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The Legal Role in Building Sustainable Public Health: New Payment Models and Delivery Systems

Dakasha Winston Senior VP & Chief Government Relations Officer
Blue Cross Blue Shield Tennessee

Mark Ison
Sherrard, Roe, Voigt, Harbison

Beth Swenson DeWeese Episodes of Care Strategy Specialist
Strategic Planning and Innovation, TennCare

THE LEGAL ROLE IN BUILDING SUSTAINABLE PUBLIC HEALTH

NEW PAYMENT MODELS AND DELIVERY SYSTEMS

PANELISTS:

DAKASHA WINTON, SENIOR VP & CHIEF GOVERNMENT RELATIONS OFFICERS, BLUE CROSS BLUE SHIELD TENNESSEE
MARK ISON, MEMBER, SHERRARD, ROE, VOIGT, HARBISON
BETH SWENSON DEWEESE, EPISODES OF CARE STRATEGY SPECIALIST, STRATEGIC PLANNING AND INNOVATION, TENNCARE

Moderated by Ashley Gholston Fowler, Bass, Berry & Sims

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Lauren Caverly-Pratt: We're going to come back together for our final attorney panel of the day. I'm just going to give everyone a second to hop back on. Like I said, yes, this is our final attorney panel of the day, our final official section of programming. On this panel today we have Dakasha Winton, who is the Senior Vice President and Chief Government Relations Officer at Blue Cross Blue Shield of Tennessee, Mark Ison, a member at Sherrard, Roe, Voigt, and Harbison, and also Beth Swensen DeWeese, Episodes of Care Strategy Specialist at TennCare. This panel is going to be moderated by Ashley Gholston Fowler, another proud alumnus of Belmont Law. Ashley is an associate in the healthcare space and health care practice group at Bass, Berry and Sims. Like I mentioned, Ashley earned her law degree with a health law certificate at Belmont and a BS in Biology from the University of Alabama at Birmingham. After completing her undergrad studies, Fowler attended medical school for several years and also directed an after-school program at the PENCIL foundation. Ashley it is so great to see you again; I'm going to hand the reins over to you.

Ashley Gholston Fowler: Thanks, Lauren. It's always great to be at Belmont, albeit virtually today, but happy to be here, thanks for having me.

Lauren Caverly-Pratt: Thanks for being here.

Ashley Gholston Fowler: And, before I get to these questions about new payment and delivery systems, I wanted to get each of the panelists to talk a little bit about their background and their practice areas to illuminate some of the different perspectives we have today. So, I'll start off with Mark.

Mark Ison: OK thank you, Ashley. Thanks for the opportunity to join this panel today, all of you wonderful folks at Belmont. I have been practicing I think seventeen going on eighteen years, have been at Sherrard, Roe, Voigt, and Harbison the entire time, have practiced primarily in healthcare transactional work, regulatory fraud and abuse, operational matters, healthcare transactions - certainly not litigation and happy to keep it that way. And, in a small firm like ours things have kind of developed organically over the years and I'm aware that I sort of combine practice areas that a lot of larger firms would split apart, but I think it's, you know it's been a fun ride so far.

Ashley Gholston Fowler: Thanks Mark. Next, I'll ask Dakasha a bit about her practice.

Dakasha Winton: Well, hi everyone, and I echo Marks's comments in the sense of thank you for having me and also, I'm very happy to not be a litigation attorney as well. I have been with Blue Cross now for thirteen years in a few roles, but primarily I work with the Tennessee General Assembly as well as members of Congress and some local members as well in trying to develop policy issues, which is the perspective that I'll try to come from. I don't really do a lot of payment delivery stuff, but our payment delivery guy is on vacation, so you're stuck with me. So, I will hopefully give you some insight from the policymaking perspective, in addition to the perspective of what we do here at Blue Cross. And so, thank you again for having me.

Ashley Gholston Fowler: Thanks. And Beth, you want to talk a bit about your practice?

Beth Swenson DeWeese: Hi good morning, thank you for having me. I'm also really excited to be back at Belmont. I'm member of the, or I graduated from the charter class of 2014 from Belmont Law. I'm an Episode Strategy Specialist at TennCare. I've been with the agency for about four years now and I use my legal background to design and evolve new and innovative payment models. I mostly focus on the Episodes of Care Program, which is our acute and specialty payment reform initiative, but I also work on a bunch of other things within the strategic planning and innovation division here at TennCare. And also excited or glad not to be a litigation attorney as well.

Ashley Gholston Fowler: Me too. Alright so I'll open it up, I'll ask you what are the trends that you all are now seeing in new payment models and deliveries?

Mark Ison: Who would you like to start Ashley?

Ashley Gholston Fowler: We can start with you Mark.

Mark Ison: Well, and I will say, my perspective on these it's not a policy perspective, it's very much a, bottom up perspective working with physicians primarily who have been asked to participate in these models, and so most of what I think I've been seeing lately is, you know TennCare has a number of episodes of care, in particular, I've had some dealings with the perinatal episode of care with TennCare, with the Medicare, of course the accountable care

organizations,[11] the joint replacement bundle payments,[12] some things like that, and patient centered medical homes.[13] So, seeing models that are driving in many cases physicians who are not in the same practice or driving physicians together with hospitals or physicians across different related specialties together to care for people either in a specific condition, something like a joint replacement episode or a perinatal episode or just covered lives more generally and, of course linking them together, either through payment incentives or in some cases putting them at risk, I mean that's a really high overview and I know we're going to talk about all of those things more over the next hour but you kind of asked what are we seeing, those are the types of things that I'm seeing on a pretty regular basis.

Ashley Gholston Fowler: And I guess to take us back, why are the current payment models unsatisfactory and what's the core issue with the way we're currently doing things? And anyone can jump in and answer.

Mark Ison: Why don't one of you two more on the payor side start there, I have some thoughts on it, but I'll wait.

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[11] An Accountable Care Organizations (ACOs) are defined as "groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients. The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, the ACO will share in the savings it achieves for the Medicare program." CENTERS FOR MEDICARE & MEDICAID SERVICES, https://www.cms.gov/medicare/medicare-fee-for-service-payment/aco (last visited March 20, 2023); Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 3022.

[12] Payment bundling is "[a] payment structure in which different health care providers who are treating [a patient] for the same or related conditions are paid an overall sum for taking care of [their] condition rather than being paid for each individual treatment, test, or procedure." HEALTHCARE.GOV, https://www.healthcare.gov/glossary/payment-bundling/#:~:text=A%20payment%20structure%20in%20which,treatment%2C%20test%2C%20or%20procedure (last visited March 20, 2023); Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 3201.

[13] A patient-centered medical home (PCMH) is "a model of care in which patients are engaged in a direct relationship with a chosen provider who coordinates a cooperative team of healthcare professionals, takes collective responsibility for the comprehensive integrated care provided to the patient, and advocates and arranges appropriate care with other qualified providers and community resources as needed." ASSOCIATION OF CLINICIANS FOR THE UNDERSERVED, https://clinicians.org/programs/programs-resource-archive/patient-centered-medical-home/ (last visited March 20, 2023); Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 3201(b)(2)(B)(i).

Ashley Gholston Fowler: Dakasha?

Dakasha Winton: Yeah, I'll jump in there. I think one of the initial issues is just the trust that's required to share the data. What the last panelists talked about how important it is for data sharing in order for us to work through the process, and as a health plan we obviously have a lot of data, and so it's really taking advantage of the opportunity for health plans and physicians and hospitals, everybody to work together. I think that's what we are seeing and trying to figure out a way to make things consistent, so that you can actually do the measurements and also recognizing that everyone, they are subjected to different things so it's kind of hard to create a completely objective approach and also try to deal with people on an objective basis in regards to their health care.

Beth Swenson DeWeese: And I'll jump in here sort of with the TennCare perspective, which of course one of the challenges I think we face is a lot of the incentives that exist in the private sector for both providers to sort of be voluntary programs to opt in, a lot of those and especially with our member base we don't have the ability to say, oh let's just wave copays, for example, if you opt into our centers of excellence program for example. That's a challenge that we have to, that's kind of unique to TennCare, that we have to incentivize providers and we also have to incentivize our members to engage in a value-based payment program and to really make it successful and we don't have necessarily the same levers that the public sector would have or the private sector. And I also think a lot of the work that TennCare does to innovate in the payment reform sphere is, it's interesting because we go beyond just having purely voluntary programs but that also, when you introduce downside risk or when you introduce programs that are maybe not as voluntary, then I think you have to really work extra hard to get the providers to buy into the program. I think it's extra challenging to really get everybody sort of aligned and wanting to work with the incentives and the program and I think that's a unique challenge that that we face, and I think it's also something that programs, I think that's the, I do think a little bit to your first question, I mean I do think that there's a trend towards having more downside risk and introduced into payment reform models, but I think that also comes a lot of challenges as well.

Mark Ison: If I could take my physician hat off for a moment and talk from more of a policy perspective, I think you asked what might be wrong with current payment models, and when you say current a lot of payments now are being delivered in a value-based way, but if we're thinking back five years or ten years a lot of what is wrong

with the system now is frankly you get what you pay for. If what you're paying for is fee for service care, if you're paying for procedures, if you're paying for visits, if you're paying for drugs, if you're paying for surgeries that's what you're going to get. What you're not going to necessarily get is health. You're not going to get population health. You're not going to get so many of the other things that some of the other speakers have been talking about. We're paying for the wrong things in the more traditional models, and you know it's very difficult to combat that mentality: among patients, among physicians, among insurance companies' health systems. To move away from that and toward a more outcomes-based or value-based, or quality-based whatever you want to call it something other than just stamping widgets and getting paid by the widget. Taking two steps back that is sort of, how, what I thought of when I heard your question initially.

Ashley Gholston Fowler: Okay, are there any efficiency problems that might be associated with changing current payment models?

Mark Ison: Well from the provider side, if everything is set up to do a more fee for service model, any movement to new payment initiatives is going to require new training, new staff, maybe new computer systems. We've already seen this with [electronic medical records ("EMR")], interoperability, and certification. Twenty years ago, there were really no EMRs, and then there were some EMRs, and they didn't have the right types of functionality. Some were nothing more than pdf and medical records.

Now we've moved all the way through to where we have rules now on interoperability and information blocking and all of that which are moving us toward a more functional standard of efficiency, but it's been a long road to get there, and I think practices from the provider side spend a lot of money at each step of the way. A lot of times, I think a lot of providers would say learning new tricks, implementing new infrastructure, dealing with the amount of data that has to be collected to make these types of payment models work.

Ashley Gholston Fowler: A follow up to that are there any structures input to help providers afford some of these new healthcare technologies or whatever else needed to keep up these new models?

Dakasha Winton: I think I'll chime in here, and I'll echo Mark's point from the last question because one of the things that we see is there are lots of restrictions around what data that you can share and

how you actually share that data. Not only do you have health plans seeking data; you also have other third party vendors seeking data as well, to how do we report that out to physician groups, how do they receive that data, and we tend to have some compliance issues, and then there's some increased risks there's anytime you talk to anyone in IT they're going to say it's not a matter of if your system has a breach, it's a matter of when. Trying to protect that data and ensuring that you are sharing it in a way that is appropriate that absolutely creates some barriers in how we administer these types of programs.

Beth Swenson DeWeese: I'll jump in again with a little bit of a different perspective because I'm on the government side. We're very aware of whenever we are developing a new payment reform, an initiative, or a payment model, we have to think about the additional administrative burden on providers, and we strive to work very hard on avoiding adding any new barriers, or any new systems, or requiring a new technology because that is a very real challenge.

We are certainly sensitive to the fact that providers have a lot thrown at them in terms of these administrative burdens. So, specifically with the episodes of care program, we deliver our, or our managed care organizations, deliver performance reports to providers. It's just in a pdf, you know, there's no additional platform or system or EMR that's required to read it. Our reports, we really designed them for episodes of care to pull in a lot of data sources or claims that individual providers in their own practice aren't going to have access to see, and it helps give a lot of insight that on the provider level, you wouldn't be able to get those claims of information pulled together and track multiple patients all in the same report, but we try to do that. Because as the government and, again with our managed care organizations, we're uniquely positioned to offer that sort of 30,000-foot view without the administrative burdens, without introducing a new technology. There's not a new platform, and I think that's where you know TennCare really adds a lot of value in the space because we do have that position to be able to do that, whereas an individual health care system, hospital system, or a large provider, that would just be a huge burden on them to develop that on their own.

Ashley Gholston Fowler: Shifting gears a little bit, how have you all seen that COVID-19 has impacted this space? Has it created any additional hurdles, has it proved to be a catalyst to get more people to change to payment models, what have you seen?

Dakasha Winton: I think you know a lot of the provider systems were...I think there are lots of things that they were doing to try to implement and address the issues that came about, but I don't know if the resources were available to extend for developing new payment models other than there's been a lot of discussion about telehealth and providing telemedicine, which was absolutely invaluable, but you had a lot of the smaller providers that actually didn't have the resources available to do that.

So, in terms of development of payment models I certainly believe that the providers who had payment models already in place where they were able to provide real quality care from the outset, they fared better than those entities that did not have payment models in place, pre and post COVID, well not quite post because we're still in it, but it's definitely one of those situations where those who could really focus on the quality of care were providing versus the dollar or the number, they were able to really enhance the services that they were providing because they had the discipline to do that already.

Mark Ison: I think a lot of the practices I worked with, I haven't worked with I mean, they've been in survival mode, not so much more recently, but certainly in the beginning, and it has taken a lot of them, I think of it as kind of a hierarchy of needs, and if your hierarchy of needs is number one you've got to have enough money coming in the door to keep your employees, to keep the lights on, to keep, and then you've got to keep your patients safe, your employees safe you're worrying about all those sorts of things. There was no money. There was no bandwidth to do new thing, and I agree with Dakasha to the extent that there was a practice that was already well set up to do things. I mean yes, telehealth fine, great some people have used that better than others, but advanced payment models, alternative payment models are a lot more than just telehealth, and telehealth may be a piece of that, but it's not even a necessary piece of a lot of it. I think COVID has been a completely different focus for a lot of providers that has probably retarded their ability in a large degree to think about engaging in some of these additional payment models. They just haven't had the bandwidth for it.

Ashley Gholston Fowler: Okay, so, if you could provide one piece of advice to an organization working with a new payment model what would it be?

Beth Swenson DeWeese: I'll start this one off, just because we love our providers, and we love our providers more specifically when they really engage with us. A lot of TennCare's programs, I'm

thinking especially episodes of care, we see the best outcomes for providers and for ultimately for patients and for our members when the providers really engage with the program. They talk, they answer the call when their MCO rep calls, they talk to the state when they have feedback.

I think a lot of these programs, these payment models seem theoretical when you read them on paper, when they're maybe first presented to you, but the rubber meets the road when you talk to the people that are helping to implement, when you're really engaging, you're providing feedback it's a dialogue. We do many things to foster provider and stakeholder feedback, and we put a lot of effort into incorporating changes into the program based on that feedback. It certainly takes effort. These payment models don't just happen; they don't just fall out at a tree and conk you on the head, and say "okay, well we've now reformed your payment, and you're good to go call it a day." It very much takes teamwork, and our [managed care organization ("MCO")] partners especially blue cross blue shield, we love working with you, and I think you do a lot of work. All three of our MCOs do a lot of work in the provider engagement area. I think that is something that is an area of focus, an area of a lot of resources and putting intentionality into engaging providers is very important on our side of the.

Then, to your point to your question about advice for the provider: engage back with us. We reach out to you, please reach back out to us and answer the call and have the meeting because I think that really gets the best results in the payment model. Ultimately, that improves quality for the patient and that improves outcomes, and I think that's my one piece of advice.

Dakasha Winton: Yeah, and from the payer perspective, I'd echo that with multiple claps if I had multiple hands to do that. The key is just really developing those trusting relationships between the payors and the providers and then ensuring that the providers are included in the design process. It's so important for us to hear back from the providers. We created back, I think, in 2014 a physician advisory council so that we could talk through new payment models, and we continue to have that conversation. I think the best piece of advice that I would give is just collaboration: collaboration and share your insight because ultimately as a payor we're not the ones that are in the room with the patients, the provider is. So, having their insight and their perspective that's the most critical thing that we can get when we're establishing these processes.

Mark Ison: Did you want me to comment? Thank you both for that because as someone who works with providers that's actually very helpful. I was going to suggest something like that, which is to say, don't wait until the last minute and think you're going to wing it. Reach out to the payor. Reach out to the to the people in charge. Find out what the goals are and work toward those goals. Don't fight the system. Work within it to meet the goals.

I have so many providers that come to me and say a payment model is not working, and they're not working toward the same goal. They're not trying to, for whatever reason. They they've got their back up, and they want to fight against it. They want to complain about it instead of saying, "okay, look, this is a fact, we've got to retool the way we're thinking about treating these patients, or this condition, or whatever to work toward this." They may or may not be successful, but you know it has to start there. So, thank you both for that. I thought that was good advice.

Ashley Gholston Fowler: I think you all have touched on incentivizing positions. Have you seen a change in mentality among providers now that they are provided with incentive payments for the quality care that they're providing?

Beth Swenson DeWeese: I'll jump in here, to build off the comments on the last question. There's always a little bit of a growing pain when you roll out a new program, and I don't care how great the program is, I don't care how great the physicians or how willing they are, change is hard and that's huge. I think that's a human universal, and people don't like having to adapt to change. After you get over the initial newness of it, of new payment models in general and value-based payment is now; it's the newness is off of the concept. There are still new programs, right? There's always something innovative, but as a concept, we've all been living with it for a while, and it's no longer a foreign territory. It's something that because it is well on the road to being most people by and large, I'm talking broad strokes here, by and large most providers see that this is the way of the future. This is not going anywhere. This is not a niche novelty that hey we're trying it, and maybe in 10 years it won't be here. It's here to stay, and there's been a change in providers that have sort of come to sort of accept that and once you get over that initial, oh it's different it's new, there's a lot of value and benefit.

I appreciate Dakasha's comments about data sharing earlier in the panel. I think that's very true; people are initially scared of data sometimes. What are you going to find when you start looking

at my data? What are you going to do with my data once you get it? But I think again these payment models, certainly the designs change, and there's always something new. It's no longer new enough that people… it's we're getting to where they're accepting it, and now we're talking about accepting nuances, and we're getting down into details, and it's not something that is a fad. It's here to stay and generally providers I've seen, they accept it even with episodes of care. We are a mature program now.

We have been around since 2015. So, at this point everyone's involved, nobody's in the first year of being in episodes of care at least for TennCare. So, we find that there's a lot more just acceptance even if you don't have feedback and even if you don't like a certain element, you kind of reckon we're here to stay. We've had proven success. We've had positive results. So, we're not just going to dissolve tomorrow because a few people don't like it, and I think that's really helped acceptance. I think you know my last comment about working with us really helped a lot of folks to say, well if we can't beat them join them, and there's been this slow evolution. We're just going to work with the system because the system is here to stay, whatever that may be: episodes of care, whatever payment model you're talking about

Dakasha Winton: I think certainly we've had the exact same experience, and maybe with the larger practices and hospitals, many of them have organized themselves to be successful in the value-based reimbursement environment. So, they're actively seeking opportunities to engage in new reimbursement models. It's no longer what is this going to look like; it's how can we show you that we can add value, and this is the ways that we can provide this model. So, we've been super encouraged by the adoption of models by our health care providers and partners in the providing of care for Tennesseans.

Ashley Gholston Fowler: Dakasha, I know earlier you spoke a little bit about compliance issues that arise if we could elaborate and discuss what are some other compliance issues that may come about with these new payments?

Dakasha Winton: Like I mentioned, when you have a data breach, that's a significant issue if you've experienced it, and we've gone through that. Back in 2009 it was not a pleasant experience and so hopefully, we won't have another one for quite some time. I'm going to probably knock on wood because somebody will call me next in the next 10 minutes like, "oh my god! what have you done," but I think certainly in terms of when we think about the regulatory

process and how government is engaging in a lot of the health care issues unfortunately, health care is probably and education are two of the most politicized issues that you could possibly think of. So whenever you have the government engaging and you have lawmakers and policy makers saying, "oh, well I think we need to do this [or] we need to adjust that," that's the one of the compliance areas wherein there's constant change. We had a pretty significant change within 2020 with the adoption of the consolidated appropriations act, and with all of that: How do we deliver information to individuals? How much information does a hospital have to provide? How much does an insurer have to provide? So, those challenges of keeping up with all of the changes and laws and regulations is probably my big compliance area that I've mentioned

Beth Swenson DeWeese: I know with my work at TennCare, one of the things that's kind of interesting, and I think is really fun is we touch on some anti-trust laws just because we are 100% managed care which means TennCare has three managed care organizations that sort of administer the bulk of our programs and so a lot of my work is actually with each MCO, each managed care organization and working with them, and we have to make sure for developing a new, especially if it's a pilot, program. So, [if] we're trying to develop a new payment model, antitrust is something that we have to keep in the forefront of our minds, and also, a little bit related one of the things I like about the government practice side of things is working with other organizations, but I'm not always working with the lawyers of those organizations, and this is a practice tip I have for government lawyers: always keep in mind who your client is. For me, my client is TennCare. So, I'm going to pick on Blue Cross just because you're on the call, but I was recently working on a project for piloting a new program, a new payment reform program, and I was reviewing documents that we received from the MCOs. Some of those ideas they were great, and I was like, "wow, this is really cool! But wait a minute, I don't think the business folks talk to the lawyers right." I could tell they talked to the clinical folks; I could tell they talked to the provider contracting; I mean these are some great ideas, but…

Dakasha Winton: they probably try to avoid it honestly…

Beth Swenson DeWesee: and yeah, I can understand the struggle, but again going back to my point you know Blue Care, for example, I'm reading their document, Blue Care is not my client so I can't say, "oh you need to look at this statute, or have you checked out this sub paragraph 2b on your proposal to look at?" No, I just have to say, "that's really interesting and creative. Have you talked to

legal? Have you conferred with your attorneys because I think you might want to," and you have to be careful because I can't provide them legal advice, and I don't want to say anything that could be misconstrued as legal advice.

But Blue Cross and all of our MCOs are very large organizations. Even the most integrated organization, you're still going to have a certain degree of silos, and you've just got to really make sure that the clinical folks, the business folks, the contracting folks aren't coming at this from a way that's not compliant with the laws. The Anti-kickback Statute[14] is a complex law and that kicks in places that a lot of business folks just don't see or they don't anticipate. Again, I can't say that's going to violate the anti-kickback statute, I just have to flag it for them in a way that they can then take it back and just making sure that when we get a new idea everything's, everyone's talked to everybody. I find that sometimes those are the more fun calls that I have with the MCOs and just always keep in mind who's your client and keep that forefront as you're interacting with your counterparts and other organizations.

Mark Ison: Yeah, and I will say I would agree with that that the fraud and abuse side of this, I mean with these models a lot of times there's here's a pot of money to be distributed, shared in some way. In many cases between hospitals and physicians or you know some other group of people who refer to another group of people, and it it's amazing to me, and thankfully now with the recent changes to the anti-kickback statute and the Stark Law, the exceptions, safe harbors for value-based payment, value-based arrangements are helpful. I think practitioners are getting used to those and what's going to be the scope of those exceptions. I think they're intended to be very broad, but we'll see, but before, with each time one of these programs would come out it had to have its own regulatory sub guidance, its own waivers, its own how does this comply with the Stark Law, the Anti-kickback statute?

War story really quick. I was working with a small surgical practice. He was contracting with a, not a rural hospital but it certainly wasn't an urban hospital, smaller hospital to do one of these CMS bundles and the hospital's attorney was not really a fraud and abuse attorney. The practice had asked me to look at it. They were headed into a really bad place. They were going to end up on paper, at least, violating any number of fraud and abuse laws based on the way they were going to do it. You had to prepare these incredibly intricate documents. There were restrictions on how the money could be distributed even once it got into the physician

[14] AntiKickback Statute (Anti-Kickback Statute), 42 U.S.C. § 1320a-7b (1994).

practice, and so those types of things are a little scary. They were forced into this. They didn't necessarily want to do it. I think it worked out pretty well for them eventually to the point of our other panelists here, but at first they could have been forced into fraud and abuse violation that they really didn't choose for themselves, and so I think as these programs become more and more prevalent it's just going to be more and more important to make sure that the rest of the law is keeping up with them so that they're not having to call and pay someone thousands of dollars to nitpick inter-party documents in an arrangement like this because "oh my goodness we didn't have this safeguard on the way the money would flow, now we violated the Stark Law[15] or something else," and so you know that to me is also happening a little bit where you have these entrepreneurs frankly who are coming up with new payment models. Then they're going to someone like TennCare. They're doing this a lot at the state level and saying pay me to manage this condition this disease state through this program.

Sometimes they come to us to help them structure those programs, and we're looking at the laws in that state or even federal laws and saying well, yes, I see what you're doing and the intent is pure as the driven snow, but actually technically you're violating this handful of things here, and you can take the Uber approach and move into a market and just do it and hope that the law catches up. And you can fight your way out with litigation but not everybody's Uber and this is healthcare and the penalties can be very severe. So, it's, there is a tension between innovation and, in particular, fraud and abuse and reimbursement. Reimbursement would be the other piece of this how are they actually going to get paid to do this. So, I would say that that's the number one concern and struggle I see with these as they roll new ones out constantly.

Ashley Gholston Fowler: So, we talked a little bit about the provider perspective and payor perspective, but as far as long-term goals go, what are the benefits and detriments to patient care that you may have seen as we shift to these new models?

Dakasha Winton: Well, I'll start here. In terms of benefits, I think you have a greater emphasis on outcomes and quality, you're better able to differentiate between providers in terms of how they provide quality and outcomes and patient practice patterns et cetera, relative to their peers. Financially, for providers, it makes a pretty big difference too. Detriments, I would say outside of the control of everybody here but, care, the cost of care is still continuing to increase in price too quickly year over year relative to income

[15] Stark Act, 42 U.S.C. § 1395nn (1989).

growth and inflation. The other detriment that I would say it is much harder to be a provider today: clinicians that have been practicing before and during this change they've had much higher professional frustration and then the burnout rates have been much higher because they've had to deal with not only the new payment models and trying to keep up with all of those things but they're also dealing with you know different type of commercial segments. So, they've historically dealt with Medicaid and Medicare. Now you have the health insurance marketplaces and what does that reimbursement look like? And so you're adding multiple things and just expected to be much smarter about a lot of things. Trying to juggle all of that is it's just complex and so I think that that's what I would say would be the detriments from the perspective that we see.

Beth Swenson DeWeese: I'll say from the 10,000-foot perspective for the state side of things TennCare is roughly about a third of Tennessee's budget. The state budget, right, we're huge, and Dakasha is absolutely right, the cost of health care is just rising and rising very quickly. If we are not able to be financially sound and well managed, and if we can't do our best at addressing those rising costs of health care then we're taking money out of the pot for other Tennessee agencies, and we're taking that money from department of ed, I mean the list goes on. We are such a huge part of our budget there's just no option to fail at this. I think it's just vital for the state, and when you think about what levers can TennCare as an agency, what can we pull, what can we do to sort of manage those costs and sort of cap the rising costs of health care, we really, you more or less have three options: we can, the lever we can pull, is the number of members that we cover, how many services we cover for those members, and what our providers get paid. I mean those are our three, again 10,000 feet, those are our core levers. Value-based payment and innovative payment models, that is critical to our ability to pull those levers and adjust…keep our costs and manage our program and incentivize our providers. And align incentives so that we can keep a dull roar on the chaos of rising health care costs

The downside if we don't do that, the margin of error is multiplied times a third of the budget. We're talking billions of dollars. So, if we don't get it right, it's a big mess, and I think that's important for us too. Value-based payment is a really big part of how we manage and how we address the rising costs when we look at especially episodes of care program, when we look at cost charts and year over year and you see the projection and then you see what episodes of care has done. We sort of bent the curve, and we've either maintained or we've lowered costs, we've increased or maintained quality that is essential to our mission and those payment

reforms have helped us optimize the money that we get and use and cover. That helps the state; that helps Tennesseans. So, I think that's how I approach it from the from the TennCare side is we just, we just can't fail. This is just too vital. We can't let the downside get us.

Mark Ison: From the provider side, I would say this is a little tricky because doctors realize like the rest of us, I mean they're taxpayers as well, that that health care costs are perhaps too high based on what we're getting for it or we're getting the wrong things for it. So, initiatives that are aimed at making health care more efficient, more effective at improving health, improving quality I think it's very hard to argue against. Those initiatives that simply tried to constrain a budget, as you might expect, are a little less popular with the people who are being reimbursed for healthcare and also initiatives that make it harder in terms of administrative costs, or other effort that has to go into treating a patient and also into reporting the metrics or whatever it has to be that make it harder to receive that reimbursement are also pretty unpopular.

I think a balance has to be struck. You asked for, okay what's a downside or a detriment: you cannot cut your way to more and more efficiency to lower and lower costs you can't keep moving the baseline. Eventually you're going to get to a point where it costs what it costs, and we're not really, the physician practice has to stay in business too. The surgery center has to stay in business too. I'm not trying to cry [wolf or] to [bad] mouth anybody here there are so many practices and providers who are very successful, but I think we have to be careful in in talking about quality and health and efficiency all of which I think most of us, all of us probably, can get behind, and just talking about whose pocket the money is going to go into, and for instance with [accountable care organizations ("ACOs")], with some of these models I've always looked at them and chuckled a little bit to myself. All these people piling in to do it it's like you realize you're just lowering your own reimbursement; you're lowering the baseline. It's getting harder and harder to make the same amount of money and a lot of people do see that, but it's so…maybe it's survival of the fittest, survival of the most efficient, survival of the smartest, but the truth is we need a lot more providers. We need especially doctors and providers in primary care in rural areas. We need innovative approaches to serving the needs of different communities. We just got to be careful that we're not taking away the money that's going to be needed to succeed in in doing that.

Ashley Gholston Fowler: Okay thanks, and as we wind down, I think this may be my last question for you all but something that [we heard] earlier about these models or have been around for a while and they're here to stay so what does this look like what do you think the reimbursement scheme will look like 10 years from now? How quickly or slowly might we actually rethink payment models?

Mark Ison: I mean as one of you said, it's here to stay right? This isn't new. It's not going away. I think at some point, maybe it already is, but I think it's a lagging indicator medical education is going to have to take this into account. How do we treat patients? How do we address the health of a patient population? And that's going to have to start way before somebody actually gets into delivering health care services. It's going to be part of training and just the philosophy of health care, and I think we're headed that direction. Where is it in 10 years? I would hope, you know it's difficult when you talk about outcomes based payments or value based payments quality, every patient is an individual and every patient brings a unique set of complications, and they don't fall necessarily into buckets all the time, and maybe AI computer technology, maybe there's hope there, I'm not someone who you know believes that we're all going to end up plugged into the meta matrix, but perhaps there will be innovations in technology that allow us to better measure baselines and improvements in ways that that more closely track the actual results that we're getting so that we can reward quality, we can reward outcomes, and at the same time doing that in a way that's taking into account the individuality of each patient. I'm hopeful that we'll get there.

Teachers always say, "how can you grade us on the performance of our students? We can't correct everything that's wrong in their lives. Every student is individual. They have other issues that may not have anything to do with our teaching, that may cause them to succeed or not succeed in school." Patients are the same way. So we we've got to figure that out if we're going to pay for outcomes in health.

Beth Swenson DeWeese: Mark's comment on every patient is individual, and I think that is something that if I had to like read the tea leaves [as to] where this is going I think getting patients involved more in the payment I think that's something that is a trend I don't want to put a five or ten year tag on it. A lot, at least on the TennCare side, a lot of our payment models, they're for the provider. So, if you're a TennCare member, you have no idea you just had an episode of care or you're not maybe aware that you are in a patient-centered medical home. You might have some understanding of the

provider type but you're not necessarily feeling that you're in a new you know innovative payment model.

I think that there's been recent regulation on patient engagement incentives that came out I believe[16] last year; the rule was finally finalized and I think that that really is a signal that there's support even at the CMS level to for these plans, these payment models to really get the patient involved and get the patient to have some, you know, I hesitate to say, skin in the game because it feels a little bit, I don't know, vulgar to say, but to get the patient incentivized. A lot of payment models talk about aligning incentives that's something we talk about at least at TennCare quite a bit, like let's get all the incentives aligned so that everyone's working towards the same goal. I see in the future, I see getting patients and getting our members also one of those incentives that's aligned that's something that's a growing trend and just getting them involved, getting them motivated. I said there's some signals from CMS that they're supportive of that. That's sort of my guess, my prediction on where this is going.

Dakasha Winton: I'll just echo their comments. I think Beth and Mark both aligned exactly what it's going to have to be. There's going, right now you have the collaboration between the health plans and the providers, but you absolutely have to have the patients become more actively involved in the care that they receive and also being accountable for that care that they receive. So, if they miss an appointment and what does that look like and how do those things occur and certainly technology is going to help those things. I think that as we continue to evolve and the data that we continue to climb through artificial intelligence all the things it is going to continue to have a significant impact on how we deliver that care. In my mind, I for one would think after being in healthcare for almost 20 years now it's just kind of like has it really changed that much? It's changed some, but in my mind it's going to happen much quicker than maybe it will happen in real life, but we'll see.

Ashley Gholston Fowler: Okay well thank you all. I think we're about out of time. So, I'll turn it back over to Lauren.

Lauren Caverly-Pratt: Thanks Ashley and thank you so much Dakasha, Mark, Beth, and also you Ashley. We thought that was really another really fascinating discussion, and I wish we could

[16] State of Tennessee: The Budget fiscal year 2021-2022, TN.GOV (2021), https://www.tn.gov/content/dam/tn/finance/budget/documents/2022BudgetDocumentVol1.pdf (last visited Mar 15, 2022).

listen to all of you talk a little bit more, but unfortunately, we can't just keep everybody here all day. We really appreciate you taking the time out of your day to chat with us and be here with us at our symposium. So, thank you all.

This concludes our scheduled programming for the day.

Thank you again everyone for attending and thank you especially to all of our speakers and panelists. It was so great to have you here with us today, lots of very fascinating discussions, and I'm going to hand it over briefly to Dean Deborah Farringer, our faculty advisor for a couple of her closing remarks.

Dean Deborah Farringer: I just wanted to thank everyone for coming. Thank you to all our attendees today, we're really grateful for your support and your involvement in the [*Belmont*] *Health Law Journal*, and we hope you can continue to join us for other events and hopefully the next ones will be in person, we can bring you back to school. So, we're hoping for that for the coming year. I also wanted to thank our speakers and panelists today for taking time and being willing to just serve as experts and help provide information to all of our attendees. I certainly learned a lot, and I think it was a good, really broad base of all of the various issues that that create sustainability in our healthcare system and all the various things that we need to think about. Lastly, I really just wanted to thank our journal members; they have worked really, really hard and tirelessly. There's their picture there in front of the law school. It takes a lot of effort to coordinate an event like this, even a virtual event, and I just wanted to thank them. I especially want to thank our Symposium Director who is labeled here as Belmont College of Law Grace Benitone, who I know has worked so, so hard over the last year doing both this fall panel and the Spring Symposium. She's doing an excellent job as our event planner and has just done an amazing work this year. And, I also just wanted to thank Lauren Pratt, our Editor-in-Chief. We could not do this without her. She keeps us all on our toes and going and keeps the train moving. I'm really excited about improvements and ways that she's improved the journal this year and we can just expect better things to come. So, thank you everyone for coming. We're so appreciative of your support and we hope we will see all of you soon.