in December for the

lame duck, but also lame duck session of Congress, but also for, you know that what President-elect Biden is going to focus on in his first hundred days.

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And then the question is, after that, there are other priorities out there, climate change, dealing with equity issues that have been so challenging for the country that I know matter for the new administration, too. So, this is going to be easier to the extent that there can be some bipartisan support behind it, but it is going to be a big lift. One other thing, Don, that I think some people are considering is whether if it turns out to be a hard legislative lift, federally, to have a public option or something like that, is it something that could be pursued at the state level?

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And that's something where the minute the new administration could have an impact to, there are so-called waiver mechanisms at CMS, such as the Section 1332 authority from the Affordable Care Act that give states an option of reorganizing their care. They've got to meet some expectations about access and quality and costs. But that could be an approach for a state to try this out. A couple of states have given this a run…Colorado, Washington. It has been challenging, especially been challenging if you're trying to do it using fee-for-service rates, which none of the providers want to see that kind of model expanded.

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And as we've talked about that, that doesn't really deliver better care. So, maybe there's an opportunity for coming at this from the state level, since the kind of traditional fee-for-service regulated price approach is there seem to be having trouble getting off the ground, even in, you know, even in purple or blue states.

[00:37:09.400] Don Crane:

So, this is all very hopeful. So, pandemic relief may be an opportunity to exact certain changes, public option and all that entails maybe in another…but we also have an existing, you know, we've got a whole range of APMs that administratively are being handled through CMMI and to a certain extent, CMS. I think there's…I don't know what the total number of programs…I do recall Seema Verma here a week or three ago saying that of the 55, only 50 saved money.

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And so, there's definitely…

[00:37:45.910] Mark McClellan, MD:

Only five saved money, I think. 50 didn't. I know, that would be optimistic.

[00:37:54.550] Don Crane:

Details. Details.

[00:37:56.020]

But the next point is the true book, which is there's a lot of attention right now on which of these programs we should sunset, which we should reinvigorate, what refinements we want, might want to make. Do you have some thoughts on it?

[00:38:12.970] Mark McClellan, MD:

I mean, it is kind of a reckoning time for the next steps in the value-based care movement. I think, you know, fundamentally, I see nothing changing. In fact, everything reinforcing that we're going to keep moving towards care models that are paid on a basis other than fee-for-service. And shift the focus of care away from sort of downstream facility-based procedures and complication management into upstream, more personalized, digitally based, home-based care and sort of extending the boundaries of how we think about healthcare.

[00:38:53.050]

And that's just where technology is headed. We're five years from now hopefully going to be able to diagnose lots of cancers really early before, you know, from so-called liquid biopsy sample of blood, before they're symptomatic. We're going to learn more based on big data about which ones we actually need to treat. We've got advances in digital surgery, micro devices and so forth. It's just going to be different. Not to mention gene therapy and everything else coming along. It is all about moving care upstream and into the home and people want that because that's better, longer lives and the like.

[00:39:34.700]

And it just doesn't work under fee-for-service. There are too many. We're going to get in, I predict in the beginning of 2021 there will be a lot of congressional debates about, well, do we keep more telehealth by expanding the current non-emergency Medicare benefits for telehealth to you, a few more doctors and a few more kinds of settings. That's never going to get to what we want. We really need to these more person-based payment approaches.

[00:40:05.090]

And I think that's consistent with what CMS and CMMI have found in the models. The ones that did seem to work, Don, are the ones that were kind of bigger changes, especially for large organizations that traditionally relied a lot on fee-for-service, for those relatively lucrative in-place, inpatient procedures that got them into downside risk ACOs. And that's why CMMI is pushing for the direct contracting models. Models with, I think, smaller primary care groups.

[00:40:36.740]

There's also some promise there for them to be able to do maybe contracts with groups that do specialized care under more holistic more longitudinal episode-based payments that are less just tied to hospitalizations. So, I think that's where the models seem to be headed. A smaller number of models that focus first on person-level and population-level well-being with strong advanced primary care as a part of that, and then a focus through more longitudinal, episode-based approaches on specialized care, either through big integrated organizations that have to take on a lot of risk or through these smaller groups that would still take on some risk, are still moving away from fee-for-service.

[00:41:28.430]

CMMI has actually ended up being…some bounces along the way…has ended up being a pretty bipartisan-supported effort now through a Democratic administration, through a Republican administration that actually ended up by the end, you know, expanding mandatory payment reform models like for radiation oncology and some parts of home healthcare and kidney care. So, I think if we keep moving in that direction and keep this bipartisan, you know it can be a good inflection or reckoning point for CMMI and for value-based care.

[00:42:03.310] Don Crane:

I agree that we would welcome that. Let me segue off into one final area and then I will let you go, Mark. So here we are, just, I guess maybe hours or days away from emergency use authorizations and so on. And we're about ready to embark on massive COVID vaccine distribution and administration programs and the like. And I'm wondering, you know, I'm just taking care. I am the lucky guy to run this organization that consists of organized groups, large patient populations, databases.

[00:42:37.460]

How might APG members be particularly helpful in the vaccination programs to come? Do you have, is there talk of that? Should we volunteer? What are your thoughts on that?

[00:42:50.840] Mark McClellan, MD:

Well, APG members unquestionably have a critical role to play. I mean healthcare providers, particularly those involved in primary care.

[00:43:00.050]

And really connecting with patients have a big role to play. And I think you're very well supported to do it. So, this first round of vaccine use is going to be very controlled because of the very limited supply of the Pfizer vaccine, Moderna vaccine. If things stay on track, those should be available. And with millions of

doses being shipped out just in the next weeks and perhaps 10, 20 million Americans getting vaccinated in December. But those are going to be very high-risk select populations under tight government distribution and control.

[00:43:45.140]

So frontline healthcare workers, they'll get shipments overseen by the federal government directly to their facilities. And the healthcare organizations themselves will manage the vaccine. So, you're going to have…and APG members are going to have…a role directly in that for their employees. And that's a really important first step in getting that right…communication…so that, even among healthcare workers, Don, there's a good deal of hesitancy about the vaccine.

[00:44:13.760]

I personally am very confident with the way that FDA's managed this process and what the…based on everything I've seen to date…the effectiveness and the safety of the vaccines that are coming out of it, but understandable, it's been a tough political year. This has happened at an incredible pace of development and testing. And so, we first have to get over the hesitancy and understandable concerns that many healthcare workers have about vaccines. So, with that foundation and that and also nursing home vaccinations are the immediate priority as we head into January, especially February, March. That's when we are getting to the bulk of the higher-risk population in the US.

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So elderly individuals, people with comorbidities, obese individuals, people with other risk factors, other essential workers, that's a 100 million plus Americans. They're going to be the next phase of vaccination that's going to have to occur out in the community, at pharmacies, at clinician offices and so forth. Hopefully guided, Don, by your members, because those are the clinicians that people trust about getting their vaccinations. It's not going to be straightforward. Most of these, with exception of the J&J vaccine.

[00:45:35.920]

Full disclosure, I'm on their board. That's a one-dose vaccine. The rest are two doses, and they have some special storage requirements. So, this ain't going to be super straightforward. One challenge that we have is that the public health data systems that track vaccine use are not well integrated with the clinical systems and the billing systems that are used on the healthcare side. And this is another, I hope, for the next pandemic, we have fixed that problem.

[00:46:07.360]

There are definite interoperability solutions to this. I would just say again that those solutions are much easier to implement if the financial support goes along with it. If we're in more capitated models and this gets to those resiliency payments I was talking about earlier. If we pay providers right now, give them

relief from which they deserve from everything they've had to go through the pandemic, but link it to steps like data sharing with public health, setting up more systems, transitioning into value-based care models. We're going to be in much better shape for doing the vaccinations as well as the future.

[00:46:42.550]

But I do worry, Don, about for your members, you're going to have to watch the claims carefully. Each of these vaccines is supposed to come with a different billing code, but also recognize that a lot of people are probably, especially early on, are probably going to get vaccinated through mass vaccination activities, special federally supported efforts where a bill might not show up or at least won't show up quickly. CMS is working on a portal to connect for Medicare beneficiary data that they get on vaccines that occur outside of the usual pharmacy physician office billing systems to get that data to health plans and hopefully primary care providers.

[00:47:27.280]

That's not set up yet. So, a lot's going to be on your members to track this, using their systems to keep in touch with their beneficiaries and probably have to do a little bit of extra effort both to make sure you know when your members are getting vaccinated, especially these high-risk groups early on. And also to do some tracking on how those people are actually doing. We have got a lot of data on the safety of the vaccines and we have a lot of good reason for expecting that they'll be very effective.

[00:47:57.280]

But the more that that the APG members can set up registries, in effect, to track how their populations are doing side effects and so forth, that's going to be really helpful as well.

[00:48:09.190] Don Crane:

I am confident my members are going to want to do that for 19 different reasons, their own self-interest and altruistic reasons, et cetera, et cetera. So anyway, Mark, this has been great. I just want to thank you for the session. I want to thank for all you do. Your leadership is extraordinary. We look forward to working with you, continuing in the future and getting us through all of what we've described during this pandemic. Get us out of this pandemic and back into transformation would be nice.

[00:48:40.040]

That's right. And this is, Don, back at you and your members.

[00:48:44.410]

Silver lining here is that we really do have an opportunity not just to show how the capitated value-based approaches that your members are taking can lead to better care in the pandemic and help us get out of it

faster but can again provide an example that we can use to make this more the norm in our healthcare system. We sure need it now more than ever.

[00:49:06.400] Don Crane:

Amen. All right, my friend, you stay well, stay healthy and we'll be talking with you soon.

[00:49:12.010] Mark McClellan, MD:

You too. Take care.

[00:49:13.870]

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