Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

September 17, 2024
9:03 a.m. – 3:11 p.m. EDT
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attendance

Physician-Focused Payment Model Technical Advisory Committee (PTAC) Members

Lauran Hardin, MSN, FAAN, PTAC Co-Chair (Chief Integration Officer, HC^2 Strategies)
Angelo Sinopoli, MD, PTAC Co-Chair (Executive Vice President, Value-Based Care, Cone Health)
Lindsay K. Botsford, MD, MBA (Market Medical Director, One Medical)
Jay S. Feldstein, DO (President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine)*
Lawrence R. Kosinski, MD, MBA (Independent Consultant)*
Walter Lin, MD, MBA (Chief Executive Officer, Generation Clinical Partners)
Terry L. Mills Jr., MD, MMM (Independent Consultant)
Soujanya R. Pulluru, MD (President, CP Advisory Services, and Co-Founder, My Precious Genes)
James Walton, DO, MBA (President, JWalton, LLC)
Jennifer L. Wiler, MD, MBA (Chief Quality Officer, UCHealth Denver Metro, and Professor of Emergency Medicine, University of Colorado School of Medicine)

PTAC Members in Partial Attendance

Joshua M. Liao, MD, MSc (Professor and Chief, Division of General Internal Medicine, Department of Medicine, The University of Texas Southwestern Medical Center)*

Office of the Assistant Secretary for Planning and Evaluation (ASPE) Staff

Lisa Shats, PTAC Designated Federal Officer
Steven Sheingold, PhD
Rachael Zuckerman, PhD

Via Zoom

List of Speakers and Handouts

1. **Listening Session 1: Organizational Structure, Payment, and Financial Incentives for Supporting Accountable Care Relationships**

   Alice Jeng-Yun Chen, PhD, MBA, Vice Dean for Research and Associate Professor, University of Southern California*

   Michael C. Meng, MBA, Chief Executive Officer and Co-Founder, Stellar Health*

   Steven P. Furr, MD, FAAFP, President, American Academy of Family Physicians (*APC-APM – Advanced Primary Care: A Foundational Alternative Payment Model for Delivering Patient-Centered, Longitudinal, and Coordinated Care* proposal)*

   Jenny Reed, MSW, Senior Executive Officer, Southwestern Health Resources*

   Handouts

   - Listening Session 1 Day 2 Presenters' Biographies
   - Listening Session 1 Day 2 Presentation Slides
   - Listening Session 1 Day 2 Facilitation Questions

2. **Listening Session 2: Developing a Balanced Portfolio of Performance Measures for PB-TCOC Models**

   Lisa Schilling, RN, MPH, Chief Quality and Integration Officer, Contra Costa Health*

   Robert L. Phillips, MD, MSPH, Executive Director, The Center for Professionalism & Value in Health Care

   Barbara L. McAneny, MD, FASCO, Chief Executive Officer, New Mexico Oncology Hematology Consultants and Former President, American Medical Association (*MASON – Making Accountable Sustainable Oncology Networks* proposal)*

   Sarah Hudson Scholle, MPH, DrPH, Principal, Leavitt Partners

   Handouts

   - Listening Session 2 Day 2 Presenters' Biographies
   - Listening Session 2 Day 2 Presentation Slides
   - Listening Session 2 Day 2 Facilitation Questions

3. **Listening Session 3: Addressing Challenges Regarding Data, Benchmarking, and Risk Adjustment**

   Robert Saunders, PhD, Senior Research Director, Health Care Transformation, Adjunct Associate Professor and Core Faculty Member, Duke-Margolis Institute for Health Policy, Duke University*

   Randall P. Ellis, PhD, Professor, Department of Economics, Boston University*

   Aneesh Chopra, MPP, President, CareJourney*

   John Supra, MS, Chief Digital Health & Analytics Officer, Value-Based Care Institute, Cone Health*

   Handouts

   - Listening Session 3 Day 2 Presenters' Biographies
   - Listening Session 3 Day 2 Presentation Slides
   - Listening Session 3 Day 2 Facilitation Questions

Via Zoom
[NOTE: A transcript of all statements made by PTAC members and public commenters at this meeting is available online: https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee].

Also see copies of the presentation slides, other handouts, and a video recording of the public meeting.

Welcome and Co-Chair Overview

Angelo Sinopoli, PTAC Co-Chair, welcomed the Committee and members of the public to the second day of the September 16-17, 2024, public meeting. He mentioned that the first day of the public meeting began with remarks from Elizabeth (Liz) Fowler from the Center for Medicare and Medicaid Innovation (CMMI; the Innovation Center) about CMMI's vision to achieve the goal of having all beneficiaries in accountable care relationships by 2030. Day 1 also included several expert speakers who discussed identifying a pathway toward maximizing participation in population-based total cost of care (PB-TCOC) models. Co-Chair Sinopoli then reviewed the agenda for the day, noting that expert speakers represent a variety of perspectives, including previous PTAC proposal submitters.

Co-Chair Sinopoli indicated that a public comment period would be held in the afternoon. Participants must register to provide an oral public comment, and public comments are limited to 3 minutes. He stated that the meeting would conclude with a Committee member discussion of comments for inclusion in the report to the Secretary (RTS). Co-Chair Sinopoli invited Committee members to introduce themselves and their experience in maximizing participation in PB-TCOC models.

Listening Session 1: Organizational Structure, Payment, and Financial Incentives for Supporting Accountable Care Relationships

Subject Matter Experts (SMEs)

- Alice Jeng-Yun Chen, PhD, MBA, Vice Dean for Research and Associate Professor, University of Southern California
- Michael C. Meng, MBA, Chief Executive Officer and Co-Founder, Stellar Health
- Jenny Reed, MSW, Senior Executive Officer, Southwestern Health Resources

Previous Submitter

- Steven P. Furr, MD, FAAFP, President, American Academy of Family Physicians (*APC-APM – Advanced Primary Care: A Foundational Alternative Payment Model for Delivering Patient-Centered, Longitudinal, and Coordinated Care* proposal)

Co-Chair Sinopoli moderated the listening session with 4 subject matter experts (SMEs) offering their perspectives on organizational structure, payment, and financial incentives for supporting accountable care relationships. Full biographies and presentations are available.

Alice Jeng-Yun Chen presented on payment and incentives for value-based care in integrated delivery systems.

- The financial incentives to participate in Alternative Payment Models (APMs) have decreased, such that bonuses to join APMs will fall to 0% in the performance year (PY) 2024, reducing the relative appeal of APMs versus fee-for-service (FFS).

- The growth in participation in the Medicare Shared Savings Program (MSSP) has stagnated over time due to relatively equal numbers of Accountable Care Organizations (ACOs) joining and dropping out. One reason for the lack of growth is voluntary participation, which attracts ACOs with lower benchmark spending. To increase the involvement of providers who care for high-risk and high-cost patients, MSSP made policy changes to its program to level the playing field:
    - Addressed the rebasing ratchet effect by adding a prior savings adjustment.
    - Added an administrative component in benchmark growth.
    - Capped the benchmark reductions due to regional blending at -1.5%.
- This benchmark update is called the 3-way blended factor because it incorporates the national and regional trends and additional factors mentioned above.
- Dr. Chen presented a policy roadmap to simplify the benchmark adjustment and encourage participation. The approach uses the initial benchmark set at each ACO's historical spending, introduces a regional convergence phase to annually update benchmarks according to each ACO's spending relative to the region, and, once convergence is achieved, adopts annual updates based on a combination of risk-adjusted regional rates and administrative spending trends.
- Additional financial levers to incentivize participation besides adjusting benchmarks could focus on requiring APM participants to also participate in Part B drug pricing programs. Models could increase participation bonus payments and shared savings rates to attract participation.
- A few recent changes were made to encourage participation among smaller organizations, including providing up-front capital investments and gradually introducing downside risk. Additional levers to improve the involvement among small and more primary care-focused organizations include the creation of a primary care-specific risk contract with capitation and capping losses based on revenue rather than a benchmark.
- Three additional factors to keep in mind include preventing gaming of the risk-adjustment system, improving financial incentives for beneficiaries to increase participation, and restructuring financial incentives to reach physicians, as this will transform clinical behavior over time.

For additional details on Dr. Chen's presentation, see the presentation slides (pages 2-14), transcript, and meeting recording (00:09:08-00:18:35).

Michael Meng presented on payment and incentives for value-based care.

- Mr. Meng is the co-founder and CEO of Stellar Health, an APM focused on value-based care that serves over 1 million patients across the U.S.
- Stellar Health pays out reward dollars through Stellar Value Units (SVUs) to providers for completing healthy actions.
- Stellar Health's model focuses on rewarding behavior change in real time with an emphasis on primary care. Positive feedback loops reinforce behaviors by making providers feel accomplished after completing an action.
- Primary challenges with population-based or value-based care reside in the delayed gratification of rewards, shared accountability for care, and obtaining rewards for frontline health care workers.
- Value-based care penetration has been limited to large and centralized organizations, and the drivers of value-based care, such as the medical team and medical staff, need to be reached.
- To address these challenges, Stellar Health aims to deliver dollars directly to those responsible for providing the care to highlight and reward healthy actions in real time. For example, Stellar incentivizes the primary care team to complete value-based actions and then delivers the reward

to the entire care team in real time, which results in the payor realizing the return on investment for improved quality scores and the patient experiencing improved care delivery and outcomes.
- Closing the care gap requires multiple steps or a series of workflows that improve patient care and outcomes. Stellar has designed a feedback loop for each workflow that uses its technology or app to document each step and assign accountability to the care delivery team.

For additional details on Mr. Meng's presentation, see the presentation slides (pages 15-31), transcript, and meeting recording (00:18:43-00:31:16).

Steven Furr presented on the role of clinical integration in achieving care coordination and team-based care in PB-TCOC models.

- Care coordination requires a team-based approach led by the primary care provider (PCP). In addition to caring for patients' mental and physical health, coordination requires partnering with community-based organizations to address health-related social needs (HRSNs).
- Clinical integration can improve care coordination across health conditions, providers, settings, and time. It can range from informal communication and data sharing arrangements to legal entities known as clinically integrated networks. Formal clinical integration may have a sophisticated data platform where all providers have access to data on cost, program, utilization, participation, and clinical outcomes. The platform may have capabilities for retrospective and predictive analysis.
- Clear communication and mutual accountability between PCPs and specialists are essential for any clinical integration, formal or informal.
- Communication between specialists and PCPs must be clear and not rely solely on technology and patient records to communicate care updates promptly.
    - Dr. Furr provided the example of an abnormal chest CT scan received for one of his patients. Instead of calling the PCP directly to report the abnormal results, the radiologist assumed that the PCP would read the medical record notes on the scan results. After a few days, the patient was in the intensive care unit, which could have been avoided with direct communication.
- Optimal care coordination does not depend on formal clinical integration but benefits from clear expectations about communication of information and accountability for care.

For additional details on Dr. Furr's presentation, see the presentation slides (pages 32-42), transcript, and meeting recording (00:31:21-00:39:41).

Jenny Reed presented on her experience coordinating care for complex patients in the Southwestern Health Resources health system.

- Southwestern Health participated in MSSP and Next Generation ACO before joining ACO Realizing Equity, Access, and Community Health (ACO REACH). It is one of the top performing ACOs in ACO REACH, is primary care-led, and has many academic, employed, and independent medical, surgical, and hospital-based specialists.
- Specialists are often overwhelmed by the number of value-based models on the market.
- Suggested solutions to encourage and facilitate specialist participation include the following:
    - Provide specialists with data on nested bundles to help aid in choosing a particular model.
    - Create a feedback loop that promptly rewards specialists for strong performance.
    - Share longitudinal, provider-based, and episode-based data for all care received under Medicare along with regional and national benchmarks.
    - Allow participation in multiple ACOs.

    - Update attribution logic to include relevant specialists.
    - Provide an advanced payment option regardless of revenue and align model changes with patient preferences and involvement.

For additional details on Ms. Reed's presentation, see the presentation slides (pages 43-51), transcript, and meeting recording (00:39:46-00:58:00).

Following the presentations, Committee members asked questions of the presenters. For more details on the discussion, see the transcript and meeting recording (00:58:07-01:39:04).

Presenters discussed the roles and disciplines essential to achieving care coordination outcomes in APMs and the financial incentives that support these outcomes.

- It is not a specific title or role that is essential; it is the actual work performed (e.g., helping with patient navigation). Rewarding overtime work and providing gratitude with fair compensation are critical. Employee satisfaction is vital to avoid burnout and retain strong workers, which improves an organization's return on investment (ROI).
- The PCP should be at the center of communication about a patient's care to achieve desired care coordination outcomes.
- Financial incentives that reward team members for successes are important, along with receiving gratitude for making a difference in a patient's life. Constructive feedback on performance can be helpful, but negative incentives do not work as well in driving provider behavior.
- The crucial roles of nurses and navigators are underappreciated. These providers can share the burden of care with physicians by helping patients understand their condition, their care, and the actions they should take to achieve better health.
- Financial incentives should be strongly tied to outcomes and distributed to frontline workers.
- The Healthy Hotspotters randomized control trial revealed that not all organizations are the same, and depending on each setting's characteristics, different roles will be more essential to achieving cost savings.

Presenters discussed how to manage and track pharmaceutical-based spending in TCOC models and how to include specialists in managing patient medication selection and adherence.

- Areas that need attention are medication selection, site of service delivery for medication, and patient adherence.
- Including specialists in a patient's care plan conversation is essential. Many models penalize hospitals for readmitting heart failure patients, but there is no incentive for the cardiologist to manage those patients and no clear attribution of the patient to the specialist. The end-stage renal disease and oncology models have demonstrated some success in incorporating specialists in managing a patient's medication selection and adherence.
- Factors that should be considered in addressing the role of pharmaceuticals in TCOC models include designing the right program, selecting the correct medication, negotiating the correct price, ensuring proper adherence, and ultimately preventing the disease from progressing.
- Sometimes specialists act as PCPs, such as OB/GYN doctors for women. Models can incentivize these specialists to drive value-based primary care.

Presenters discussed the characteristics of low- versus high-performing ACOs and how to refine incentives or models to engage lower-performing ACOs.

- ACOs entering APMs that are performing better at baseline had lower spending than their regional average. It became harder for ACOs with higher than regional spending to participate

after an update to the benchmark calculation in 2019 that required ACOs with higher spending to have more significant savings for incentives. Blending of regional benchmarks is recommended at a gradual pace to encourage greater participation from high-spending ACOs.
- The ratchet effect resulted in high-spending ACOs exiting and low-spending ACOs staying in models.
- It is important to remember that health groups taking insurance risks have a potential risk of ruin.

Mr. Meng further discussed the elements that SVUs measure and reward, such as coding accuracy and care management, and shared how rewards are distributed among clinical staff.

- At Stellar Health, individual organizations define their desired actions for incentivizing. The SVU is dynamic and allows for adjustments as frequently as necessary compared with the Physician Fee Schedule (PFS), which is updated only yearly. If providers know the potential earnings up front, they are typically amenable to frequent updates.
- Stellar Health encourages physicians to share roughly 20% of the reward earnings with the staff member or member performing the work. A 20% reward share equates to a staff member earning an extra $300 to $500 per month, which boosts morale and helps to drive the desired clinical behaviors and outcomes. Each medical group, however, can decide the percentage it will share.

Panelists discussed how large organizations can engage specialists to improve cost, quality, and equity, at the same time as saving money.

- The connection between quality and equity is evident whereby each dollar invested in equity improves access, quality of care, and, eventually, cost savings. The reward for investing can often be delayed, but the savings become clear once in motion.
- ACO REACH prepayment dollars can incentivize specialists to drive value-based care. For example, an ACO successfully contracted with skilled nursing rehabilitation and home health agencies to secure payment rates different from Medicare FFS, including a payment withhold and payback for quality and TCOC performance.

Panelists discussed rewarding outcomes-based rather than process-related metrics, rewarding lower-cost drugs, and rewarding patients for healthy behaviors.

- Stellar Health has found that physicians do better when rewarded for patient-level outcomes, such as controlled HbA1c or hypertension, rather than grander population-level health outcomes. Stellar Health's technology tracks the conversion rates and outcomes of the entire patient population and adjusts pricing accordingly.
- The rewards for prescribing generic drugs or other less costly options at Stellar Health are based on the clinical protocol decided by a clinical committee. The incentive is designed to drive the whole group of providers to adhere to the clinical committee's decision.
- The ROI of rewarding patient behavior is not clear. There is not enough evidence to support incentivizing patients.

Panelists discussed using e-consultations to facilitate access to specialists.

- In rural areas, specialists, especially mental health providers, gastroenterologists, and cardiologists, use e-consultations. Broadband access is still a limiting factor, but access to audio-only consults has helped.
- E-solutions have been used to solve problems related to access and timing.
- The MSSP started reimbursing e-consultations to incentivize participation, which is a step in the right direction.

Listening Session 2: Developing a Balanced Portfolio of Performance Measures for PB-TCOC Models

SMEs

- Lisa Schilling, RN, MPH, Chief Quality and Integration Officer, Contra Costa Health
- Robert L. Phillips, MD, MSPH, Executive Director, The Center for Professionalism & Value in Health Care
- Sarah Hudson Scholle, MPH, DrPH, Principal, Leavitt Partners

Previous Submitter

- Barbara L. McAneny, MD, FASCO, Chief Executive Officer, New Mexico Oncology Hematology Consultants and Former President, American Medical Association (*MASON – Making Accountable Sustainable Oncology Networks* proposal)

Jennifer Wiler moderated the listening session with 4 SMEs offering their perspectives on developing a balanced portfolio of performance measures for PB-TCOC models. Full biographies and presentations are available.

Lisa Schilling presented on identifying appropriate performance measures for PB-TCOC clinical performance outcomes.

- Ms. Schilling suggested that organizations with more infrastructure (e.g., Kaiser Permanente, Mercy, Stanford Health Care) are structured to focus on clinical acuity and use sophisticated methods to evaluate population outcomes, care trajectories, and episode treatments.
- Organizations with less defined infrastructure (e.g., Contra Costa Health, Alliance Medical Center), including safety net systems and Federally Qualified Health Centers (FQHCs), are structured to focus on social acuity with clinical interventions.
- Considerations for performance measurement in health organizations include the following:
    - Measure what matters and reduce the overall number of measures.
    - Streamline measures and operational definitions.
    - Establish improvement targets for year-over-year performance.
    - Use real-time data reporting.
- Quality measures should be safe, timely, equitable, effective, efficient, and patient-centered.
- There are several necessary measures currently under development, including patient safety measures for diagnostic reliability, patient-reported experience outcome measures focused on patient trust in health care, and equity measures.
- Provider-level measures should focus on process, intermediate outcomes, and care experience. High-performing and low-performing providers can be positively incentivized or penalized for their performance.
- Group and system-level measures should focus on episodic care and population-based risk-adjusted outcomes. Infrastructure is needed to assess outcomes.
- The group infrastructure should not be so large as to lose the essence of the frontline care provider or so small that the practice is unable to manage in the desired way. The goal is to have the minimal structure necessary to maintain a clinical operating system.
- Components that allow organizations to perform in incentive programs include a large enough population cohort, a data warehouse including clinical and operational data, financial data and cost accounting integration, and structured safety and learning systems to adopt evidence-based practices.

- Considerations for different types of incentives that could help providers participate in PB-TCOC models include the following:
    - Structural incentives can group populations and provide infrastructure over time, particularly for public and private organizations.
    - Pay-for-performance can improve provider-level participation. State-based initiatives already use this type of incentive.
    - APMs and population-based payments are a step in the right direction for TCOC measures. In California, some APMs reduce reliance on relative value unit (RVU)-based FFS payment and instead use per-member-per-month (PMPM) payment. A base encounter payment from the health plan and an up-front PMPM wrap payment from the state are being tested. Organizations will continue to receive PMPM payments, but over time, there will be a shift from RVUs to PMPM payments.

For additional details on Ms. Schilling's presentation, see the presentation slides (pages 2-15), transcript, and meeting recording (00:01:11-00:10:28).

Robert Phillips presented on performance measures and health equity.

- Dr. Phillips shared measurement strategies for PB-TCOC models to support equity, including access, continuity, comprehensiveness, a person-centered primary care measure, and trust.
- A 2021 Primary Care National Academies of Sciences, Engineering, and Medicine (NASEM) report called for measures that are meaningfully parsimonious, fit for purpose, aligned to the internal and external motivations of the actors, and supportive of primary care value functions. A chapter within this report discusses measures aligned with TCOC.
- Metrics that measure the continuity between a PCP and a patient lead to many of the outcomes desired for TCOC. Measures of continuity are associated with lower total cost, fewer hospitalizations and emergency department (ED) visits, less overuse of health care, and reductions in mortality. Continuity is also associated with higher cancer screening, childhood health screenings, vaccinations, medication adherence, early disease diagnosis, and patient and physician satisfaction.
- Although providers must commit to continuity as a requirement of Advanced Primary Care Management (APCM) services, continuity is not used as an outcome measure or an evaluation measure.
- Empirical research validates that long-term continuity between a PCP and a patient is associated with reduced mortality rates.
- There are several ways to incorporate social determinants in benchmarks and risk adjustment. The Area Deprivation Index (ADI) can increase resources to care for underserved patients. These neighborhood-level metrics serve as a proxy for the individual.
- In addition to the social services already available (Supplemental Nutrition Assistance Program [SNAP], Department of Housing and Urban Development [HUD]), the average practice needs between $60 and $93 PMPM to address social needs. FQHCs need approximately $115 PMPM to address social needs.
- It would be helpful to adjust payments and quality scores based on the risks of the populations being served.
- Considerations for accounting for social risks in health payments include the following:
    - Increased funding and payment adjustments are needed for clinicians caring for disadvantaged populations to address social needs.
    - Resources and funding must reach practices and patients.
    - Policy targets must include improved health outcomes and equity, and not be based solely on overall savings.

- A future policy that accounts for social risk in Centers for Medicare & Medicaid Services (CMS) payments should reduce provider burdens, reduce risk adjustment gaming, titrate funding to address social needs, and create accountability for addressing social needs.
- Small ADIs work well because they are not burdensome and can be attached to patients based on addresses. They are reliable, address concerns about the geographic fallacy, and align payments with measures, allowing practices to focus on the patients with the highest risk.
- Adjusting payment, assessing patient social risk, addressing social needs, and improving accountability by allowing providers to evaluate performance based on the patient population's risk create a virtuous cycle.

For additional details on Dr. Phillips' presentation, see the presentation slides (pages 16-25), transcript, and meeting recording (00:10:41-00:20:14).

Barbara McAneny presented findings from different models and proposals, including the Community Oncology Medical Home (COME HOME) Model and the Making Accountable Sustainable Oncology Networks (MASON) proposal submitted to PTAC.

- Dr. McAneny indicated that the CMMI models have led to minimal cost changes and slight quality improvement, and increased consolidation. Consolidation has been a significant driver of cost. Many of the CMMI models (e.g., Bundled Payment for Care Improvement, Kidney Care Choices Model, Primary Care First) have not achieved the goal of improving the quality of care while lowering costs.
- In 2012, Dr. McAneny received funding from CMMI for the COME HOME model. COME HOME was not a payment model; the model was focused on how to operate a practice and keep cancer patients out of the hospital by addressing potential issues early in an office visit. This strategy led to lower costs.
- The COME HOME model informed both the Oncology Care Model, which added data collection requirements and increased providers' risk for the cost of care, and the Enhancing Oncology Model.
- Strategies utilized in the COME HOME model included robust health IT systems; an ongoing relationship with an oncologist to provide continuous, comprehensive care; physician-led team-based care; patient education on how to prevent readmissions; integrated and coordinated care with an automated real-time decision support system to provide symptom management; evidence-based medicine and performance measures; and enhanced access for patients (e.g., late hours, same-day appointments). Practices were offered resources and payment for building infrastructure and engaging in the model's activities.
- Even though the COME HOME model was not intended to save money, the model saved an average of $673 per patient. There was no organizational or provider risk in the model. The model encouraged building patient trust which resulted in savings when end-of-life care was needed.
- Dr. McAneny summarized her thoughts on ACOs, including the following:
    - ACOs have not increased access to primary care.
    - ACOs have minimal savings.
    - Models have led to unintended consequences, including providers cherry-picking patients and avoiding sick patients.
    - Model rewards are inadequate for physicians.
    - ACOs are focused on population health and lack processes to manage urgent needs.
    - ACOs have contributed to increased consolidation.
    - ACOs have also disadvantaged some cancer patients.

- Physicians respond well to receiving tools and payments to deliver quality care. Risk should not be placed on physicians.
- Dr. McAneny summarized her thoughts and recommendations for quality measures, including the following:
    - Access measures should include the days between the first phone call and the appointment and same-day visits. Treating patients when they wish to be treated reduces emergency department (ED) visits. Mid-level practitioners (e.g., nurse practitioners and physician assistants) can support same-day visits.
    - Hospitalization and ED usage are measures of cost. The site of service tends to be the most variable in costs. CMS could consider the site of service to reduce costs.
    - Outcome measures include (1) clinical quality measures (e.g., treating patients with the correct drug or treatment), and (2) patient access and satisfaction measures. Regarding clinical quality measures, academic institutions should be directed to create additional pathways beyond oncology.
- Dr. McAneny asked that CMMI and PTAC reconsider putting physician practices at risk, trusting physicians to know where the waste is, encouraging specialty societies and academic institutions to create additional pathways, reconsidering surgical payment as it is forcing consolidation, conducting pilot programs, and recognizing that one size does not fit all.
    - Dr. McAneny shared recommendations for future CMMI models, such as focusing on specialists and attributing patients by a primary disease, using artificial intelligence (AI) to determine the optimal cost of pathway-driven care, including access to care as a quality measure, removing risk as a requirement and replacing it with accountability, holding physicians accountable only for the care they control, allowing different models for different specialties and communities, and paying more for rural and disadvantaged patients.

For additional details on Dr. McAneny's presentation, see the presentation slides (pages 26-38), transcript, and meeting recording (00:20:18-00:40:39).

Sarah Scholle presented on developing a balanced portfolio of performance measures for PB-TCOC models.

- Dr. Scholle introduced the Alliance for Person-Centered Care, a multi-stakeholder group formed to facilitate the collection and use of patient-reported data in clinical care and quality programs. Alliance members have different perspectives and backgrounds, including people with lived experience and various types of providers and systems. Members believe that person-centered care should be the benchmark for quality, and effective use of patient-reported data can enable person-centered care.
- Benefits of using patient-reported data include shared decision-making aligned to patients' goals; improved patient expectations about their experiences and outcomes; empowered patients who self-monitor during recovery; facilitated communication between physicians and patients; enhanced treatment by embedding patient-reported outcome measures (PROMs) in patients' electronic health records (EHRs); and reduced disparities in access, treatment, and outcomes for previously underserved racial and ethnic groups.
- Integrating patient-reported outcomes into measures used by providers will rely on the support of the entire system. Patients need to feel empowered; clinical teams need to know what to do with data; and tools should be easy to use and equitable. Policy must support these efforts, and investments must show value.
- Dr. Scholle defined different types of patient-reported data and measures.

    - A patient-reported outcome (PRO) is what is being measured (e.g., depression symptoms).
    - A PROM is the tool or instrument used to collect data (e.g., Patient Activation Measure).
    - A patient-reported outcome performance measure (PRO-PM) is how PROs are calculated to determine whether there is improvement in performance (e.g., gains in Patient Activation Measure scores at 12 months).
- The Alliance focuses on patient-reported data on various topics relevant to patients' care (e.g., goals, well-being, relationships, preferences). Patient-reported data include surveys or questions that ask individuals about their beliefs, preferences, experiences, symptoms, functioning, and other topics without a clinician interpreting their responses.
- The Alliance is working on several deliverables related to policy, data and infrastructure, and implementation. Its first report was focused on developing principles to govern the use of patient-reported data. The Alliance also developed a comment letter using these principles and submitted it to CMS in response to questions about the PFS. The principles developed by the Alliance include the following:
    - Start with what matters to patients. Evidence suggests that the use of PROMs and PRO-PMs is impactful. However, using PROMs and PRO-PMs requires changes in attitudes, workflows, infrastructure, care, and outcomes. Patients and families should have leadership roles in defining measurement topics that matter and guide decisions about measures. Patient-reported data should be collected with a clear purpose, and the data should inform clinical care.
    - Rebalance measures by removing legacy measures with lower value and encouraging a focus on value, equity, and innovation. Measures should generate data and insights that impact the outcomes important to patients and clinicians. Measures with the potential to meaningfully address disparities, and the needs of specific groups (e.g., patients with complex needs) should be prioritized.
    - Invest in sustainable implementation and improvement. New measurement approaches require investment, and the resources needed should be considered in the context of the total reporting burden. Measures should be developed with ease of use in mind. Data should be available to patients and clinical teams. Opportunities for learning and improving performance and outcomes are essential.

For additional details on Dr. Scholle's presentation, see the presentation slides (pages 39-52), transcript, and meeting recording (00:40:48-00:55:19).

Following the presentations, Committee members asked questions of the presenters. For more details on the discussion, see the transcript and meeting recording (00:55:20-01:28:51).

Presenters discussed attribution and how to balance patient choice with ensuring that measures are relevant.

- Consideration is needed regarding where data are collected and how they are used. The attribution issue arises because a clinical team member wants to know how a patient's symptoms evolved or what a patient's goals are. That information becomes part of the clinical care plan. Attribution is applied after the fact; instead, it is a part of care.
- One challenge with measurement is having a large enough sample size to understand where performance should be and if benchmarks are met.
- Finding balance depends on the PRO-PM used. If a PRO-PM is focused on value, the measure is about the patient, and attribution is less of a concern. However, if the PRO-PM is focused on the patient-provider relationship, then attribution matters. For example, a driving metric for primary

care is the number of new patients seen per month, which is focused on value and not on the patient-provider relationship. This measure likely will not work for a clinician through attribution, but rather, this might be more meaningful for the system.
- If a system does not have attribution built into its model, measures will assess the patients' ratings of how the system meets their needs and not their relationship with their provider.

Dr. McAneny discussed the roles and integration of nonprocedural specialists in ACOs.
- When a physician sees a cancer patient, they serve as a PCP. Attribution should follow the provider who manages the patient's disease.
- Integrating other specialties into an ACO requires a model redesign. For example, a clinically integrated network assigns quality measures and PMPM management of various activities to the appropriate specialist. The PCP serves as the umpire. The goal is to create a clinically integrated network that pays specialists well for managing expensive chronic diseases.
- The COME HOME model identified when patients would have acute exacerbations and used early intervention through office visits. Early intervention prevented hospitalization and ED visits and reduced costs. Quality measures and interventions should be redirected toward identifying and reducing exacerbations of chronic disease.
- There is currently a shortage of providers. Physicians should receive incentives to perform extra work (e.g., when patients need same-day visits).

Presenters discussed the role of ADI in value-based care, including how it should be used as a marker of social needs.
- CMMI has used ADI for payment adjustment, typically as a global payment. The Maryland TCOC Model used Health Equity Advancement Resource and Transformation (HEART) payments to support practices serving patients with social needs based on ADI. Examples of how practices used the funding include hiring community health workers and social workers and providing food vouchers.
- ADI is vital for population health assessment. For example, patient addresses can be used to define service areas covered by providers.
- ADI also allows providers to understand the social risks of their patient population. For example, providers have mapped their patients with food insecurity to identify neighborhoods needing mobile food delivery or a SNAP-subsidized farmers' market.
- ADI can be used to identify patient quality differences. Providers can understand how their efforts make a difference for specific subpopulations.
- Clinicians, patient care coordinators, and other providers working in underserved areas tend to cost more than providers in other locations, such as cities. Philanthropy has been used to pay patients' bills and address other needs. It is critical to support patients who report a social determinant of health (SDOH). Not providing support to a patient who reports an SDOH erodes trust.
- Infrastructure should be set up, potentially through a bulk payment, to manage SDOHs and other patient needs.
- One presenter noted that it may have been advantageous for CMMI to partner with the Indian Health Service (IHS) or Medicaid when developing the Enhancing Oncology Model or Oncology Care Model.
- Medicare Advantage (MA) plans initially seem attractive to patients because plans have $0 copayments. However, patients then discover services they need are not covered under their MA plan.

- Although academics could be held accountable for creating pathways because of their expertise, one presenter suggested that CMMI work with the Health Resources and Services Administration (HRSA) and others to build networks. Efforts should create collaboration among organizations with social and clinical support without allowing the system to become too large.

Presenters discussed the misalignment between drivers for business success in a medical practice versus drivers of population health.

- Providing physicians with financial incentives should be a best practice; however, placing risk on physicians is not ideal. Risk can drive physicians out of business, leading to burnout and practice abandonment. CMS should consider the physician shortage.
- PROs should be built into dashboards; currently nurses are managing PROs.
- Copayments for coordination of care codes should be removed. Coordination of care saves lives, and patients cannot afford the copay. Chronic care management (CCM), principal care management, and transitional care management should be first-dollar claims (i.e., no deductible or copay).

Presenters discussed the importance of trustworthiness in the health care system.

- Physicians earn patients' trust by showing up consistently and building relationships. The health care system is focused on episodic care, making building trust difficult. Leadership must value and reinforce trust.
- Trust is earned by recognizing patients' cultural issues.
- One presenter recommended asking the community what it needs. One way to do this is to offer career paths to people in the community. For example, offer individuals an entry-level position and help them grow.
- A sense of belonging is critical to trust. Some patients will drive further to receive care from providers they trust. There are opportunities to measure where patients choose to receive care versus where the closest provider is located.
- Longitudinal relationships have a therapeutic effect, and trust is at the heart of the relationship. Measures should align intrinsic motivations (e.g., what the provider thinks is best for the patient) with extrinsic motivations (e.g., what the provider is paid to do). Burnout is the product of misalignment between intrinsic and extrinsic motivation. It is essential to support the capacity to be trustworthy as a clinician.
- Measures should be designed around what patients and families report as important. Programs should be designed to attend to individuals' needs while offering care teams a way to serve patients through a mutually rewarding relationship.

Listening Session 3: Addressing Challenges Regarding Data, Benchmarking, and Risk Adjustment

SMEs

- Robert Saunders, PhD, Senior Research Director, Health Care Transformation, Adjunct Associate Professor and Core Faculty Member, Duke-Margolis Institute for Health Policy, Duke University
- Randall P. Ellis, PhD, Professor, Department of Economics, Boston University
- Aneesh Chopra, MPP, President, CareJourney
- John Supra, MS, Chief Digital Health & Analytics Officer, Value-Based Care Institute, Cone Health

Chinni Pulluru moderated the listening session with 4 SMEs offering their perspectives on addressing challenges related to data, benchmarking, and risk adjustment. Full biographies and presentations are available.

Robert Saunders presented on accelerating the adoption of accountable care by setting benchmarks and determining financial risk.

- Benchmarking has traditionally been a strong predictor of whether organizations join value-based payment (VBP) programs and influences provider participation length in VBP models. Benchmarks are set in many ways and differ across types of organizations.
- Dr. Saunders shared research results examining benchmark impact on VBP.
    - When examining the MSSP savings rate, in performance year (PY) 2016, the probability of achieving shared savings increased as the benchmark increased. However, in PY 2022, there was no association between shared savings and benchmarks, and shared savings were generally higher than in PY 2016. Results were attributed to lessons learned from ACO participation in shared savings over time and worse-performing ACOs leaving the MSSP.
    - A separate study confirmed that organizations with higher benchmarks are more likely to stay in VBP programs.
- Organizations may not participate if the benchmark is unfavorable or challenging to meet, either from being set low initially or rebasing or ratcheting down over time. An unintended consequence of benchmarking is that organizations are micro-sculpting their networks to bring in partners most likely to succeed.
- Safety net organizations may not have a culture of coding, which impacts their risk-adjustment scores and benchmarks.
- Social factors currently incorporated into benchmarks are limited by data availability and mainly include broad geographic factors. A safety net organization in an urban area may not benefit from the current social adjustments to benchmarks.
- VBP participants have felt disadvantaged compared with MA participants because of incentive differences and benchmarking risk-adjustment algorithms, which influence financial sustainability.
- Technical factors that continue improving include:
    - Obtaining SDOH data beyond geographic data.
    - Standardizing the approach for collecting individual-level data to inform social risk data.
    - Using health equity benchmark adjustments to capture the full population health risk.
    - Capturing frailty or seriously ill patients in algorithms to inform benchmarks and risk adjustment.
- Benchmarks are part of the financial equation for many health systems, requiring up-front capital.

For additional details on Dr. Saunders' presentation, see the presentation slides (pages 2-10), transcript, and meeting recording (00:00:49-00:11:23).

Randall Ellis presented on risk adjustment for PB-TCOC models.

- As used in the Marketplace, concurrent risk-adjusted models are preferred in PB-TCOC models because they adjust for insurance plan turnover, unlike the prospective risk-adjustment models currently used in Medicare. Another limitation of prospective risk-adjustment models is the inability to recognize and pay for acute care conditions accurately.

- A risk equalization process, as currently used in the Affordable Care Act (ACA), has the advantage of greater predictability for budgeting without rewarding for upcoding as compared with an add-on or budgeted formula used in MA.
- Risk adjustment should not be viewed as one formula but as a family of formulas that allow for separate incentives, such as targeting primary care in addition to the overall budget goals of the practice or ACO.
- Dr. Ellis uses samples of 60 million commercially insured eligibles in his research, allowing for precision in examining rare diseases. His team developed a system of 2,000 disease groups, which have been used to predict total spending.
- Risk-adjustment formulas should be adjusted regularly. For example, the Netherlands and Germany update their formulas annually.
- To increase participation in PB-TCOC models, economists recommend mandating participation or creating an attractive incentive ("the carrot") for providers while reducing the administrative burden of participating.
- A penalty ("the stick") can be necessary for mistakes or unacceptable behavior, but punishment should not risk the livelihoods of providers.
- ACOs and providers should be rewarded for caring for complex, high-cost patients. The health care system should avoid overpaying for healthy patients and instead focus its resources on complex patients. The Hierarchical Condition Category (HCC) risk-adjustment formula does not reward caring for complex, high-cost patients; rather, it overpays for healthy patients.
- The ACA and the Marketplace have different risk-adjustment formulas in the Medicaid and Massachusetts Health programs. There are separate formulas for ACOs that provide only medical services and for ACOs that offer outpatient and/or inpatient behavioral health services in addition to medical services. Using separate formulas adds complexity, but these formulas have been implemented successfully. Separate risk-adjustment formulas are also used in MA.
- It is critical to move beyond the HCC risk-adjustment system, which has remained unchanged since 2004. Increases in fraud and gaming could be reduced by punishing providers for coding diseases they are not currently treating.
- Dr. Ellis shared the results of different payment formulas across groups of enrollees, clustered according to disease rarity.
    - Both the HCC and the Charleston Comorbidity Index overpay for common diseases and underpay for rare diseases.
    - The Diagnostic Items Classification System and Diagnostic Cost Groups frameworks correct for underpayment for rare diseases and are recommended.

For additional details on Dr. Ellis' presentation, see the presentation slides (pages 11-106), transcript, and meeting recording (00:11:27-00:22:33).

Aneesh Chopra presented on addressing challenges regarding data, benchmarking, and risk adjustment.

- Originating with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, data sharing in health care has been governed around administrative transactions. CMS guides a team that oversees the regulations, as the National Center for Vital Health Statistics advises. This data sharing method is the electronic data interchange (EDI) transactions governance program.
- Adding new requests to an EDI system has been challenging to date. Two high-profile examples illustrate this point. First, CMS sought to address prior authorizations for advanced imaging, requiring physicians to document in the EDI system that their clinical judgments were informed by the literature. When tested, the EDI system could not accommodate this technical need. Second, the Food and Drug Administration wanted medical device identifiers to be available in

EDI data to track safety recalls better. The EDI system was also unable to accommodate this request.

- Under the Health Information Technology for Economic and Clinical Health (HITECH) Act, investments were made in EHRs to collect sharable modern data through a RESTful application programming interface (API).
- There is a need to converge on the following policy objectives:
    - Understand the benefits that insurance companies make available to patients.
    - Collect clinical information to administer programs such as the Enhancing Oncology Model. Currently, there is no mechanism for payers to access clinical data, especially in the United States Core Data for Interoperability (USCDI) framework.
    - Share data using the minimum data necessary principle. Systems need to talk to each other and filter data appropriately.
    - Embed specialty bundles or shadow bundles within TCOC models.
    - Make data available to consumers, as well as the applications and services that help consumers understand it.
- Through the Sync for Social Needs collaborative, Epic Systems made social screeners available, reducing patient burden through Fast Healthcare Interoperability Resources (FHIR)-based data sharing.
- CMS programs such as the Special Supplemental Benefits for the Chronically Ill (SSBCI) may list patients as eligible for the program if the patient has a specific diagnosis (e.g., chronic obstructive pulmonary disease [COPD], diabetes). Computer systems with the capability to read words to understand eligibility requirements are needed.
- M Code Light is an open-sourced data model being made available for those participating in CMS programs.
- The Trusted Exchange Framework and Common Agreement (TEFCA) for population health is an example of bulk FHIR.
- The Veterans Affairs (VA) Under Secretary of Health announced, through the veteran interoperability pledge, that half a dozen health systems can now verify if a person is a veteran.
- The Project Clarity program aims to provide open-source episode bundles to produce reasonable price estimates.
- Aligning patient engagement with new AI tools is needed to help interpret health care data. The Office of the National Coordinator for Health Information Technology (ONC) shared that 93% of newly diagnosed cancer patients access their results through their patient portal before talking to their oncologist. An AI second opinion could assist patients in interpreting their results.

For additional details on Mr. Chopra's presentation, see the presentation slides (pages 107-114), transcript, and meeting recording (00:22:36-00:33:24).

John Supra presented on pathways on the value-based care journey toward open data exchange and shared analytics.

- ACOs or provider groups considering participating in value-based programs face many challenges. To build a data analytics infrastructure for success in value-based care arrangements, the following need consideration:
    - Obtaining different data types, such as clinical data, EHR payer data, program data, and third source data to inform risk adjustment.
    - Combining data types and obtaining regular updates.
    - Processing the data for quality, financial, and operational reporting.
    - Other requirements such as selecting vendors and learning about data systems.

- Applications are needed that allow organizations to understand patient risk, perform risk stratification, attribute patients to various primary care or specialty care providers, support and drive the workflow of care management teams, and engage and communicate with patients. The goal is to build data applications to transform care.
- Establishing a data and analytics infrastructure requires substantial initial and annual financial investment. Organizational costs are weighed against the VBP's potential upside and downside financial arrangements. Paired with analytics investments, the complexity and burden for providers supporting clinical transformations is extensive.
- Progress is evident as CMS, CMMI, and ONC established foundational standards, such as FHIR interoperability resources, and common frameworks to manage data exchange. These are necessary steps to reduce the burden of data infrastructure.
- As standards are being established, timely data access is also critical. Timely use of data, however, still requires expert skills to drive clinical transformation and improve outcomes. Incorporating API-driven access to the CMS data model is essential.
- Alignment can encourage greater participation in risk-based contracts by accelerating the speed at which data are available. Alignment requires shifting toward data system-ready or machine-readable formats.
- Many MSSP and ACO REACH reports were designed for human review. Expanding the file formats supports ACOs in incorporating this information into data applications more efficiently.
- CMS can lead by encouraging public and private investment to drive innovation and success in value-based models at much lower entry and operational costs. The VBP infrastructure has become more complicated, and the costs and efforts required continue to increase.

For additional details on Mr. Supra's presentation, see the presentation slides (pages 115-125), transcript, and meeting recording (00:33:27-00:44:57).

Following the presentations, Committee members asked questions of the presenters. For more details on the discussion, see the transcript and meeting recording (00:45:00-01:29:00).

Presenters discussed how new models for obtaining and integrating data fit into non-Epic workflows.

- The Assistant Secretary for Technology Planning regulated EHRs through the 21st Century Cures Act such that data must be exported with the FHIR standard to enable application access. Clinicians can now download a smart FHIR app and read medical charts from any system.
- The software and modeling created for the diagnostic items risk-adjustment model are posted online as a supplement to Dr. Ellis' Journal of the American Medical Association (JAMA) paper. Health care systems in Belgium and Korea have already implemented this framework.
- Workflows can continually be improved or added because of the standards established by regulatory bodies. In addition to EHRs, other public and private opportunities can develop workflows that are helpful to clinicians and care teams.
- Real-world adoption helps with the demand for government regulations and mandates. User feedback is needed to iterate and improve. Supply-side regulation is high, but demand clarification is low, which results in inadequate implementation and testing. It would be beneficial to enable a real-world implementation to test and validate technologies before releasing them to the public.

Presenters discussed their wishes to achieve meaningful data at the point of care to execute the visions of value-based care and outcomes.

- A more organized demand signal is needed. A standard demand signal for an SDOH risk adjustment would benefit payers, such as defining what constitutes a patient with food insecurity. After a demand signal has been established for an outcome measure, the next step is automation.
- A gap exists in measuring administrative burden in value-based care. A measure of burden is needed if organizations use substantial administrative costs to assess attribution, track the benchmarking trend, identify gaps, and address rising risks.
- The U.S. would benefit from a learning health system to support decision-making. No public-private partnership databases combine clinical and administrative data in the U.S. A learning health system exists in Israel, which produced early COVID-19 treatment outcomes. This lack of infrastructure is the most critical gap in learning how to adopt and scale. In the U.S., there is also a substantial data lag in the MA program.
- Monitoring for unintended consequences while pursuing AI in health care is critical. AI has great potential but can create biases and inequities. An AI model may not understand that lower health care utilization could be associated with an access issue.
- Social drivers of health tools need standardization. The excitement about social drivers of health has resulted in the creation of many tools and increased administrative screening burden. Most clinicians are not trained to screen for social drivers of health and do not want to ask questions without solutions. Provider buy-in will increase when meaningful next steps are available after identification of social drivers of health.
- Medicaid data, which are siloed and not standardized, should be shared across states.
- CMS is implementing restrictions on people taking data out of their own computer systems, significantly impacting researchers.
- Dr. Ellis described his work in Massachusetts using state Medicaid data, which include enrollee census block information. The models have performed well because they capture the lived environment (e.g., pollution, water quality, and food availability). There is also a geographic component in providers selecting patients, underscoring the importance of this data source.
- A leading priority is aligning value-based care models across business lines because many ACOs manage Medicare, MA, and Medicaid models. Quality metrics could be incentivized to achieve this alignment.
- Data sharing needs standardization, and modern data management platforms should be used. Data-to-data point transfers are challenging. Open-sourcing methodologies are also recommended.

Presenters discussed how to lower barriers related to data sharing, as well as potential near-term solutions for CMMI to achieve its goal of 100% participation in PB-TCOC in the next 6 years.

- Data sharing options must be decoupled from participating in payment models associated with downside risk. Physicians can access CMS claims data only to inform their risk-adjustment models if enrolled in an APM. There may be an opportunity for providers to obtain their claims history using the proposed APCM billing code.
- CMS needs to enforce laws on timely communication. CMS requires each hospital in the Medicare program to give doctors admission, discharge, and transfer notices when their patients are admitted to the ED or transferred. Few doctors know this requirement, and there is no enforcement action.
- CMS logic should be open source for every attribution, benchmarking, and trend forecasting model.
- CMS posts the software needed each year for risk adjustment of MA and HCCs, but researchers report a high level of burden in translating and reengineering the SAS code for use.

- Health plans ask beneficiaries if they will allow doctors to coordinate with other providers and health care entities, and the majority of beneficiaries agree to allow coordination. Unfortunately, the interconnections between emergency rooms and hospitals are inefficient. CMS should strive for a communication source that permits greater patient data sharing across health care settings.
- Participating ACOs could remain in the program longer with open-source access to data and logic. CMS could create a toolset with transparent dashboards and share best practices.
- Data are needed to engage with specialty providers. Data on the types of procedures and quality of care specialists provide have been limited to date. In combination with CMS creating shadow bundles, providing granular data on use, cost, and quality would help health systems engage with specialty care.
- One reason participation is low in ACOs is because the savings are generated due to patient selection. Eliminating patient selection in 6 years is an ambitious goal.

Presenters discussed whether large language models (LLM) and AI systems have progressed in capturing meaningful information during patient examinations.

- Care management teams use ambient listening to collect interactions between the care manager and patient. The care interactions are then summarized in a note with instructions for the patient or care team. SDOH screenings can also be translated into discrete fields for tracking, and transcripts are available for verification and editing.
- An AcademyHealth 2024 Health Datapalooza vendor demonstrated how data elements intended for the Enhancing Oncology Model (EOM) will be summarized, mapped, and measured using LLM. These EOM data elements are not currently captured in standard care processes.
- The VA held a half-million-dollar prize competition for ambient dictation and a document summarization tool. Over 200 companies competed, illustrating the interest in this technology.
- A voluntary, self-regulated body has been formed to govern how to minimize risk because these activities are not formally regulated. More information can be found at healthcareAIcommitments.com.
- Dr. Ellis' son is a practicing physician who has begun recording his clinical meetings with patients. He describes that his administrative responsibilities have been greatly simplified. However, his complaint is that the goal of the software is to maximize patient complexity because health plans/ACOs are more greatly compensated if more detail is recorded and coded.
- Ambient listening is being implemented in health systems worldwide, although distribution is uneven. AI can streamline administrative burden, but integrating AI into the care delivery systems is rife with issues. There are many unintended consequences of AI tools and cybersecurity.

Presenters discussed the insights they would like CMMI, CMS, and the Secretary to implement by 2030:

- Implement a simple payment system for all PCPs that reduces administrative burden while maintaining accountability. This approach would mimic European systems, which have straightforward payment systems.
- Predictability remains challenging as many benchmarks and risk-adjustment models change over time. A simple, predictable set of indices is needed.
- The health care system needs data tools that enable health care providers and community benefit organizations to drive outcomes in value-based care.
- Physicians need the ability to learn about the patient prior to a visit. This will contribute to overall longitudinal care improvement. Decoupling data will also be a critical driver of growth.

Public Comment Period

Co-Chair Sinopoli opened the floor for public comments. There were no public commenters.

Committee Discussion

Co-Chair Sinopoli opened the floor to Committee members to reflect on the day's presentations and discussions. The Committee members discussed the topics noted below. For additional details, please see the transcript and meeting recording (1:29:06-1:55:55).

- Adjustments are needed to support socially underserved populations, including the potential for the ADI to allocate more funding to account for risk. Additional funding can be invested in community-based organizations to meet the needs of underserved populations. An integrator in the community could help coordinate these services into a more efficient network.
- CMS should make data easily accessible and understandable for physicians, including decoupling data.
- Patient-reported, longitudinal, and access-related measures need to be considered, developed, implemented, and linked to payment within APMs.
- The skewed nature of Medicare spending is primarily driven by seriously ill individuals and those with chronic complex conditions. The current risk-adjustment system is ineffective because it fails to account for factors such as frailty.
- Due to cumulative fee reductions, CMS has created a less favorable environment for providers to remain in FFS. Although the intent is to encourage providers to transition to value-based care, this shift has been challenging for many providers. Specifically, ACOs are best suited to manage high-risk patients efficiently but have struggled due to benchmarking and risk-adjustment issues.
- Patient and beneficiary involvement in their own care is critical. Incentives such as waiving copayments could help encourage individuals to take greater ownership of their health.
- Long-term patient-provider relationships—whether with a provider or a health care entity—are valuable for patient and provider well-being (e.g., reducing burnout). Additional information is needed regarding how churn affects these relationships and its implications for workforce sustainability.
- Carve-outs for high-cost activities or therapeutics significantly impact total health care costs and can create perverse incentives.
- Identifying current rules and regulations related to data sharing could help identify opportunities for enforcement.
- Although downside risk is an important feature in many existing models, some experts question whether it is necessary for certain types of providers.
- Changes are needed to make value-based models more appealing compared to the current state, such as using financial incentives (e.g., drug margins and Parts B & D) to encourage participation, especially for primary care.
- In future models, access to care and continuity measures could be quality measures.
- ACO benchmarking needs improvement because poorly performing groups are disincentivized from joining ACO programs due to artificially low benchmarks. A low benchmark requires ACOs to perform significantly better to qualify for shared savings, making participation unappealing. Alternatively, the "ratcheting effect" forces high-performing groups to out-do their own past performance. The goal should be to ensure that all groups can succeed and that high-performers continue to benefit from their achievements.
- Despite focusing on making value-based care more appealing while making FFS less attractive, APM rates are declining with the expiration of the APM bonus. This trend does not align with the strategic initiatives for promoting value-based care.

- A tailored pathway for smaller PCP groups or PCP-only groups is needed to encourage greater participation in value-based care.
- Beneficiaries must also have incentives to participate in value-based care. For example, MA plans can offer discounts on copayments and deductibles. ACOs should explore similar options to enhance their competitiveness. Copayments for high-value services, such as mental health care, CCM, and new APCM codes, should be eliminated. This change is achievable using the current rule-making process.
- Collapsing of the site of service payment differential should be accelerated to move services to outpatient hospital departments and hospitals.
- Instead of trying to capture savings from primary care, the focus should be on increasing funding. Primary care is the only specialty that demonstrably enhances health outcomes nationally.
- Currently, there are many SDOH screeners; the industry should work toward standardizing and using one SDOH screener.
- Market consolidation can lead to higher prices and lower quality of care provided. APMs offer a way to address this gap through shared savings.
- It is critical to consider the business and financial success of providers in PB-TCOC models due to an aging population. The financial motivations of providers, however, may not align with the needs of patients and society, such as better patient outcomes, equity, quality of care, and cost control.
- The ACA was designed to enhance health care coverage and promote care. Although the ACA achieved some of its goals, it also led to the unintended consequence of increased complexity requiring more sophisticated data analysis and administrative burden, incentivizing provider consolidation. This consolidation has contributed to rising health care costs and physician burnout. Additionally, improvements in care by providers do not always translate into financial savings for them.
- Medicine is a business, and the drivers of providers' financial success need to be considered when developing reimbursement models for population health.
- Not all visits should be compensated equally. Initial visits require significantly more investment than follow-up visits; however, current payments do not reflect this difference. Payment levels should also ensure that practices are adequately compensated for handling urgent cases, which are less expensive than ED visits.
- Specialists face ongoing challenges in value-based care. While there were discussions about hybrid models combining capitation with FFS, no solid solutions were proposed for creating payment models specifically for specialists. "Nesting solutions" for specialists could be an important topic for future meetings to explore viable strategies in this area.
- Health care data need decoupling. They should be open source rather than proprietary and incorporate PROMs and SDOH information. Additionally, LLMs can enhance data acquisition.
- Primary care should have more compensation.
- There are capacity issues within an antiquated delivery system. Payment models may help to ease capacity issues; however, as providers consolidate, this may create less access and increase costs.
- Immediate actions could include democratizing data and source coding and improving data sharing.
- Simplicity, generous incentives, and care flexibility are critical to enhancing clinician participation and engagement with payment models. Although technical design features in models (e.g., benchmarks, risk adjustment) can improve, these technical improvements are less impactful without a foundation of simplicity and generous incentives.
- The specific recommendations about data from the last session should be in the RTS.

Closing Remarks

Co-Chair Sinopoli and Dr. Wiler announced that this would be their final public meeting as Committee members, since their second terms are ending. They expressed their gratitude for the opportunity to serve on the Committee. Co-Chair Sinopoli adjourned the meeting.

The public meeting adjourned at 3:11 p.m. EDT.

Approved and certified by:

//Lisa Shats//	12/10/2024
_____	_____
Lisa Shats, Designated Federal Officer Physician-Focused Payment Model Technical Advisory Committee	Date