PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

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PUBLIC MEETING

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The Great Hall
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

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Tuesday, March 26, 2024

PTAC MEMBERS PRESENT

LAURAN HARDIN, MSN, FAAN, Co-Chair
ANGELO SINOPOLI, MD, Co-Chair
LINDSAY K. BOTSFORD, MD, MBA
LAWRENCE R. KOSINSKI, MD, MBA
WALTER LIN, MD, MBA
TERRY L. MILLS, JR., MD, MMM
JAMES WALTON, DO, MBA
JENNIFER L. WILER, MD, MBA

PTAC MEMBERS NOT PRESENT

JAY S. FELDSTEIN, DO
JOSHUA M. LIAO, MD, MSc
SOUJANYA PULLURU, MD

STAFF PRESENT

AUDREY McDOWELL, Acting Designated Federal Officer (DFO), Office of the Assistant Secretary for Planning and Evaluation (ASPE)
LISA SHATS*
STEVEN SHEINGOLD, PhD, ASPE

*Present via Zoom

A-G-E-N-D-A

P-R-O-C-E-E-D-I-N-G-S

(9:00 a.m.)

* CO-CHAIR HARDIN: Good morning and welcome to Day 2 of the Physician-Focused Payment Model Technical Advisory Committee, known as PTAC.

* **Welcome and Co-Chair Overview - Developing and Implementing Performance Measures for Population-Based Total Cost of Care (PB-TCOC) Models Day 2**

My name is Lauran Hardin, and I am one of the Co-Chairs of PTAC, along with Angelo Sinopoli.

Yesterday, CMS1 Deputy Administrator and CMMI2 Director Dr. Liz Fowler started our day with opening remarks on how our work fits into the Innovation Center's vision.

We also had several excellent guest presenters share their ideas on opportunities to improve the development and implementation of performance measures for population-based total cost of care models to drive care transformation and improve outcomes and satisfaction.

Today we have a great lineup of

1 Centers for Medicare & Medicaid Services
2 Center for Medicare and Medicaid Innovation

experts participating in an exciting roundtable panel discussion, a listening session, and a panel discussion with CMS leadership. We've worked very hard to include a variety of perspectives throughout this two-day public meeting, including the viewpoints of previous PTAC proposal submitters who addressed relevant issues in their proposed models.

Later this afternoon we will have a public comment period. And we welcome participants, either in person or via telephone, to share a comment. As a reminder, public comments will be limited to three minutes each.

If you have not registered to give an oral public comment but would like to, please email ptacregistration@norc.org by 2:30 p.m. today. Again, that's ptacregistration@norc.org.

Then the Committee will discuss our comments for the report to the Secretary of HHS3 that we will issue on developing and implementing models, performance measures for population-based total cost of care models.

*** PTAC Member Introductions**

Because we might have some new folks online who weren't able to join yesterday, I'd

3 Department of Health and Human Services

like the Committee members to please introduce themselves. Share your name and your organization. If you'd like, you can tell us about the experience you may have with our topic. And I will cue each of you.

So, I'll start.

I'm Lauran Hardin. I'm a nurse and Chief Integration Officer for HC2 strategies. I spent the better part of the last 20 years focused on complex and underserved populations, developing models, and scaling them in multiple environments, as well as being part of the team that started the National Center for Complex Health and Social Needs.

And I'll go next to Angelo.

CO-CHAIR SINOPOLI: Thank you, Lauran.

Angelo Sinopoli. I'm a pulmonary critical care physician. I'm presently the Executive Vice President for Value-Based Care at Cone Health System in North Carolina. Spent most of my career working in large integrated delivery systems, building and managing clinically integrated networks, and enabled companies to help improve their performance.

I'm happy to be here today. I'll turn it over to Jennifer.

DR. WILER: Good morning. I'm Jennifer Wiler, an emergency physician by training. Currently, I'm the Chief Quality Officer at UCHealth Metro, one of the largest health care delivery organizations in Colorado, serving patients in the Rocky Mountain region.

I'm also co-founder of UCHealth CARE Innovation Center where we partner with digital health companies to grow and scale their solutions that improve patient care and outcomes. And a tenured professor at University of Colorado School of Medicine, and former co-developer of an Alternative Payment Model that was reviewed and endorsed by this Committee.

DR. LIN: Good morning. I'm Walter Lin, founder of Generation Clinical Partners. We are a medical practice based in St. Louis dedicated to helping senior living organizations transition into the world of value-based care through more efficient medical care delivery models.

DR. WALTON: Good morning. My name is Jim Walton. I'm a general internist by training. Started my career in Waxahachie, Texas, as a rural doc, and transitioned into community health improvement working for Baylor Health Care System

in Dallas, Texas, developing community health strategies for the system.

Evolved to be the Chief Health Equity Officer and then took over as a CEO of a large physician IPA4 in Dallas, creating an ACO5 that took risk for Medicare, Medicare Advantage, and Medicaid patients, and did that for about 10 years.

Recently retired and now serve as a consultant.

DR. BOTSFORD: Good morning. I'm Lindsay Botsford. I'm a family physician in Houston, Texas.

I, in addition to serving as a PCP6, I am Medical Director with One Medical. We have practices across Texas. Also manage our practices in Houston that are focused on older adults on Medicare where we take full risk, and participate in the ACO REACH7 Program.

I've also been working in the quality space, certified medical quality and quality improvement.

DR. KOSINSKI: Good morning. I'm Dr. Larry Kosinski. I'm a gastroenterologist by

4 Independent Physician Association
5 Accountable Care Organization
6 Primary care provider
7 Realizing Equity, Access, and Community Health

training. I spent my entire career in private practice in suburban Chicago building a large GI[8] practice there.

For the last 10 years I have been involved in value-based care, having founded a company named SonarMD which had its roots in Project Sonar, which was the first PTAC-recommended physician-focused payment model recommended for testing.

I also sit on the governing board of the American Gastroenterological Association, and have been involved with oversight of guidelines and metrics committees.

I'm in my third year on this PTAC Committee.

DR. MILLS: Good morning. I'm Terry Lee Mills. I'm a family physician. I have a 25-year history of implementing and operating CMS pilot innovation projects over several states and several health systems. A long career in practice transformation, operational efficiency, quality improvement.

Most recently I've served as Chief Medical Officer of a regional provider-owned health plan, operating a total cost of care

8 Gastrointestinal

health plan system in the commercial exchange and Medicare Advantage space.

CO-CHAIR HARDIN: And is Josh or Chinni online, Amy? No?

I want to acknowledge our other partners who are unable to join us today, Dr. Jay Feldstein, Dr. Chinni Pulluru, and Dr. Josh Liao who have all contributed significantly to this topic. And we want to thank them for their work in preparation of this meeting.

So, next we're going to go to our first roundtable discussion. And I'm excited to welcome these experts for this panel who are going to share a stakeholder's perspective. It's really important to be hearing directly from our stakeholders at the point of care, and really connected to implementation.

And they will be talking about best practices for measuring, spending, and quality outcomes in total cost of care models.

You can find their full biographies posted on the ASPE PTAC website, along with their slides.

And at this time I'll ask our panelists to go ahead and turn on your video, if you haven't already. And after all four

panelists have been introduced, we'll have plenty of time to ask questions and engage in what we hope will be a very robust dialog today.

So, presenting first we have Dr. Danielle Whitacre, who is the Chief Medical Officer of Bloom Healthcare.

Danielle, please go ahead.

*** Roundtable Panel Discussion: Stakeholder Perspectives on Best Practices for Measuring Spending and Quality Outcomes in PB-TCOC Models**

DR. WHITACRE: Thank you. I'm deeply honored and grateful for the opportunity to address the Committee today.

My name is Danielle Whitacre, and I serve as the Chief Medical Officer of Bloom Healthcare. I have over a decade of experience as a family physician practicing home-based primary care.

I began my career with rural medicine on the eastern plains of Holyoke, Colorado, where I provided comprehensive care in a primary care clinic, nursing home, and a critical access hospital. This experience instilled in me a profound understanding of the challenges in accessing care, a theme that resonates strongly

in my work with homebound patients.

For over 10 years, I have been part of Bloom Healthcare and its predecessor Physician House Calls. Our focus is on delivering in-home primary care. And we take pride in operating our very own high-needs ACO.

We employ our team of approximately 80 nurse practitioners, physician assistants, and physicians to bring primary care directly into our patients' homes.

Our patient population spans across the metro region of Denver and the Front Range, encompassing nine counties. Each of our patients faces significant challenges in leaving their homes, with some even relying on ambulance transport for mobility outside the home.

The majority of our patients, averaging 87 years of age, require varying degrees of assistance with daily activities, from bathing and dressing to managing their finances. While many are elderly, some are younger individuals with disabilities who require in-home primary care to meet their needs.

Seventy percent of our patients reside in congregate care settings, including senior apartments and assisted living facilities, while

the remaining 30 percent live in their private homes.

Notably, we do not serve nursing facilities.

Our overarching mission is to support these high-need individuals in aging in place, fully optimizing their function and well-being.

Next slide, please.

I'd like to talk about our key take-aways of our ACO experience, starting with what went well.

The claims-based high-needs ACO REACH quality metrics are precisely what we need. We are held to three: rate of unplanned hospitalizations; all-cause 30-day readmissions; and my favorite metric, days at home.

I cannot think of better metrics for high-needs populations. They are simple, cause no burden to collect, and they are aligned with what our patients want.

Another element that is right is concurrent risk score. Given the progressive and rapidly changing conditions within a high-needs population, incorporating concurrent risk scoring within the measurement year is crucial.

Claims alignment with quarterly

voluntary alignment:

High-needs patients come to us in dire need of a practice designed to meet those needs. They need to be aligned to us quickly.

Reasonable patient minimum participation allows smaller practices like ours to participate in value-based arrangements.

Primary care capitation and payment allows smaller business to have the funds to operate.

Multiple risk options: Bloom opted for global risk. But not every practice is prepared to do that. Having another option allows more practices to embrace value-based care.

Now, what needs improvement?

We need expanded inclusion criteria. We touch roughly 10,000 patients each year. Less than half of those have straight Medicare. Only 1,400 aligned to our practice currently. We know that many of our patients who don't qualify for the high-needs program should qualify.

Benchmark predictability and stability: Regional benchmarks are more accurate and stable than historical benchmarks due to the ever-changing nature of a high-needs population.

We need a patient survey that is

designed for high-needs patients.

We need faster access to data.

And attribution, we need expanded ability to voluntarily align in the home setting. The rules make it impossible for us to discuss programs like ACO REACH in the patient's home setting. A place where you would be allowed to would be a waiting room. We don't have one of those.

So, thank you. I look forward to our discussion.

CO-CHAIR HARDIN: Thank you so much, Danielle. We really appreciate you being here today.

And next I would like to introduce Dr. Brian Smith, who is a family physician with Versailles Family Medicine.

And, also, Dr. Smith, I am a Kentucky resident as well, so really happy that you're here to join us today.

Please go ahead.

DR. SMITH: I knew you were a Kentucky resident the moment you pronounced Versailles correctly.

CO-CHAIR HARDIN: I'm glad you noticed.

DR. SMITH: So, I've been in Versailles

for about 20 years now. And started Versailles Family Medicine. I employ several nurse practitioners and physician assistants.

We've been in an ACO pretty much since the beginning. Recently we closed our ACO called 2IP, and then joined Evolent out of St. Louis. And we were also working with another ACO out of Florida on some other contracts.

We, Versailles is kind of halfway between Lexington and Frankfort. I was thinking we are a rural area if you're from New York City or Washington. We are a suburban area if you're from the Front Range of Colorado.

And we do pretty much full-scope family medicine, newborns to nursing homes. We don't do any obstetrics, but we do see lots of newborn kids, preemies. We work in three nursing homes, two assisted living facilities, and two memory care facilities.

So, we're pretty busy. And we also we're, my home hospital, which is where I'm speaking to you from now, is a critical access hospital in Versailles.

Next slide. There you go.

So, some of my frustrations -- I guess I probably should have started out with

positives, but I'm just going to go straight into my frustrations -- are I feel like we spend more time, you know, we have our population we'll have people coming and going from, you know, California or Ohio or Michigan moving to our area, and then tracking down their reports on their last colonoscopy or their mammogram.

That seems very challenging, and we spend a lot of time doing that as opposed to talking to our patients about why it's important to get it done or getting them scheduled for the next one.

Another thing I don't quite understand is, if CMS is paying for a mammogram, or a colonoscopy, or an eye exam, why do they not, or maybe they do know that they're done, why can't they tell us that they've been done, and where they were done, and when they were done?

Similarly, vaccines, you know, done in pharmacies -- there’s no consistent reporting for that. And CMS is paying for those vaccines.

So, here in Kentucky we have Kentucky Health Information Exchange, and the vaccines are uploaded to that in an inconsistent fashion from pharmacies it seems like. And then when we are trying to reconcile, you know, if somebody got

pneumonia vaccine and then tracking that down for our quality reports, that can be challenging.

And it should, seems to me, that that should be automatically known and be able to be fed into us as opposed to us feeding it up to CMS.

Similarly, like with a microalbumin being done at Quest or an A1C being done, my understanding is that those are reported. And even the range is reported. So, I don't know why all that information has to come from us as opposed to going from the lab to, you know, a national clearinghouse and then down to us if it's done outside of our office, I guess.

So, and then one of the other things that's getting frustrating is the CPT29 codes. And there seems to be a variety of between Medicare, Medicaid, and Medicare replacement products. They seem to want to collect the data in different ways. And so, we're having to report, or they would like us to report, you know, some people want us to do CPT2 codes and some people want us to do ECQM10 reporting.

And, you know, that not being

9 Current Procedural Terminology
10 Electronic clinical quality measurement

consistent is burdensome.

And then, you know, the last statement I think is self-evidentiary, the things that we can control and, like, directly in our office, like whether a test was done or not, whether they were, a patient was referred or not. That seems more fair to judge us and pay us by as opposed to if the patient went and got something done, or improved their A1C, or you know, lost weight or whatever. It's hard, I think, to judge clinicians based on those types of outcomes.

That's all.

CO-CHAIR HARDIN: Thank you so much, Brian.

And just for the Committee to be aware, we will have time for you to ask questions after all four presentations are done. So, please begin gathering these for the presenters.

So, next we are excited to have Dr. Adrian Hernandez, who is the Executive Director of Duke Clinical Research Institute and Vice Dean at the Duke University School of Medicine.

Please go ahead, Adrian.

DR. HERNANDEZ: All right. Thanks for having me here.

So, I'm a practicing cardiologist.

Actually grew up in Texas, so it's actually good to see some of the members, where they're from and what they're doing. And I focus clinically in heart failure. And over the last nearly 25 years, I have often said as heart failure goes, so does America.

And the reason I say that is that it's an example of a major chronic health condition that's a huge public health problem. There's been a lot of attention in terms of improving quality of care, especially as we have new evidence in terms of how to do so.

And also, it's important in terms of how we improve health not only around preventing mortality or preventing admissions to hospital, but actually improving people's health status.

Over the years, I have had the privilege of overseeing quality of care at the Duke Heart Center, as well as leading quality improvement initiatives across the U.S.

In my current role, I have two perspectives, not only as a practicing cardiologist, but also overseeing large clinical research institutes where we work across the U.S. and, actually, around the world, especially around improving the health of people across

different health conditions and different health care settings in the U.S.

And I also see this through the lens of what we do locally, meaning locally at Duke, Durham, as well as North Carolina. And often what we are challenged to do is that we're really trying to improve a person's day every day. And we're trying to do that every day everywhere.

And so, if you think about where we're aiming to go for in terms of aligning our systems of incentives, how can we do so in a way that actually honors what we need to do for patients, which is when they come in and ask a question, "Will I be better off tomorrow?" or "Will I have better days ahead?" how can we answer that with clear direction in terms of where they are now and what we need to do to improve so that they actually have better days ahead?

And so, this graph actually highlights all the different places we get to work with, so-called look under the hood and seeing what is easy, what is hard, and what do we need to do next.

If you go to the next slide, I'll highlight some things that we've learned over the years. And there's certainly opportunities and

challenges.

We do spend a lot of time in research in terms of developing patient-reported health outcomes that are actually designed to actually understand the benefits or risk of a therapy: a medical product or a strategy of care.

Those patient-reported outcomes have been designed to have -- to ensure that they're valid measures, that they mean what they are intended to do, they're responsive to an action. And that action is clinically meaningful, either from a patient perspective or a clinician perspective.

There's also been increasing interest in using patient preferences for our consideration. And so, how do we do that also in health care delivery as people have different perspectives and actually may have different things that we need to do to improve their overall health and to improve population health?

And there's a ton of data in terms of that we generate for discovery for understanding benefits and needs in terms of what are the gaps in terms of patients' health status? And then how can we address those gaps in terms of both improving precision health, how we action on an

individual patient, but collectively how we improve population health so everyone has so-called better days ahead.

From the health system perspective, there are several challenges. And while the research world can often generate data that shows benefits or risk of different strategies of care for medical products, doing so in an integrated fashion of measuring, and reporting, and actioning on patient-reported outcomes to accelerate either prevention, diagnosis, and treatment can be a challenge administratively.

There are literally thousands of patient-reported outcomes that one can choose. They may have different characteristics that may be operationally feasible or operationally valid in certain settings. But there are definitely some that can be clear prognostic measures, actionable measures, and actually guide us in terms of what may be needed to improve care.

And this can also address both the benefits and safety, and actually improve the overall patient experience and population health.

And so, it is the challenge of these diversity of measures and the complexity they have, but we're now, like, in an era where things

can be done in a more digital way. Doing things where we meet the patient before they come into clinic or to the hospital.

Another real challenge is how do we get rewarded from a health care system, either publicly or financially so we are considered, these incentives are aligned with adding the burden that may come with it so we can realize the total benefit.

And because it is true a lot of these measures have been around for a while, many decades in fact, they are rarely reimbursed or rewarded. And so, I think the opportunity is for sure to address the needs for precision payment models, developing new treatment paradigms that essentially focus on and incentivize better days at home or home time.

And then also ensure that we, whenever we have a strategy of care or use of medical products or improving quality of care, that we're facilitating a long-term gain in terms of total benefits of healthy days at home.

And then, also, ensuring we're closing inequities that may exist as well, doing so, as well as underscoring what's valuable population health.

So, appreciate the opportunity here. I look forward to the discussion.

Thank you.

CO-CHAIR HARDIN: Thank you so much, Adrian. I really appreciate your perspective.

And next we are excited to have Dr. Moon Leung, who is the Senior Vice President and Chief Informatics Officer of SCAN Health Plan.

Please go ahead.

DR. LEUNG: Good morning. Thank you for giving me the opportunity to participate in this discussion today

So, my name is Moon Leung. I am the Chief Informatics Officer at SCAN. The team and I providing the informatics function to support all business, as well as quality improvement at SCAN.

SCAN's mission is keeping seniors healthy and independent. So, SCAN was founded by seniors, for seniors in 1977. We were originally in Southern California, but now expanded into four additional states where now we are serving about 287,000 Medicare members and contracted with over 30,000 of the providers.

So, in the SCAN Health Plan size, we tried to evolve the portfolio of the product to

serve all different types of Medicare beneficiary. So, from the traditional MAPD11 to special needs plan. And this year we just launched a PACE12 program, as well as a program that's providing mobile care to the homeless senior.

You can go to the next page.

So, in the first one, as I kind of mentioned about, I have been involved in the value-based model, as well as the incentive program, providing incentive program after the days which I was in the commercial plan.

So, I believe it is a value-based model with sufficient incentive program to kind of incentivize the health care quality or have the best outcome in terms of, like, giving the flexibility for the provider to manage the care, as well as motivating them to improve the quality.

So, in terms of the success for the incentive program, it has to be transparent. And then the measure set needs to be balanced to including all aspects of the care, ranging from some of the preventive service, to patient experience, and then to the clinical outcome.

11 Medicare Advantage Prescription Drug plan
12 Program of All-Inclusive Care for the Elderly

So, sometimes we want to incentivize the different achievements, not include just the performance. So, so we have developed a program to incentivize three aspects of the care:

One is the performance, which is meeting or exceeding a target level;

Or the improvement, which is incentivize the year over year improvement;

And the excellence, so we want to also award the best performers and recognize them.

And then in terms of, like, the measure sets, I think we hear it a lot from the provider that the patient is different, the patient is sicker. So, we try to do as much as possible to have all the measures be case-mix-adjusted.

We can go to the next page.

So, some of the measures that I want to kind of mention that we will discuss that in the following discussion is we find there's, like, a true measure of the access to primary care and specialty care, is this from the patient experience perspective, or actually using the primary data to measure those? Have highly correlated with the lower utilization of the acute utilization by the year and

hospitalization.

So, we're really encouraging they include those kind of measures.

We also have, like, started to measure, something we call, like, an access-related never event. Like, for example, if the patient has a new diagnosis of cancer, it shouldn't take, like, more than 14 days to get an appointment for oncology. So, we want to kind of measure that, what the provider provides a partner who can provide those services right away.

In terms of the health equity, both CMS and us, we want to promote the health equity. One thing is the health equity is not the income or the disability. So, in our own study -- we find this is high correlation between the payer of the patient, and the provider language, and the outcome. If the provider and the patient speak the same language, the outcomes both on utilization and the quality measure are better.

But on the other hand, if they are not speaking the same language, the outcomes are worse.

And go to the next page. Oh, okay.

So, yeah, I think it's, like, the

other side is the mental, mental care, mental health care also. So, we also look at the mental health care measure. And they are also highly correlated with the utilization. So, by controlling mental health care, we also have on the medical utilization also.

That's it.

CO-CHAIR HARDIN: Thank you so much, Moon.

All of these presentations were very interesting. And I'm really excited to have the diversity of perspectives here with people at the point of care actually implementing this, as well as looking at this from a research and design standpoint across multiple settings.

So, at this time we're going to ask questions. And Committee members, if you have a question, please tip your name tag up. And we'll go through each presenter getting a response to the questions.

Just for the sake of time, if you can keep your responses to a few minutes. We do really want to hear the depth of your understanding, though, so please feel free to also play off each other if you hear something interesting in what one of the other presenters

has said.

So, I'm going to start off with one question to get everybody going.

So, are there gaps that exist between what is currently being measured and the types of performance measures that would be most meaningful for providers and patients of caregivers? And what are those gaps?

And we'll start with Adrian.

DR. HERNANDEZ: Yes. I'll say that there are two kind of big buckets here. So, if you consider a patient's perspective, one of the things that they often comment about is time at home.

And so, we're not necessarily focused on that. And so, yes, that's something can be measurable, it can be actionable. And also can have at least some idea in terms of what we're doing as a health care system in terms of providing the supportive services that actually may be better for transitioning patients from hospital to home. And, also, ensuring that they have healthy days at home.

The other thing is more specific. For certain conditions, and I'll use heart as an example, there is a wealth of data in terms of

health status measures, such as the Kansas City cardiomyopathy questionnaire. It's prognostically important. It's meaningful for our patient's perspective, as well as clinicians. And it's actionable.

It's actually feasible in a research setting. Yet, in a health care setting, it may be more administratively complex. But as things are evolving where we're actually engaging with patients before they come into clinics, asking them information such as their insurance, we should also be able to tailor our engagement to ask more information that would guide their visit experience and help us focus on what their clinical needs are.

And certain domains, and there are multiple across many different chronic health conditions, where there are patient-reported outcomes and health status measures that can pass the test and be easily implemented. And we should do so.

CO-CHAIR HARDIN: And, Adrian, can you speak a little bit more, you mentioned engaging patients before they come into clinics. How is that being done best on a national level?

DR. HERNANDEZ: Yeah. Well, I'd say

it's highly variable. So, but, and it goes in waves.

And so, as people have concerns about, say, mental health, then that's a, say, for example, a common measure that was actually engaging patients before they came in to see if they had any mental health concerns, or using structure measures such as a PHQ13-9.

And so, that's an example that could be done that helps guide us in terms of what we may have missed, or what someone may not necessarily be comfortable saying in clinic. And we should be able to integrate that.

And then there are some examples where in disease-specific areas for which we're getting information before they come into clinics to help guide us in terms of what's most important for the patient and their family.

CO-CHAIR HARDIN: Thank you so much.

Let's go next to Danielle.

DR. WHITACRE: Yes, thank you.

Yeah, there are, there are definitely, my, you know, my patients would say there are definitely areas of opportunity. I really hesitate to create more things to measure to try

13 Patient health questionnaire

to, to try to address things like gaps in care.

And I said in my introduction, the high-needs ACO metrics that we're held to really encompass, you know, the things that matter to patients. And looking, looking at the individual patient and figuring out how to keep them at, you know, how to increase their days at home, how to, how to, you know, avoid hospitalizations and unnecessary send-outs to the emergency room.

We need the flexibility to be able to decide what means we take with our patients to get that done. So, so yes, when we look at, when we ask our patients if there are gaps in care, they definitely will have areas of opportunity they'd like us to look at. During transitions, you know, having health care professionals collaborate more between different, different settings.

But looking at, you know, things to measure to improve that really, you know, really makes it difficult and burdensome on, on providers.

CO-CHAIR HARDIN: That's very helpful.

Moon, what would you say?

DR. LEUNG: Yeah. I was saying it's the mental health kind of measure that Dr.

Hernandez kind of mentioned about. Like, for example, we start to measure whether the provider is doing the PHQ-9, or to the having the visit, as well as the provider have the follow-up visit, or when the member has the mental health-related admission.

So, the other thing is I like what Dr. Hernandez kind of mentioned about, like health status. But one of the challenges when we kind of measure that performance measure in our setting, because there's a lot of patients that's not kind of necessarily coming to the, to the health plan or maybe not even coming to the office all the time, so we all rely on sending them the survey or calling them to fill the questionnaire.

So, sometimes the non-respond biases could be quite unusual when we kind of tie this to the performance kind of measure. So, I would like to kind of hear what others thought about what they are doing what can reduce that bias.

CO-CHAIR HARDIN: That's great. Thank you.

And, Brian, how would you answer?

You are muted right now.

DR. SMITH: You unmuted before and

muted me back.

But, all right, I think the clinical measures are pretty robust that we currently are required to report. I can't find any, you know, gap there. I mean, I think it's a little frustrating.

You know, you've got an 85-year-old, and their blood pressure is 142/92, and that's out of range. But then I try to give them an additional blood pressure medicine, and then they're in the ER for a syncopal event.

You know, so, like as opposed to, like, the blood pressure the last office visit may be average of the year, or, you know, the guidelines I think for older people -- and I'm sure Dr. Hernandez knows this better than I do -- it's a little bit loosier goosier for systolic and diastolic blood pressure control. And so that can be a little bit frustrating from the clinical gap standpoint.

From a patient-oriented standpoint, you know, we have students, and what I tell them is the patients come into an appointment with an agenda. And I come into an appointment with an agenda. And my agenda very rarely matches that patient's agenda.

I want them to get a mammogram, and a colonoscopy, and their lung cancer screening done, and lose weight, and take their medicines appropriately, or just fill their medicines. And they're coming in and, you know, somebody in their family just died, and they want, you know, something to help them sleep and get through this tough part in their life.

But then their blood pressure is up because they're stressed out. And so what am I supposed to do?

So, I think an interesting patient measure would be, you know, not doctor-patient communication necessarily, and that I explain what each medicine was for, and why I'm ordering a colonoscopy but, you know, something more general like where your goals of care match. Like, the reason why you came to this appointment, was that satisfac -- were you satisfied with the outcome of the appointment?

And then I think to address something Moon had mentioned, I think, you know, if there's a way to get us to -- and I don't mean us, I mean you because I've got enough to do -- a way to get the patient the survey, like, on their way out the door almost, instead of, you know, a week

later or a couple weeks later.

You know, if it's, you know you see all these advertisements these days about text communications. And, you know, I'm sure that's not HIPAA14 compliant and stuff. But I would imagine there's a way to do that, you know, where you're getting that, you're getting an answer closer to the time of incident as opposed to I don't even remember what I did last weekend, let alone what I did at the doctor's appointment last week.

CO-CHAIR HARDIN: Some really key points.

So, I'm going to put that out to the group. So, Adrian, and the rest of the group, are you seeing any best practices in getting that real-time patient-reported outcome or perspective data that you would share?

DR. HERNANDEZ: Yeah. So, and that's also relevant to Moon's comments. I mean, we do have to make things as super easy for patients or caregivers to report into, because otherwise for patient-reported outcomes otherwise they, there will be a bias sample. And so that wouldn't give the perspective that we want.

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The second thing, actually, we need to close a loop in terms of do something with it. So, where I've seen best practices is actually centered to someone's practice, patients understand, like, hey, we really care about X, and let's just say heart failure. To help us follow this to ensure that we're doing, helping you over the next six months, periodically we're going to ask you about this. And this will help us understand what, how you're doing, how is your journey, are we going in the right direction?

And, so, at least they know that, hey, if I do this, actually there's going to be something that I report back that will be helpful here. And maybe there's even a carrot, because if you're doing really well, we may not actually make you come in. Because coming in isn't necessarily always a benefit, having to deal with traffic or parking.

But if you're not doing well, then we want to contact you to see how we can get you better.

And so, that at least, you know, makes sure that patients understand these, say, health status measures, are meaningful. There are going to be actions. And it's not just something that

we're reporting into the government, or our corporate offices, or our payer; that this is going to be something meaningful.

Same thing happens in cancer for certain areas, as well as mental health as noted earlier.

DR. LEUNG: Yeah, one point. Go ahead. Sorry.

CO-CHAIR HARDIN: Go ahead, Danielle.

DR. WHITACRE: All right. Yeah, I was going to ask Dr. Hernandez, has there been, has there been work with determining how best to obtain patient feedback in high-needs populations?

You know, I really worry that the standards CAHPS15 survey with 60 questions, with a high-needs population where 65 percent have cognitive impairment, it's, it's not meaningful. And our CAHPS surveys, the response rate is so low, so we haven't been able to figure out how to use it for, for anything. It has not been meaningful for our practice.

DR. HERNANDEZ: Yeah. And I think that's where, like, you know, the idea that, like, we have to have these things tailored.

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Unfortunately, as everyone knows here, one size does not fit all. And so we have to meet people where they're at.

Also, I consider how we're engaging others that are around the patient in terms of proxies or caregivers.

And then also, like, for those who aren't able to, say, you know, do something for example digitally, how do we do something that's, you know, for them in the waiting room or for them by telephone? And so, you know, we've got to do things in a way that's going to meet the person where they're at.

And also, I think, for your other point, the burden. Like, I have a visceral reaction to anything that's 60 questions. And so, and there are ways for us to think about easy measures that, you know, people can do, you know, visual analog scales. It's not perfect but does it give you directionality here?

And on average are we doing something better? Have we made sure that that person's experience and their health is doing better, going the right way?

DR. WHITACRE: And I think to Dr. Smith's point, I mean, sometimes our agendas are

different. And so what you want at the end of the day is, to me, something like a net promoter score. Like, would you recommend your provider to somebody else?

And I don't know. You know, that might be too loose for value. But I think it does give us some information. Right now I get nothing from the patient experience survey, unfortunately. But I have a different population than this.

CO-CHAIR HARDIN: Thank you.

DR. LEUNG: So, a couple things. Like I think we're always trying to do, like, we're trying to shorten the survey, instead of 60 questions, we're trying to make it like a short survey. Depends on what you want to measure at that time. So, we're trying to, like, orderly set it out so we can measure the things kind of like consistently.

So, I want to also, like, comment on some of the things that Dr. Smith kind of mentioned out.

In terms of, like, the patient, what matters for the patient, I think it is some age stuff for any system measurement as you do your developing is going to kind of help. Because

we're also seeing some providers, they have implemented, like, they call it a "my story." So, every single patient they have, they are asking them, what is their story? Because it is trying to measure different people, their motivation is different.

Some patient is, the motivation is going to the daughter's wedding, so they can improve their health. Some people it is going to travel. So, the motivation is different.

So, I think it is one of those type of measures like an age kind of friendly type of measure.

The other thing I want to kind of mention is, like, I know CAHPS survey is not good for Brian. But I have seen some of the providers using some HIPAA compliant app that patients installed in the mobile phone. They can get those quickly, respond after the visit, as well as the provider can do a follow-up with the patient using the app, which is HIPAA compliant.

So, more models available. I think we should try and look at that.

CO-CHAIR HARDIN: That's really helpful.

Go ahead.

DR. SMITH: One other thing. And this has to do with technology, I guess, and, you know, rural and underserved.

We have a lot of patients with either poor internet or no internet connection, or a flip phone. And right now they're being punished because I'm being punished via telehealth with reduced reimbursement if I can't do a video chat with them and not just a phone call chat.

And, you know, that's, I mean it's almost that's the opposite of equity, I would say. And so that, you know, from a technology, just goes around the technology standpoint there. I think I wanted to throw that in.

CO-CHAIR HARDIN: That's really helpful. We're very interested as well in hearing very specifically about the challenges in rural related to measures and the policy opportunity there.

Danielle, did you want to add anything related to your access?

DR. WHITACRE: I'm sorry, my internet had a pause. I didn't hear the question.

CO-CHAIR HARDIN: We're very interested in the rural perspective about barriers and also policy opportunities related to that. And when

Brian was speaking about the telehealth and, like, the broadband access issues, wondering how that's impacting your intersection with clients, and recommendations?

DR. WHITACRE: Yeah. Home-based primary care has a population that where telehealth doesn't, isn't a possibility. Not because there isn't access to internet in metropolitan areas. There is. But because our patients are cognitively impaired, and they can't use a smartphone or a smart device.

We do, we have created some workflows to assist in that in cases where it is an on-demand service. So, we're deploying staff that essentially act as a telepresenter for, you know, to connect with the provider who's, you know, sitting at their home so that, you know, the staff can be deployed in different regions to be able to access that.

So, but yeah, there's technology issues, but there's also cognitive impairment that you have to keep in mind, and the fact that a lot of our patients just aren't able to use those technologies.

CO-CHAIR HARDIN: That's very helpful.

So, there's another question. And,

actually, I'll go to Jen next.

DR. WILER: Thank you so much for being with us today. I've already learned so much.

I actually have two questions.

My first question is I think focused at Drs. Whitacre and Smith. I'm curious how much of your total practice costs are dedicated to data collection, meaning getting information to make clinical decisions?

So, we've heard a little bit about the having to manually, the challenges related to manually collecting information that's outside of the practice, person-to-person verbal collection of data. So, that's my first question, what would you estimate is the total cost to your practice for that?

DR. SMITH: Significant. I mean, I think the other, the trick there you said to make clinical decisions, and I think the problem is that I, if I have a gap in data that I, you know, the patient I know had a CT16 done, you know, two months ago at a different hospital. And they think it showed something that needed to be repeated, but they're not sure what.

Then, you know, to make that, then I'm

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going to just order another CT. So, it's going to increase the cost as opposed to, you know, me having one of my staff track it down.

I employ three people in case management out of a staff of 26. And one of their chief things is to retrieve records from outside hospitals that I'm not integrated with, or other doctors' offices so that I have that information on hand.

So, it's, I mean, it's at least, you know, outside of provider expense time, I would say it's at least 10 percent of my employees spend time collecting information, or spend 10 percent of the time collecting information, whether that be one employee, you know, two employees out of 20 doing it full time or, you know, 20 employees doing it 10 percent of their time.

DR. WHITACRE: Yeah, and I think with a high-needs population and with metrics that are absolutely claims-based, you know, I don't have the burden for my performance metrics.

That being said, there, there are -- there's opportunity that I think, you know, we, we could utilize more resources. But I think for many small practices, you're not going to --

we're missing an opportunity to take a look at some of the data that's given to us through the ACO REACH program. We do get claims data.

The data that we get, it takes a data analyst to even know what you're looking at. And so we, we have, you know, we've been in a part of this value-based program for a few years now, and so we finally figured out with the data analysts how, how to look at the data. But we, you know, there's definitely insights we could be getting but aren't currently because we don't have the staffing and the resources to really crunch these numbers.

I know there are vendors out there. But we're, I mean, we've talked to people that have quoted us, you know, over $100,000 a year to crunch numbers. It's just not, it's just not feasible.

And I think, you know, I think that, you know, through looking at a value-based model and you're providing your participants with claims-based data, make it, make it understandable. I mean, it seems like, it seems like instead of having each individual practice hire vendors or hire their own staff to crunch numbers to find valuable insights into

utilization, seems, seems a little backward.

Seems like, it seems like there could be a way to present it in a way that's more useable.

I'll stop there.

DR. WILER: Yeah, thank you. That actually tees up into my second question.

So, again, I think I'll start with Drs. Whitacre and Smith.

First of all, again I just want to acknowledge, thank you so much for what you do. This Committee had a chance to focus just on rural care at one of our last meetings. And not only are you looking at vulnerable patients, you are in resource-poor environments and, you know, you're choosing to participate in programs that take on full risk.

I mean, it's really this trifecta that I think you all have a really important special voice to share about not only what you're doing and why you chose to do it.

So, that leads into my question. And the reason I asked the first question was really around they're not hidden costs, they're actual practice costs that are important to delivering high-quality care, which is the focus of our

discussion today. But they're more indirect costs as opposed potentially to direct costs.

And, you know, you're quoting double digit percent of your total spend dedicated to doing this important work.

So, my question for you all is, you know, this Committee thinks about incentives, financial incentives. Can you talk to us about where are there opportunities to improve what you're doing through incentives? What would those look like? What, what would make your practice better from a financial incentive perspective? Or what would incent your colleagues to do more of what you're doing?

DR. SMITH: I had a radical solution years ago, and it will never happen. But it was to, you pay the specialists when they send us their consult notes, and that's when they get their payment. And I think we'd get 100 percent of our consult notes in that case.

Certainly could be extended to hospital discharge summaries, and patient needs, and imaging done in hospitals.

Right now I don't -- I see all of the -- I mean, of course, I'm a primary care physician so I don't know what outreaches CMS is

doing to specialists and to hospitals to force them or encourage them to cooperate and send us more data.

And it's, you know, and then sometimes it's, you know, when it does get turned on, it's I'm getting, you know, glucose measurements four times a day on an inpatient at a neighboring hospital that happens to be a patient of mine, but I don't get their discharge summary.

You know, and so it's I don't -- I think the incentives have to come at them. I feel like, you know, we're doing as much as we can. And I think, you know, you know what the problem is at least. You think patients, you know, well, I went to X, Y, and Z hospital so I'm going to follow up with the doctor that works for that X, Y, and Z hospital because they're going to have an integrated health record with what happened in that hospitalization .

But I think hospitals lose track of, you know, I don't know the exact statistics but I think it's, you know, we provide 75 percent of the care, and they spend 75 percent of the money or, you know, something along those lines. And that's so I think it has to come from you all at, directed towards the specialists and the

hospitals.

DR. WHITACRE: I agree with what you're saying, Dr. Smith. And transitions of care are particularly problematic. And, you know, I think you highlighted some of, some of the dropped balls between those transitions.

I think with the ACO REACH program, we do have the ability to create benefit enhancements. And I think this is, it's an area of opportunity that we, we started to explore. But it's really hard to figure out the incentives for our preferred providers without the data to back it up.

And so, we get, you know, we get our performance data, but it's totally aggregated. And so, I don't have specific patient-level data to know, like, which of my, you know, SNFs17 are doing a better job.

So, I think there are opportunities within the ACO REACH program now to allow us ability to incentivize those that we're working with that are taking care of our patients well, and incentivize for the good work, the good transitions of care, you know, better outcomes with, you know, home health and, you know,

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shorter lengths of stay in the hospital, whatnot.

There are opportunities, but without the data to be able to pinpoint what teams and, you know, outside entities are doing a good job for us it, it hamstrings us to create and design incentive programs for those partners that will make sense. And that they'll buy into and, like, you know, be able to do the work.

CO-CHAIR HARDIN: That's really helpful.

Walter.

DR. LIN: I wanted to add my thanks to our panelists for just a really informative discussion. This is, I have two questions actually. One for Danielle about her practice specifically, and then the second one more for the broader panel.

So, Dr. Whitacre, you mentioned maybe 12 to 15 percent of your 10,000 patients in Bloom are part of the high-needs ACO. My question is, are the remaining 85-ish percent of your patients in the value-base program, and if not, do you feel like they receive kind of different care than those in the high-needs ACO?

DR. WHITACRE: Yes, I'm really glad you asked me that. I can say because of the ACO

we've been able to create, even though we have 1,400 in our ACO currently, our census is about 6,500 at any given time.

Right now all of our patients are receiving the benefit of that interdisciplinary care team. So even, you know, we don't, currently we're able to do that. You know, we don't discriminate because of the payer.

So, you know, we've got a really robust team of social workers, nurse care managers, you know, pharmacists that are supporting our providers out in the field and helping with transitions of care, you know, helping collaborate with our home health organizations and SNFs that are taking care of our patients. And that wouldn't be possible without ACO REACH.

In effect though, the other payers that we're working with are benefitting from ACO REACH. So I just, I want to emphasize that many people are benefitting, many of our patients are benefitting from ACO REACH even when they're not in the program. Not to say that that's right, but it's the reality.

DR. LIN: Thank you for that. And actually the second question is both for you and

the rest of the panel. So we've heard a lot about the importance about the interdisciplinary team. You just mentioned it as well. That is, for your population. We've heard it from different talents in this session and in prior sessions.

And yesterday one of our experts mentioned the importance of a balanced portfolio of performance measurements in value-based programs that includes measurement of care integration of care provided by the interdisciplinary team. And my question is, do you have a good way of measuring that, how do you measure interdisciplinary team care that's as effective?

DR. HERNANDEZ: I'll chime in and say, you know, I think that's a really hard concept to measure directly. And for couple a reasons, you know.

One, for different areas, it may be more difficult in terms of access to different team members. Second thing is that, how teams are formed also may be different depending on the health condition or health area.

And then the third thing is that, there may be, I'll just say, different successful

models are tailored to different communities. And so, it has a variety of challenges. Even if the, you know, we have demonstrated that that of practice or health care model is highly successful, it poses a host of challenges in my view that is highly valuable. So that's a real conundrum. I look forward to the magic answers that others may have.

DR. SMITH: A proxy for it could be CCM18 billing. I don't know if everybody even does that though, but that's, I mean, that's how I fund my, you know, interdisciplinary team is through the billing that we're allowed to do now for CCM.

But I agree, it's, I mean, it's imprecise to say the least. But that would be the only way I could think of that's already being done to measure that.

DR. WHITACRE: I think in an indirect way, I think within, like within our practice, for example, we impanel our patients to team. So we know that, you know, we've got multiple interdisciplinary care teams.

So if we had patient level data that we could, you know, because we impanel, we know

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which teams are doing things better than their peers. And so, we could pinpoint top performing providers, top performing teams. And in doing so, we might be able to find successful strategies that those teams are employing and maybe try, attempt to replicate that.

It also could help us determine areas of necessary improvement as well if we see a team not as effective as another team. So I think there are ways within our practice, anyway, that if we had the data to back it up.

And currently, like I had mentioned, the barrier is the fact that our performance level data is aggregated. And it's also almost a year, you know, it's a year-long lag so it's really hard for us to do anything meaningful with that, with that data.

That being said, there are leading metrics that we're utilizing, so a lot of opportunity through the ACO REACH program to utilize data that, you know, is unrealized at this time. But we, our practice has really dug into risk stratification and finding, within our population, metrics that would help determine where to deploy our resources.

And we're utilizing our internal data.

We've designed a way to integrate with our, or not integrate, but get data from our health information exchange and know like, how many times our patients are hitting the ER and the hospital. And so we've got dashboards that kind of alert us to certain, certain data points that can help us decide where to deploy our resources.

And there again, our patients are seen in the home. And we go to see them proactively. So it's, yes, so it's a different practice model that I think is really, you know, really a benefit to high-needs patients.

CO-CHAIR HARDIN: And, Moon, did you want to comment as well?

DR. LEUNG: Yes. I don't have much to comment, but I think it is our kind of mostly using the claim or encounter database to analyzing the data so it relies on the provider to code those.

One comment I have is about the health information exchange. It sounds like it could be available to the provider if it is easy to access to it, and then the cost for access to the health information exchange. Because it kind of, because of our experience, it's not cheap to get the access to it. So I think it will be helpful

to kind of reduce that, make it easier for the provider to get access.

CO-CHAIR HARDIN: Thank you so much. Jim, you had your tent up. You're good? All right. Larry.

DR. KOSINSKI: Well, you all seem like you're in the trenches trying to do your very best. And I'm impressed with the concept of days at home. Something I probably haven't given enough thought to.

That's a great measure. But how do we know what's going on during those days at home? And so, something this Committee has worked very hard with last year in our, in crafting models for specialty care, was the concept of high-touch proactive care.

And so, I guess my question is, and I've heard the word proactive from Dr. Whitacre just a few minutes ago, all this reactive access to data is great. And what the patient feels like after their visit is very important. But what are we doing to avoid problems?

What are you doing out there proactively?

Are there use of wearables, use of digital devices in the home, blood pressure

monitors, even scales? Are we doing anything to know what's happening during those days at home?

DR. HERNANDEZ: I can comment on --

DR. WHITACRE: I can speak to that a little bit, Dr. Kosinski. In our high-needs population, we are definitely proactive. I think it's even, it's simpler though even than wearables.

And I think our patient calculation are, we tried that. We tried to do some in-home patient monitoring and didn't find it clinically valuable for our patient population. I think there is certainly populations where it could be.

But I think it's really simple in that, you know, getting in front of patients, building relationships and understanding what matters most to them. You know, the five M's we talked about in geriatrics.

But really making sure that we are, you know, we are proactively managing and actively in there finding opportunities that our patients don't raise their hand and tell us about. Optimizing that med list, finding areas of opportunity to improve their function in the home. Improve symptom managements that, again, our patients, they think they're old, they don't

know to raise their hand and figure out, you know, have their providers work together and figure out how to make things better, how to improve quality of life.

So I think, you know, it's got to be high-touch. And unfortunately I just, I don't see in our population, we haven't seen the value be realized for things like, you know, the wearables and the home patient monitoring.

DR. HERNANDEZ: I guess two comments I have on this is that just because there's an app out for, out there for it, it doesn't necessarily make it useful. So it's along Danielle's comments is that there can be situations where data overload isn't necessarily useful, it's not actionable. Like how do you know like if someone had something that was different today versus yesterday? And so that's the challenge, for example, for wearables.

The second thing is that to integrate with a person's life, I often find that the best kind of remote monitoring or integration of those types of data is that in the passive collection where there are alerts that are integrated in terms of triggering when someone is doing poorly. And that can be actionable.

Now how that would get integrated in terms of, you know, the context here of physician practice, measurements or health care system measurement, that's really complicated. And at least I would favor doing things that are simpler and that combine a lot of different things. And allow different practices, for instance, to tailor how they would actually so call improve the home experience or the home time.

CO-CHAIR HARDIN: And, Brian, you're muted.

DR. SMITH: I think you run into the paradox of people that need that kind of monitoring the most are, in my practice at least, are the people least able to use the technologies successfully. And push the button at the appropriate time or not push the button at the appropriate time. Or, you know, weigh themselves before breakfast or after breakfast. You know, that kind of thing is, that's what makes home monitoring tough for me.

We did have a success with it with, I think with heart failure patients, but they're stable for a month, then they remove the monitoring equipment, and then you're like, what do I do now? And then that becomes, you know, it

doesn't seem to be a permanent solution becomes nobody pays for it for the rest of their life or whatever.

DR. KOSINSKI: I think you just said the magic word, nobody pays for it.

(Laughter.)

CO-CHAIR HARDIN: Let me go next to Lindsay.

DR. BOTSFORD: Maybe that's good. Dr. Kosinski and I are on the same page here. So I guess maybe for Dr. Hernandez, I think we've heard arguments and good rationale for why there's opportunity in the spaces, patient-reported measures. How does it get paid for?

(Laughter.)

DR. BOTSFORD: What are, is it, you know, as we think about the move towards total cost of care, is that something that is baked into that we're going to need to think about baking into these total cost of care models that this needs to be part of it, is it paid for through other ways, and how can we reduce the cost associated with it?

DR. HERNANDEZ: Yes, so I think that's the real, one of the big challenges is that despite these measures being around literally for

decades, and some cases how they translate into health care delivery does require financial alignment. And so if that is incorporated in terms of the total cost of care, again, for certain measures that are valuable, actionable, and we know data that supports that they will improve the health and well-being of someone, then that can be integrated in terms of value-based care model. The health systems will certainly align with that here.

I think that one of the key challenges here is that, do you address it in more general ways across large populations, or are they focused on high-priority populations for which we want to really improve the health and well-being for outcomes for patient populations that have a high burden of disease and expenses here? And so I think that's why I use heart failure as a good example, that that can align in terms of very valid measure, it can be incorporated and relatively easily done in care delivery, it can be actionable.

And there are other areas like that. But it can be for everything, for everyone. And as noted part of the discussion here, unfortunately many patients don't just carry one

single disease. And so the complexity of comorbidity or other health problems ought to be considered, as well as, you know, the other surrounding factors that may be difficult for improving their health, so. But it can be done. I think we can find areas where it should be done.

CO-CHAIR HARDIN: So we are also very interested in equity and health-related social needs, that I wanted to put out to the panel. Moon, you mentioned the impact of language and how important that was in the population. What measures are you finding meaningful related to equity and health related social needs, and what recommendations would you have for the Committee in looking at that as part of performance in total cost of care models? So I'll start with Moon.

DR. LEUNG: Yes. And first and foremost, we are trying to like correct the data. Like, I think like the member, kind of what language they speak, as well as the race. CMS can provide some information about the race.

It's also helping us, is to getting some other information about where they live, and then the social, kind of in that it's going to

help us to push, verify the member. So in terms of the measure we try to measure, try to like environmentally improve proposing the health equity by looking at, like for example, we see that the African-American member has much lower, like a flu shot rate.

So we kind of deploy and incentivize the provider to get this rate up. So we have seen this like increase by 50 percent in the year by doing so. And also like, for some of those measures, like controlling the blood sugar, as well as medication adherence on statin measure, and the hypertension medication is much lower for the Hispanic population.

Part of that will be the voucher, part of that is a going to be a language barrier. And we kind of like are trying to deploy like the culture difference. Kind of like the staff in talking to them, trying to understand why they're not on medications, is there any kind of barrier? And we see there's like improvement like a few percentage point improvement. Which is big for medication adherence as well.

So we are trying to be focused on certain aspects, as well as a certain kind of population so we can focus and deploy them and

improve. And then we share with the medical group because it's very important to share the best practice, what works in the peer and with the provider, provider and provider medical group so they can deploy those.

And they have seen this, if they improve the medication adherence, improving the Hemoglobin A1C control, if they are kind of like being the cause of care, they have seen this also with using utilization which means we'd be using them.

CO-CHAIR HARDIN: Thank you so much. We'll go next to Adrian.

DR. HERNANDEZ: Yes, I guess, you know, these are important issues, and so I think this is one of the things that we want to make sure is done in terms of understanding like, you know, what gaps and how to make sure to close gaps in health equities, and so again, as things go forward, like being attentive to where we can actually address these things will be important.

And from, I'll just say from a health care system perspective, it's in everyone's minds, and it's helpful to have those kind of directions in terms of where we should focus on them.

CO-CHAIR HARDIN: And, Brian or Danielle, who would like to go next?

DR. WHITACRE: Yes, I can speak to this. So for the high-needs program, there aren't specific metrics for us that are posed at ensuring equity, but the program does allow us to design within our practice our own means of looking in on equity. And one of the ways in which we opted to is to look at the completion of annual wellness visits, which we find are valuable in population.

And we wanted to ensure that our different counties that we serve, we are completing those annual wellness visits equitably because there are different makeups in the different counties that we serve. So that's what we -- but the ACO REACH program for high-needs allowed us to design our own means, so it's much less burdensome than having the program tell us what, how we must meet the needs of our populations.

So I think when designing programs, I just love the fact that our program allowed that flexibility. And I would encourage future models to allow practices to do that, so.

DR. SMITH: I would probably just

reiterate what I had said earlier about, you know, discriminating on a payment basis whether people have high-speed internet or smart phones or not, and whether visits can be done that way. And then also, you know, you mentioned annual wellness visits. That occurred to me, also there is some payers that don't let you do annual wellness visits via telehealth. Or they let you do them, but they don't pay you for them I guess.

And so that is, that creates barriers for patients that don't have, either the ability to get out of the house or to, or have technology that lets them have the face-to-face conversation. And that can be frustrating I guess.

CO-CHAIR HARDIN: Lee, let's go next to you.

DR. MILLS: Great presentation. Appreciate the really rich discussion. Dr. Smith, something you said struck me, as I'm sure it did several other members of the Committee, which is just the nonsensical nature about you having to report to Medicare, and frankly any payer, claims-based measurements that the payer already knows more accurately than you'll ever know it.

And I think at some glorious future, we're in a world that metrics, whatever they are, are driven by the sum total of all population providers and then aggregated. We're obviously in the transitional state that may be the worst of all possible worlds right now.

That we're starting to, we're trying to use a fee-for-service mechanism to pay for population based care, but requiring all the reporting and data to come from the individual physician or practice as opposed to the population of providers caring for a patient through their journey.

So I'd like to unpack that just a little bit. How would you, and I guess I'd like to ask you to start, but then the whole panel will have thoughts on this. How would you parse through and weigh out the risk benefits of population-based quality metrics based on the sum contribution of all providers to that patient's care journey, meaning that then inevitably some of that's going to be out of your visibility and control, right?

You thought the blood pressure measure was in control, but they saw an urgent care while traveling in Tennessee you didn't know about, and

the blood pressure was out of control there, and now it's against you, right? So there's benefits to weigh there.

Secondly what, as you think about that future time, what shape would you recommend, and who would you think would be best positioned to be the trusted data aggregator and reporter that you would be willing to trust with that?

DR. SMITH: That's tough questions. The, I guess -- so we have, our integration with KHIE19 was free to us. And it's actually part of our requirement for meaningful use many years ago.

And from a population perspective, I think that is, I don't know, I guess it's weird because we talk about population but then, you know, I think about the individual patient that I'm putting the information to practice, or putting the information to use with. So less of the population as opposed to like gathering the information from, it was aggregated up to, you know.

And that's a good point. You know, like they are in Florida six months out of the year, and they get their flu shot down there, and

19 Kentucky Health Information Exchange

that's obviously not going to land in KHIE's database. But, you know, if they got a Lortab filled in Florida, that's certainly going to land in the KASPER20 database.

So I know it's, you know, possible to do these kinds of things. And I, I mean, I have to think, you know, from like numerical outcomes, like blood pressure, A1C, microalbumins, you know, anything like that. I don't understand why, I mean, computers are so good at numbers, why it's not, you know, an aggregate average of a number or a trend of the number.

And as far as, you know, who to trust, you know, it's, I don't know the answer to that because you are, you know, our population is so mobile, you know, if they get a service done in a different state, I don't have access to that information automatically. You know, I don't know what you pick as a, as like the low.

I mean, I guess what I would do is I start with kind of low-hanging fruit. And to me low-hanging fruit are vaccines. And everybody, you know, Medicare and Medicaid and, you know, the commercials all pay for vaccines, and why it's not a requirement, or not all vaccines

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20 Kentucky All Schedule Prescription Electronic Reporting

obviously, but for like flu shots, why that's not required to be reported, I don't understand that. And that's what I guess I would want.

I'm not really answering your question because I think you asked a question that will not be entered for the next, in my lifetime at least. You know, back in, when I was at Duke in 2020, there was, this is all going to be fixed in 10 years and integrated. And I don't know that it's gotten, I feel like it's gotten more siloed and less integrated.

Let somebody else solve that problem. Dr. Hernandez, Dr. Whitacre.

(Laughter.)

DR. HERNANDEZ: Yes, actually over the weekend I went and bought the easy button. I keep on tapping it, it doesn't work yet, so.

You know, I think one of the challenges is like, for us, for clinicians and practice, like the easy thing to do is to act on the last patient where you discovered something.

That doesn't, it isn't convenient for a performance measurement because on performance measurement we're considering, what on average is happening to the population we care for. But I think the integration issues that you highlight

still haven't been fully realized. I have hope, so as things get smarter and smarter, I should be able to do this.

DR. WHITACRE: Yes. And while we don't have the perfect data in front of us, I think allowing us flexibility to figure out with our patient right there in front of us what the most valuable thing to do with them today is.

And, you know, I emphasized in my introduction, and I think I probably sound like a broken record now, but the claims-based, you know, performance metrics that we're held to in the ACO REACH program for high-needs patients, they make sense. And, you know, it's what my patient wants. They want me to keep them out of the ER and hospital, they want me to increase their days at home.

And how I get there I get to decide as a provider. And work with my patient. And I find areas of opportunity with them together.

They don't always have the same agenda as I do, but sometimes what matters most to them is going to be the most valuable thing to address today. You know, we won't get anywhere if I try to address something different.

So, you know, you take the

opportunities where they come with your patients. And so, that, I'll get off my soapbox. Flexibility. Flexibility.

DR. LEUNG: I just want to make a comment. I don't know Dr. Hernandez, what is the color of the button you bought? The easy button. Is it a blue button? Like CMS talks about like a blue button to try to integrate all of the clinical information.

But for us, like because we have the health parameter and the payer, we collect data from the provider. We being the aggregators for the data, and then we provide those aggregators back to the provider so they know who has the mammogram done, who has the blood pressures in control or not. And hopefully we get those, kind of like the data more timely. So the feedback to the provider is more timely.

The other thing I want to comment about, attribution. Because it's like, in-house situation is a lot about, provides primary care, so they're supposed to be coordinating all the care. So the quality of management is attributed to the primary care provider.

But we also have the situation, we have kind of like a fee-for-service type of

configuration. So the attribution really depends on how many times the patient has seen that provider. So the more, like the time the patient has seen the provider, more weights of the measure performance to the provider. So it may not be fair, but that's what we did.

DR. HERNANDEZ: And just one other comment about that is that, you know, I do think that those kind of attribution models are feasible, and so then it helps a portion where people are getting the most care and for what kind of care so that we can direct the measures for that.

DR. SMITH: Yes. About attribution, and I know, Danielle, you said you guys have a lot of mid-levels. My understanding is there is some problem with attribution, you know, if they see a mid-level that works for me or works for Danielle 10 times, but then they see a MD one time, they get attributed to that MD as opposed to my practice.

I think there is an issue there because it's not always based on tax ID. And as I think, as, you know, the use of mid-levels, and I don't know if you guys are going to have a different committee on that, but that's only

going to grow exponentially. I feel like as, you know, we had a limited number of medical schools. DO[21] schools seem to be expanding. But I think we have the same number of MD graduates as we did 20 years ago with a population of 50 million more.

You know, I think there is going to be a bottleneck where we have to figure out that the mid-levels are, in the outpatient world, you know, as an MD, you hate to say this, but as they're sufficient to be our equals in the outpatient world in a lot of ways.

DR. WHITACRE: So yes, I think, I think there may be challenges in other programs. In the high-needs ACO REACH, it's all about plurality. And I don't think that we've seen problems with our NPs[22] or PAs[23] not being able to have the patient attributed to them even when there is an MD maybe seeing them outside our practice.

Our high-needs patients are, they have such difficulty accessing care. We're the only ones seeing them anyway.

Our biggest problem is we have them,

21 Doctor of Osteopathic Medicine
22 Nurse Practitioners
23 Physician assistants

you know, on average our patient's life expectancies, once they join with us, is about two and a half years. And so it needs to be rapid to get us, get them attributed to us. And sometimes, you know, so sometimes that's our limitation.

But it hasn't, you know, because we get our NPs and PAs into the program as participant providers, we're able to get those patients attributed to us. It's just the lag is the problem for us because when they come to us, they're in dire need, and they don't see anybody but us because they can't. They can't get out.

So that's not the problem. But it's the speed at which they get attributed to us that is important for our practice.

CO-CHAIR HARDIN: I want to thank each of you for your very valuable insights. It's really informed our perspective today. And the diversity of the perspectives that you've come from has been particularly helpful.

We want to encourage you to join us for the rest of the day if you're able. At this time, we're going to be going to a short break that will last until 11:00 a.m. And again, thank you so much for sharing your valuable time and

insights, we'll truly appreciate it. And we'll go to break.

(Whereupon, the above-entitled matter went off the record at 10:39 a.m. and resumed at 11:01 a.m.)

*** CMS Panel Discussion**

CO-CHAIR SINOPOLI: Welcome back, everybody. At this time, we're excited to welcome our esteemed CMS colleagues. We have Dora Hughes, Michelle Schreiber, Doug Jacobs, who I think is on the line, and Susannah Bernheim from CMS. And I'm going to let them introduce themselves as we get started.

And Committee members, we have about an hour with them. And hopefully within that time we'll have plenty of time for questions. And just turn your cards over. And, Josh, if you're on just raise your hand on Zoom. And so, I'll turn it over to you all.

DR. HUGHES: Thank you. Yes. Okay, so the microphone works, but don't have to blast everyone out. Dora Hughes, I'm the Acting Chief Medical Officer and Acting Director for the Center for Clinical Standards and Quality.

For our panel today, I thought I would just kick it off, just give a few words about our

National Quality Strategy. And then pretty quickly turn it over to my colleagues who are going to go deep on all of our various issues. And then we'll have some time, we're hoping about 20 minutes, possibly a little bit more, for questions and answers.

I do have to say, at the very outset, before I forget, I do have to note that our quality, the CMS Quality Conference is April 8th through the 10th.

(Laughter.)

DR. HUGHES: We hope that everyone is registered. It will be, we are excited that we're going to back in person, although it will be hybrid. I think last count, we have over 2,000 registrants, and so we intend to fill up the hotel, but also make sure it's a robust experience for those that have to sign in virtually.

All of us will be there. And so we, in many ways, will be able to continue the conversation that we're having here today. So I did have to start out with that plug on behalf of my other colleagues at CMS who would very much want me to make sure I mention that.

For us here today, continuing on our

conversation, I thought it was very helpful, our Principal Deputy Administrator, Jon Blum, noted that for us, given that many of our beneficiaries, certainly already on the Medicaid side of course, but increasingly on the Medicare side, is more of our beneficiaries are getting care through the plans.

We have a less direct relationship with providers, less opportunities in many ways to influence health care delivery through payment. Because many of those decisions are being addressed through the plans. And so because of that it does even, increase even more so the importance of our quality measures, our quality reporting and payment programs.

And that is why, certainly for us, it's very exciting to see this even, even more increased interest in all of the work that we do on quality. Historically it's always been a top priority for CMS, but even more so in this current climate where we're seeing the trends with our beneficiaries, how they're receiving care.

And for CCSQ, since we're going first, I could always note that for CCSQ, I don't always have the numbers right, Michelle will correct me,

but I think if we have maybe 24, 27 different quality reporting programs, 20 of them sit within CCSQ. And so for us our quality programs very much is our, the top priority for us at CCSQ. Very much our North Star for what we do on behalf of CCSQ, but really across all of the Centers for CMS.

We also house the QIO24 program, which allows us boots on the ground to address quality issues across the range of facilities. We also survey. We have oversight over accrediting organizations. CCSQ is very much the lead Center for quality here at CMS.

And you'll hear certainly more about the work that we're doing. But equally exciting for us is the work that we're doing across the Center's alignment.

And I think that's very much reflected in the CMS National Quality Strategy. Especially as you're thinking, as you're hearing more about the Universal Foundation measures. How we can make the work that we're doing in quality seamless, well integrated across all of our programs and policies on the Medicare side, the Medicaid side, the Marketplace side, is very

24 Quality Improvement Organization

much, has been increasing a part of our focus over the last two years.

As you know, the CMS National Quality Strategy that was released in 2022, that was our first, I think cross, truly cross-center effort to really think holistically about our quality enterprise here at CMS. I'm excited to be sitting by one of the main authors of the strategy, Michelle. And she'll certainly dive deep.

But a high level, as we stated, our quality mission is to achieve optimal health and well-being for all individuals. And we think of it as very important as part of that, is implicit. And we also try to make it explicit. It's across all of our care settings.

And when you think about as much as we focus on hospitals, increasingly more on long-term care facilities, but that also encompasses whether we're talking about our hospice programs, home health, inpatient psych, inpatient rehab, skilled nursing facilities, if it's rural emergency hospitals, across all settings, across the care continuum, is a really important part of our focus for the National Quality Strategy.

In our vision, I'm just going to read

it, CMS, a trusted partner, emphasis on the trust part, in shaping a resilient high-value American health care system that delivers high-quality, safe, and equitable care for all.

We have four priority areas with two goals within each. And importantly we have objectives and targets for us across each of these areas.

The first priority area focuses on outcomes and alignment. I have mentioned the importance of alignment across all the Centers, but outcomes of course. And that is, as we look across the quality measures, we're looking generally across all of our programs.

But we do have some particular areas of focus. Maternal health of course is one example. Behavioral health. Organ transplantation. A number of other priorities that you'll hear more about through our comments.

Our second priority, equity and engagement. Of course coming off from the CMS Innovation Center where I later held equity strategy that remains near and dear to the heart, to my heart.

And I think true for CCSQ across, our goal has been across all of our programs that we

will have a specific focus on equity. And we are very much on track.

Very, we are measuring our performance on that. And we think by the end of the year, we will have, or early next year, we will achieve that. In part through our embedding social determinants of health screening requirements across many of our programs.

For hospitals, we are stratifying our quality measure sharing, the findings, confidentially with hospitals, other providers. I really hope that if we're able to identify areas of disparities that this will help to incentivize hospitals providing TA25 to hospitals on how they can address.

The third area, safety and resiliency. And I'm going to go in reverse. Resiliency, I think coming out of the PHE26 has been the obvious area of need, obvious area of focus.

But certainly we've signaled that we, even before the change incident, that we are expanding our focus and resiliency, thinking about cybersecurity, thinking about how can we help health systems address issues with drug shortages another example, climate change. We're

25 Technical assistance
26 Public health emergency

looking very broadly across issues of resiliency for hospitals and health systems, other settings. And also thinking about, what does that mean for our workforce as well?

Safety of course we have not achieved. Our pre-pandemic levels of safety, and increasingly, and certainly through, even through this rulemaking cycle, you'll hear more about more proposals on other safety measures and initiatives that we intend to lead.

And the final areas, interoperability and scientific advancement. We have committed that we want to fully transition to all digital quality measures, all digital data collection by 2030. Again, we think we are very much on track to achieve that objective. And we think that will be hugely helpful in advancing our overall quality strategy.

And scientific advancement, certainly for us, and is in our prior strategy. We noted our new coverage pathway for our coverage analysis group, transitional coverage for emerging technologies, or TCET. But even broadly from that, specific pathway or specific interests, we are looking very generally how can we make sure that we are supporting learning

health systems, how are we thinking about evidence, more evidence-based approaches.

And not only for within CMS, but across our other agency partners notably, NIH[27] and FDA[28] and ONC[29]. And I think you're going to hear more about this broader look about how can we increase and share our data in ways that will advance learning throughout our agency programs and policies.

And so, with that I'm going to turn it over to Michelle for the deep dive portion. And again, thank you for your time today.

DR. SCHREIBER: So, it's still morning. Good morning.

(Laughter.)

DR. SCHREIBER: I'm Michelle Schreiber. I'm the Deputy Director for the Center for Clinical Standards and Quality under Dora. And most of my work is around quality measurement and these value-based programs. So all of those 27 value-based programs, not the CMMI ones, but the general Medicare ones are those that I work on.

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27 National Institutes of Health
28 Food and Drug Administration
29 Office of the National Coordinator for Health Information Technology

And as Dora pointed out, we have done more and more alignment, not only across CMS for our measures, so alignment from CCSQ or Medicare with Medicaid, with CCIIO30, which is the Marketplace measures, now with CMMI and the model measures. That actually didn't always happen as much as it's happening now.

And I'm really pleased to say that we meet weekly because of the CMS National Quality Strategy that's a cross-cutting CMS initiative. We meet weekly to talk about quality issues across all of the Centers of CMS.

And we've done a lot of work in driving alignment and standardization because we do recognize the challenges of having similar, but not same measures. In other words, hypertension is 140/90 in this measure, and 130/80 in this measure. And it's 65 and above in another measure. We get that.

And so what Doug will be speaking to after this is our Universal Foundation where we are trying to create standardized measures that we will drive across all of the programs that we have. Which will be the same measure.

30 Consumer Information and Insurance Oversight

We work closely now, not only within CMS, but also across the federal government. So we now meet routinely with CDC31, AHRQ32, SAMHSA33, and HRSA34 to some degree, as well as VA35, to try and standardize our measures across all of these programs. And to do joint measure development.

So for example, the safety measures which are so important, as Dora said, you'll see more safety measures coming out. We're working in conjunction with CDC. And probably will be moving many of our measures to NHSN36 reporting. And reporting through FHIR37. So we're working more with other agencies so that we are standardized across the federal government.

And then on top of that, we participate in the CQMC, the Core Quality Measure Collaborative, which has always been led by AHIP and the consensus-based entity to try and standardized measures across all payers.

Now it's not easy, because I will tell you, every time a payer signs a contract with a

31 Centers for Disease Control and Prevention
32 Agency for Healthcare Research and Quality
33 Substance Abuse and Mental Health Services Administration
34 Health Resources and Services Administration
35 Veterans Administration
36 National Healthcare Safety Network
37 Fast Healthcare Interoperability Resources

provider, they change the measures because they, I'm sorry, want their dashboards to look good. And so this panoply of measures and having to report different measures is not only a problem within CMS itself, but really a much broader problem across the entire ecosystem.

Our measurement strategy really is similar, almost the same, as the CMS National Quality Strategy. Outcomes, equity, the key clinical areas that Dora already outlined. We have 27 reporting programs, again, not counting the CMMI ones. Plus public reporting programs, plus the Stars programs that exist for many of these programs.

Generally speaking, CMS stewards, about 38 percent of our own measures, in other words, we develop them, we steward them, we own them, we change them. NCQA38 is about 20 percent of our measure portfolio. And the rest of the portfolio can be many others. CDC, AHRQ, specialty societies, and so forth and so on.

As you noted from the ASPE report, which by the way I really enjoyed reading, thank you, it was well done, on measures, we have, again, made this concerted attempt to align but

38 National Committee for Quality Assurance

they aren't always aligned.

The MIPS39 program has, by far and away, the largest number of measures. And there's a reason for that. It's because the statutory requirements of MIPS said that we had to have measures for every specialty, and we have to have cost measures to cover 50 percent of Medicare Part A and B spending. So that led to a large number of measures within MIPS.

We are trying to standardize that as well because MIPS really had a very large choice. If you were a provider, there were several hundred measures and over a hundred improvement activities that you can choose from. And some of those measures really don't get used often enough.

And one of the issues that we heard back from providers is that these don't apply to me. And so our strategy going forward, and I'm sure you're aware of this, is what's called the MVPs -- The MIPS Value Pathways, which are basically measure sets.

And they have all four categories of the statutory MIPS program. Quality measures, improvement activities, cost measures, and

39 Merit-based Incentives Payment System

promoting interoperability. But they are themed around either a specialty, like cardiology, but within that, it's meant to be team-based. So if you're a nurse practitioner, if you're a PA but you're kind of in a cardiology practice, these will be for you too.

And I recognize all of the subsets of cardiology. There's EP[40] and heart failure and interventional cardiology, and so forth and so on. But the broader MVP is meant to have enough choice that any of those specialists can actually find meaningful measures there too.

Within the MIPS program, we not only have the measures that CMS stewards, but also there are a number of registry measures that can qualify to be in MIPS as well. So MVPs are meant to be smaller, smaller sets, less confusing, more meaningful to the providers who report those particular measures.

And they're an important strategy going forward in CMS because we're going to use those intentionally in specialty reporting in ACO programs and in specialty models. And so you can start seeing these themes that will be emerging over the next several years.

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40 Electrophysiology

The first year of MVP reporting, however, was just in 2023. So this is even new for us. But that we're hopeful going forward, and again, trying to align around this strategy.

In the past several years, some of the things we worked very hard on, in not only alignment, but burden reduction. We've decreased our overall measure portfolio.

In most of our measures, as I said, being in MIPS, we have reduced that portfolio as well. We're looking at, however, a few gaps that are very obvious. One has been around equity, which I'll address in a moment. And we think we've addressed that. Care coordination is another important topic. And frankly, patient-reported outcome measures.

And Susannah may touch on that because she's really leading the agency efforts around patient-reported outcome measures. Because we recognize that the importance of the patient voice in really hearing about their care.

There are a couple of comments in the ASPE report about measure endorsement and the process of measure endorsement so I just want to touch on that for a moment. You may wonder, well, why aren't all measures endorsed? And in

part, the answer is because it isn't mandatory for all of the programs.

So for the MIPS program, for example, that wasn't part of the Social Security Act 1890, 1890A. That's what had talked about endorsement. And the consensus-based entity MIPS was actually not included in having to do that. And so, some of the measures don't have to go that pathway. Although we frequently choose to do it.

Most measures, however, follow the standard, measure conceptualization, measure development. Gets put on the measures under consideration list, which generally opens in May of every year. CMS considers measures, and measures can come from anyone. Any source, any entity, anyone can submit a measure to CMS for our consideration.

We will cull that list, we will make it public. And then that goes to the consensus-based entity who then holds meetings with what's now called the PRMR41. Patient-reported, I'm going to blank on what PRMR stands for, that's terrible of me.

Formally the measures application process. But it's now a large group of

41 Pre-Rulemaking Measure Review

individuals who really weigh in on, are these measures really applicable to the various CMS programs? And so, that's very important feedback that we get. That goes into the determination of whether or not a measure will be proposed in a program.

If they are proposed in a program, it's the normal rule writing scenario where they get published first in a rule proposal. There's a 60-day public comment period before the rule is finalized. And then after that, either the following year or further in the future, the measure is implemented in a CMS program.

The development of measures is not for the faint-hearted. It’s about a five-year process that I just spoke of. From measure conceptualization to where you see it in a CMS program. And frankly it's frequently longer than that.

Although I think our all-time record was during COVID when we got the measures in two years. Those were the COVID vaccination measures. Because there was such a public health crisis that demanded that.

All measures are carefully thought out. They have technical expert panels with

clinicians and wide stakeholders on them. All have significant input. And again, every step along the way, not just development but in rule proposal and in the PRIMER meeting, there is a lot of public comment and public input.

Dora talked a bit about some of what our key topics have been over the past several years. Maternal health. So we've had a new suite of maternal health measures, particularly around maternal complications and the hospital.

We've had a whole suite of measures around equity. The social drivers of health measures which, again, the same way we're trying to do this for other measures, we're trying to drive them into every single program. For those social drivers of health programs, they started in the hospital, and they are now in every program that we have across CMS.

COVID vaccination, the one that was most commonly used in the ASPE report, the same thing. Drove it across every one of the programs.

And some of the newer measures now, climate change, workforce, drug shortages, these are things that are coming up for the future. And problems I already touched on a bit.

Equity, however, was not just in measures. We've made a concerted effort to really raise up organizations looking at equity. So we have a measure around, are you committed to equity, are you using your data, are you stratifying your own data?

And then we provide confidential feedback reports. As Dora said, we started in the hospital, but this is a strategy for every program. We've chosen most important measures, and we're providing information that is stratified now by dual, sometimes race and ethnicity.

We're looking at ADI42. How you define the vulnerable population is actually a very complicated question, but we're trying to provide confidential feedback report to facilities.

And then we're trying to modify payment adjustment as well. So there's the rewarding excellent care for underserved populations called re-cup or re-up, depending on who's speaking.

(Laughter.)

DR. SCHREIBER: And what that did is

42 Area Deprivation Index

we changed the scoring methodology. And like the SNF value-based purchase program or the hospital value-based purchasing to actually award incentive dollars to organizations who are doing well with their underserved population. So we're using it not just for measures but to also drive payment reform.

(Off microphone comments.)

DR. SCHREIBER: This is my two-minute warning?

(Off microphone comment.)

DR. SCHREIBER: Okay. Good, then I can go to my very favorite topic which is the transformation of measures in a digital way. Because that is something that CMS has been driving now for several years. And I would encourage all of you to be thinking along these lines.

As you make recommendations for measures, I would think much more about the future. Technology is changing; interoperability is very important in how we get data and can actually look at care coordination for a population that's going to be dependent on having that digital information that resides in many places.

Most patients see providers, not just in a single hospital or hospital system, but in many places. They get their care at CVS for their immunizations and in a community center. And so CMS is really making a lot of efforts to move towards FHIR-based reporting, FHIR API[43] reporting, electronic clinical quality measures, the ECQMs. Not without a lot of pushing and screaming along the way from virtually everyone in the ecosystem because this has changed, and this has worked.

But if you look at the Hopkins article in JAMA[44] a few months ago, it is clear that electronic quality measures are cheaper, much more efficient, much less burdensome by orders of magnitude compared, not only to measures that are chart abstracted, but even claims-based measures. And they are the only measures that can capture the rich information that's in the electronic medical record.

And so we really need to think along those ways in what does that take. That takes standardized data elements. We work closely with ONC and the USCDI[45] and the USCDI+ to identify

43 Application programming interface
44 Journal of the American Medical Association
45 United States Core Data for Interoperability

standardized data elements that we can be using in digital measures. And we have to be growing interoperability, such as through health insurance, such as the HIEs, the Health Information Exchanges, and TEFCA46.

The advantage of digital measures is, first of all, the capture of all of this data, the reduction in burden, but that we can leverage them for advanced machine learning. AI. You can layer on advanced analytics to this. You can provide real-time results. I mean, our measures are old by the time people get them.

But for electronic measures, organizations can use it at the time that they collect it. They can use it tomorrow, for example, for a safety trigger tool.

And finally, providers then need more information. They need cost information, for example. And payers and providers need closer linkages so that they can provide that. We need standardization, as I pointed out, in the overall transition then to true operability.

Speaking of standardization, now my two minutes are probably up. I'm going to turn to Doug Jacobs, who is the Chief of Medical Officer

46 Trusted Exchange Framework and Common Agreement

for Transformation for the Centers for Medicare to talk about the Universal Foundation and our attempts at standardization. Doug, I think you are on the screen.

DR. JACOBS: Great, thanks. Can you guys see me? I can't see myself, though. Okay, as long as you can see me.

Hi, everyone. It's great to be here virtually. Sorry I'm not here in person. But I'm happy to talk to you about the Universal Foundation. I'll try to be a little bit quicker with my portion so we still have time for Susannah and questions after that.

So, as Michelle and Dora mentioned, over time there has been a proliferation of quality measures. And in many ways that's a, that's a good thing. We can measure aspects of our health care system that we could never measure before.

And we have intricate looks into different types of quality measures, with all sorts of facilities and outpatient settings.

And on the other hand, as we've had more of these measures proliferate over time, there's a tension there in that simultaneously it adds administrative burden if there's lack of

alignment. And so, part of our effort to really align these measures across the different Centers within the Centers for Medicare & Medicaid Services, so Medicare, Medicaid, the Marketplace. And really think more cohesively about these measures has been the development of the Universal Foundation.

And so it's -- the Universal Foundation as a concept, has been out for more than a year now. And the idea is that there is a universal set of -- CMS will put our stake in the ground for a universal set of quality measures to use across as many quality and value programs as is feasible.

And, when, Michelle mentioned that we have this Quality Working Group that meets weekly. We really did this across our different, in a different -- or across our different Centers in the selection of these measures to really align these measures that we could conceivably align even better in the future.

And so, when thinking about these measures, we tried to select measures that made a meaningful impact on patient outcomes. That also were either digital now or capable of becoming digital in the future. Michelle touched on our

overall digital measure strategy. And we thought that that was an important piece as well.

Also, the measures are either able to be stratified now with known gaps that point to disparities, or they're capable of being stratified in the future. And so, these were measures that we could prioritize more for developing stratification methodologies going forward.

And, finally, we were trying to select measures that had no unintended adverse effects. Sometimes, for example, you screen for something more, and you end up doing more procedures that might be unnecessary. So, we're trying to figure out ways to minimize any harmful effects of potential measures.

And so, last year we published the Universal Foundation in both adult and pediatric settings. And these measures also focus on cancer.

The Cancer Moonshot is an important goal that this administration has so that, so there's measures for the breast cancer screening, colon cancer screening. There's behavioral health measures in both adult and pediatric settings, focus on depression, substance use

disorder. And there's also measures related to preventative care, chronic disease management, hypertension, and diabetes, and coordination of care. And also, finally, patient experience measures through CAHPS.

And so, this is the first iteration of the Universal Foundation. And we've gotten a lot of feedback from folks over time.

And now that we've come out with the Universal Foundation measures, and we've also demonstrated progress towards alignment as well. So, Michelle touched on the MIPS Value Pathways, or MVPs. And the MIPS Value Pathway for primary care has now all of the Universal Foundation measures in it. And we made that change last year.

Also, we've solicited comment in Medicare Advantage and the Medicare Shared Savings Program and in getting to these measures over time. And there's been some changes made as well to move the Universal Foundation in Medicare Advantage.

And, also, on the Medicaid side, there's a lot of alignment already with these measures, which is great, both in Medicaid managed care, and outside of it.

So, as we think -- and also the Marketplace, too, has great alignment with the Marketplace quality rating system.

So, I have the pleasure of being the co-lead with Susannah and Michelle on the National Quality Strategy. And so, collectively we've worked towards building towards the Universal Foundation. And I think that going forward some of those goals that we have, and prioritizing these measures for additional transformation, for stratification, and observation of, like, inequitable care gaps, we're taking the next step in those areas as well.

So, I think with that I'd be happy to talk about the Universal Foundation more as we could get into the discussion portion. But maybe I'll turn it over to Susannah to go over her portion of the talk.

Thanks for having me.

DR. BERNHEIM: Hi. You all got to hear from me yesterday. But I'll reintroduce myself.

I'm Susannah Bernheim. I am the Chief Quality Officer and Acting Chief Medical Officer for the CMS Innovation Center. And I'm just

going to spend a couple of minutes talking about how we think about the quality strategy within the Innovation Center.

And I'll mention again some recent work on our new quality pathway, which is an internal initiative to elevate our focus on quality outcomes and experience at the Center.

So, first, all of the work we do really sits in the context of two things:

One is the statute that created the Innovation Center which tells us to look at Alternative Payment Models and think about both reducing costs and improving quality.

And our recent 2021 Strategy Refresh. And that -- the objectives of that strategy refresh focused on accountability, on equity, on innovation, on affordability, and on partnerships. And as a part of the document that we put out, we really declared an intention to broaden our vision of what success of our models is.

There's been historic focus, understandably, on reducing spending. But we wanted to very purposely step to thinking about models, improving based on the impact on transforming care for the benefit of patients.

So, our quality strategy sits in the context of both of those pieces.

And one of the other things is that we realize it's not just about the quality measures in our models. The models have the opportunity to influence and improve quality in a number of different ways, so I'll talk about that as well.

And then, finally, we described in the New England Journal of Medicine catalyst piece last fall that we also want to increasingly use the models to understand in more detail how care gets better, how to, how to use the models, how to test to understand how care redesign can really make improvements for patients.

So, with that backdrop, how do we decide what quality measures to use in one of our models?

And I think first and foremost, we are focused on determining that the primary improvement goals, with a focus on outcomes and experience for that given model. Our models are quite varied, right. Sometimes we're looking at small primary care practices. Sometimes we're looking at large ACOs. Sometimes we're looking at the work of nephrologists.

So, for every model there's

distinctive and different participants. Sometimes it's a state Medicaid agency. So, we want to ensure that each of the models has a primary goal and an aligned set of strategies driving towards those goals, focused on the benefits to the patient from this model. But also noting that the quality measurements are just a piece of what we can do to drive that.

And we have to really think about that measured entity. This has come up in the conversations you guys have had, right. It's very, it's a very different world in terms of quality measurement, depending on who's being measured, where they're accountable, what quality measures they're already held accountable for in other contexts. So, we're thinking about that as well, we're thinking about alignment with MIPS.

So, as we build a quality strategy from the new model, to oversimplify, once we have our kind of North Star, we first look to identify familiar low-burden aligned measures. We look to the Universal Foundation, where it fits into the model's goals.

This alignment with the Universal Foundation you'll see particularly in, like, our primary care focus models where we're also

thinking about multi-payer alignment. For instance, our Making Care Primary Model, you'll see a lot of line-up with the Universal Foundation for those reasons.

But we are also able to and looking to broaden the use of outcomes and experience measures. And as you've heard, we have a particular commitment at the Innovation Center to the use of patient-reported outcome measures.

We fundamentally want to drive towards more person-centered health care. The voice of the patient is really critical. And you've heard that from many of your speakers in the last day.

And we understand that these are not easy to implement. So, we're offering, introducing those measures sometimes in pay-for-reporting context. We are often providing tools to support participants in the data collection. Our learning system is supporting participants as they build the infrastructure to collect these tools.

And then, when we need to, we build new measures. So, we, we look to have aligned measures. We promote outcomes and experience measures. And we build new measures, like the days at home measure that you heard a participant

talking about in the ACO REACH model.

We've built a measure that looks at the time to dialysis in the context of our Kidney Care Choices Model. That's a really important patient-centered outcome.

And then the new dementia model, Guiding an Improved Dementia Experience Model, we're going to be looking to build a new measure looking at the stress and strain on caregivers because that's such a central piece to what we're trying to improve in that model.

And then finally, as a small component of really a very broad equity strategy in our Center, which Dora is the architect of. For an increasing number of models, we are directly providing participants with stratified data to help them look at disparities in the quality measures that we're using.

So, when we build these strategies -- and people have been talking a lot about our portfolio -- we're really thinking about competing but important means of burden and alignment of driving new measurement tools. And thinking about outcomes and patient-reported outcomes.

I'm going to say just a couple more

words really about how what we're doing differs and complements what's happening in CCSQ and CMCS.

As you know, there's a lot of important quality measurement programs that are built out of CCSQ. And we have a very strong collaborative approach. As you've also heard, we meet often, and enjoy that.

And so, all of our work is also sitting inside those overarching roles of the National Quality Strategy. And we're driving towards similar outcomes measures, digital measures focusing on equity.

But what's slightly different for us, and what I hope your recommendations can help us with is that we aren't setting measures into predefined programs. We have a lot more flexibility. We need to tailor our measurement strategy to distinctive participants with distinctive goals.

And as I mentioned, there's also other tools that we have to drive improvements. We want to think about how we take advantage when there's a waiver, or what our learning system can do, or multi-payer alignment. And we think about the equality strategy as really just one

component of how we're improving things.

Also important is that commonly we are putting out voluntary models. This means we really are accountable to having a measure design that makes sense to providers, that they feel is meaningful, that they want to join us to participate in.

And we have a lot of flexibility in how we use measures. I think our next panel is actually going to speak to that a little bit. We can think about how to build benchmarks. We can think about how to introduce accountability. We can test measures without going through the processes that are required for CCSQ.

So, we have a little bit more of a nimble context. So, we can really think in building our portfolio of measures how to take advantage of those flexibilities and introduce things.

And then we need to think about how we're building things that can be used more broadly. Because this focus on alignment is crucial, but we're doing it a little bit retrospectively.

So, the other thing we're thinking about in the Center is are we building things

that might have use in the future in other contexts? Can we be a tool for the agency as a whole to think about novel approaches to measurement?

So, that's a lot that's on our mind when we try to build a quality strategy for a new model. And we're really looking forward to your recommendations.

As I mentioned in my opening remarks yesterday, we're really in the midst of launching an initiative at the Center called the Quality Pathway which further sort of articulates and strengthens our focus on quality outcomes and experience from the earliest part of the model design through evaluation. And there's more coming at the Quality Conference. You'll hear from us about that. That's April 8th through 10th. And a publication that's forthcoming.

But it centers on this concept of building aligned pieces of our model towards central quality goals, focusing on outcomes and patient-reported outcomes in particular, and patient experience.

And then, finally, we're also thinking a lot about how to design our evaluations so that we can really assess the impact we've had on

those quality goals so that we can not only support quality improvement but evaluate and disseminate successful strategy.

Thank you for your recommendations that are forthcoming.

CO-CHAIR SINOPOLI: That was great. We appreciate all that information.

So, we're going to open it up to the Committee members for questions. I'd like to start out with one.

I think, Dora, you mentioned in your conversations about interoperability and scientific advancement a willingness to share data going forward. And I wanted you to comment a little bit more about that.

And so, is that more about process improvement, or are you willing to share de-identified data for large scientific exploration? Or what are you, what are you thinking in that regard?

DR. HUGHES: So, I think for CMS it would kind of be a both and answer. But I think even starting especially true for the CMS Innovation Center, historically the data was kind of locked. We used it for evaluation and then that was that.

We're trying to think more creatively how can we use the data internally, but also share it with our external stakeholders. That can only help us. We have bandwidth, we have financial issues. If we have colleagues externally who are willing and able to do additional analyses that even target issues that we're not able to address, that can only help us, as well.

And also, just to have an external set of eyes validating the work that we're doing internally. So, that, so that's on a narrow but really important, a path that we're on.

But broadly, and I will give credence to our colleagues at NIH and FDA who are thinking big, very, very big. How can we all use our various very large data sources across the Federal Government, almost like a whole of government approach, to really work through whatever intractable issue or challenge that the various agencies are facing as part of that? I think the, at least the internal name is the EVGEN Working Group, evidence generation.

I think ONC is also part of the spearheading this initiative, came up with the cooler term, I think.

But, and so that is the effort that is really moving on a conceptual to -- and if we were to do this, what would be required?

So, so at this point I can't give more specifics because they truly don't exist. But we've had really senior leadership buy-in, we have committed folks who are working on it. And I think, I mean, there is just a lot of excitement to think through how truly can we work across these huge operating divisions to use our data more productively for all of our programs and policies.

CO-CHAIR SINOPOLI: Thank you for that.

You do have rich data. And that's exciting to me. We've always wanted access to be able to learn a lot from the data you have. So, I'm hoping that that comes to fruition.

So, thank you.

DR. BERNHEIM: And can I just add specifically, just because I think it's really important for folks to know, that a few years ago there was a decision to try to make it possible for folks to look at the, all of the models. And so our Business Services Group has been in that process of model by model putting out.

I think you can get it through ResDAC47. You might know better than me. So, you can see who is participating in the model, and that allows researchers, exactly as Dora said, to take their own look at what the evidence is that's generated by the models.

I think we're up to 20 models now that are available through that process.

CO-CHAIR SINOPOLI: Great. Thank you.

Jennifer.

DR. WILER: Thank you so much for giving us this opportunity. And we're so excited about all of the great change you've described and that's forthcoming.

My question's going to be around much of what we've heard, not only through this meeting but through previous meetings, from the stakeholder community, is around the importance and, yet, challenges around coordinating care.

And although that is implicit in everything you've described in terms of strategy, we've heard some recommendations about very tactical levers that could be used to improve that coordination, including in our last session requiring or creating a metric around sharing of

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information specialists to primary care, inpatient, to ambulatory setting.

So, my question is around how are you thinking about care coordination and the very big levers that you all have to incent what we know from an outcomes perspective is good care delivery, and from a value perspective, more cost-efficient?

DR. BERNHEIM: You know, I think one of the themes you'll hear is it depends a little bit on what authority we have and what we can do. Right? So, in the context of broader models that cross multiple settings, I think you can get at some of that by measures that -- and this, again, came up a bunch yesterday -- by measures that sort of hold many different entities in different settings accountable. Right?

So, when we have a bundle, you start to, by design, create opportunities for coordination and hold. I think it's, it's harder when we -- and I think you mentioned this, too, Michelle -- we, we sort of have looked for this magic individual measure that says, oh, my care was coordinated. And I don't, I don't think there is a single measure that does that.

I think, I think patients have a lot

to tell us about that, so I think patient experience is really important. You know, some of these measures ask questions like does my practice know me? I think there's places in the world of diagnosis that we need to really get better coordination. And there's a lot of work going on for those measures.

But, again, it sort of depends on whether you're in a context where you can look across entities and hold a system accountable versus an individual or a given institution.

So, that's how I think about that.

DR. SCHREIBER: Thank you. It's really an important question. And it's very complicated, as you're already pointing out.

Completely agree with what Susannah said. What ONC, CMS, and others have been trying to do is to ensure that exchange of information, right, for both promoting interoperability. Virtually every program has in it the exchange of information. So, in other words, the release of information to the next provider, the release of information to the patient, information blocking rules that came from ONC.

So, all of that infrastructure is trying to be built. And now it's a matter of

making sure that people do receive that information within a model or within a shared approach to taking care of a specific population. You can hold people accountable for that a little bit more easily than you can by individual facilities.

We have, you know, proxies for care coordination, which is, like, readmission, which isn't the greatest but we recognize that was the attempt at care coordination. And we're starting to be explicit in some measures about the exchange of information, the time to consultation, time to somebody seeing that.

But I think some of this in the end may have to be patient-reported outcome measures and their perception of the actual coordination of care.

DR. JACOBS: I just want to add one thing from our perspective, Center for Medicare.

So, even beyond the worlds of specific quality measures, what we pay for and both inside and outside of value-based care models and programs, can be really important in driving care coordination.

So, over the last 10 years or so, Medicare has started paying initially for

transitional care management, which essentially pays more after the follow-up of inpatient admission to an institution.

Doing that work of trying to see what happened during that inpatient admission and then, in an outpatient setting, making sure that we coordinate effectively, all the medication is right, that there's no barriers to the treatment plan.

Additionally, we have the chronic care management codes. And, actually, just this last year, we finalized new codes for community health integration and principal illness navigation. These are primarily for patients that have unmet social needs that affect the diagnosis and treatment of their medical problems. Or in the case of principal illness navigation have some kind of high-risk condition. And that also involves care coordination. And are the first codes that are really designed to describe services performed by community health workers, peer support workers, and other care navigators.

This builds on that care management history that I mentioned earlier. And we've seen over time that patients who get these care management services do have less readmissions.

And so that that feeds back into what Michelle and Susannah were talking about, too, in that when patients are receiving this kind of coordination of care, we can see it in the readmissions measures. It's not the end all and be all, but it's an important indicator.

DR. WALTON: This is going to be a challenging question, but it's mulling over in my head so I want to see if I can get it out.

Sometimes I sit in the PTAC meetings, and I think of all my, all our colleagues out in the field. We just heard a couple in our meeting. And we've heard this before, but and I guess the thing we think about as doctors is this idea that our colleagues, the profession itself and the colleagues within the profession are feeling pretty burned, burned out, you know. And that the profession itself is underperforming, maybe on quality as a consequence of that, right?

Having run a medical large physician network that are independent, you know, primary care doctors as an example, you know, made more referrals when they were more burned out. Right? They're frustrated with the administrative load that they were given in the ACO that we were bringing to them.

So, I guess one of the things I think about as a PTAC Committee, when we get together in our private conversations as a Committee, one of the things I think that comes up for me often is this idea of what would we say to our colleagues as we went back and took back the message of what are we able to recommend that would help you guys do your job representing us, that we could then say out to the community, I think we're making progress in reducing your burnout by -- the burnout of, the burnout that's being caused by quality measures, or quality documentation, or your frustration with interoperability.

You know how bad that is, right? I mean, you all know this.

And so, it's almost like there's a message that needs to go out as a collective of us, you know, the people who are in practice and people that are dedicating their lives, like you guys are, as physicians to doing something for the profession which then ultimately produces better quality for patients, and it's safer, the beneficiaries are benefitting, and the patient-reported outcomes are better.

So, I'm curious, if we could actually

write that script out, what would that, what would that sound about like from each of you all that you would recommend to us to recommend to you all? You get the idea? All right.

DR. HUGHES: Why in some ways, starting from me first, it's not directly but I think even what Doug just mentioned that we are establishing codes, we are starting to pay for, in the context of the question was on care coordination, bringing in others on the team who could, who could at least in theory lighten the load.

And I think that is proving to be the point.

So, I think, I think -- I do think being more direct, tying the payment to what we're asking physicians can be helpful.

I also think on the quality measure side, and we're hearing more and more, I don't know how much of it's recognized on the inside, but even, you know, I think there is a pretty -- we're taking a hatchet to the number of measures. And so, we're certainly not doing that, but still are being very thoughtful about which of these measures, frankly, are not driving quality? Which ones are tapped out? Which ones, which

ones need to be removed?

And so, knowing that that continues, I do think that we need to do a better job in some cases for some settings understanding where we may need to do more to accelerate. But I do think that we have continued at a heightened sensitivity to the issue of burden.

And, also, we don't talk about it as much, but I also wonder for a future session if, if our colleagues, I don't know if you've heard from our colleagues in OBRHI, Office of the Burden Reduction and Health Informatics -- you can get lost in the acronyms -- but even just hearing some of what they were able to do, for example, with the prior authorization rule.

That was you don't often hear OBRHI, but in fact they are leading some of, some of the work in direct response to what they're hearing from providers. And, of course, that's -- OBRHI doesn't act alone, of course, is working across the Centers, but bringing us together I think through.

But I think even if we thought about more it more, I have no doubt there's a number of other examples that we would, that we would want to add to the list.

Maybe I'll turn to Michelle to hear what some of your thoughts.

DR. SCHREIBER: So, I guess my number one recommendation would have to be accelerate the digital course of measures. It's clear that these are the most efficient measures, the least burdensome measures.

They're not least burdensome to begin with, because there's work to map your workflow to this. But once that's done, the data can flow seamlessly from clinical care where the provider doesn't necessarily feel like they're just a data entry clerk, which is part of the problem right now.

Make electronic medical records more user-friendly. I think it is critical to part of this as well. And then the interoperability of data. Health care has been slow to the digital transformation compared to many industries. I think we, you know, we all know that. We all recognize that.

And there are multiple barriers along the way.

But the end goal of interoperable data that can be shared and used, that can ult -- that can ultimately inform better patient care, that

can be used on a real-time basis at the level of clinical decisions support, is tied to clinical guidelines, and that is the ultimate goal. And, frankly, the further we can break through the barriers and get there, the better I think we will all be.

DR. BERNHEIM: So, for fun I'll add a few more.

Actually, Doug, it's hard for us to see you, so let me pause and see if you want to add anything before I do.

DR. JACOBS: Sure. I can add a few things.

So, I agree with what everyone's said so far. I think in the quality metrics space it's interesting. It's -- I do think identifying a universal foundation and moving towards there will make a meaningful impact on burden, and agree with everything else that's been said.

I want to double down on something that Dora said in the prior authorization space. That makes a tremendous amount of burden. And this, the rule that recently OBRHI, the Office of Burden Reduction and Health Informatics, came out with provides not just for prior -- but also in just in a way that providers access data.

So, if you're in multiple value-based care arrangements and, like, you as a provider need data from all of them in order to know, like, the entire patient population you see, it is tremendously burdensome to go one by one into patient portals and access that data just for that one payer.

Because as clinicians, we don't really think all the time about what payer is paying for this patient's care. We think about this patient's walking in the door, what can I do to help them?

And so, I think that's important.

And on the Medicare Advantage side we have made new requirements that went into effect this year to make Medicare Advantage prior authorization no more restrictive than traditional Medicare. It should, hopefully, make a big difference in the prior authorizations space as well.

Well, I think that the last -- I don't know how to exactly capture my last thought here. But there is, I think, an element of clinical practice that is more about, like, the joy of seeing patients and practicing medicine that can't always be widgetized or captured.

And I don't know exactly how to put it, but I think it has to do something with training and, like, what people find joy in their daily work, and whether they find their work to be a calling or more of a job. And I think there's been some work in this space, but I'm not intelligent enough to speak on it or know what our levers are here. But I just mention for maybe some further exploration.

DR. BERNHEIM: So, I think all of the things of sort of reducing the burden of the measures, moving towards digital, thinking about what we're paying for.

And the only thing I'll add particularly in the primary care space that I think we're doing but we need to continue to do is that we're, you know, we now have three models that purposefully are expanding investment in primary care.

And I think that investing in primary care and creating flexibility for physicians to practice in a different way is going to be key to addressing some of these issues as well.

CO-CHAIR SINOPOLI: I'll remind the group that we're at time. But we're having a great conversation so I want to turn it back over

to Larry. I think you had your card up.

DR. KOSINSKI: Thank you very much for this detailed presentation. I really enjoyed it.

The one word I didn't hear is "attribution." And it became a huge problem in MIPS. And what are you doing to wrestle with that word?

DR. SCHREIBER: Attribution is something that we think about often because it comes up certainly in the cost measures, it comes up in the quality measures, but really in the cost measures even more.

What provider actually can be held accountable for X, Y, and Z, either the quality or the cost?

This gets discussed endlessly in the Technical Expert Panels, and people weigh into this. Is this ICD code included? Is that one? Is this provider included? Is that one?

And it's a tough conversation. We try really very hard to be as focused as we can for attribution. But in the end I think there has to be some shared understanding among providers that we're all in this.

And take tobacco cessation for example. Now, the dermatologist doesn't want to

be attributed tobacco cessation, right? That's not what I do, they say.

Well, is that true? Do we as a collective have some greater good calling that all of us should be accountable to? I don't have an answer for that. But I think it's part of the question we have to address, too.

DR. MILLS: Sure. I'll be brief.

I appreciate the great discussion. I'm relishing in the opportunity to for one brief minute bring something to the top of your inbox and get to your attention, which is focused squarely on first and second National Quality Strategy priority areas of promoting aligned metrics and advancing health equity. And that is the huge variation in data sets required for race, language, ethnicity reporting among CMS' portfolio of programs.

MA48 is using the expanded OMB49 list, whereas ACA50 is using the simple lists, state Medicaids are using about, I don't know, two dozen different lists.

HEDIS51 is currently using the simple, but in a hypertension change recommendation form

48 Medicare Advantage
49 Office of Management and Budget
50 Affordable Care Act
51 Health Effectiveness Data and Information Set

working its way through the system, they're moving their RLE52 data segregation into the hypertension measure to a wholly new cloth list of RLE reporting that's not either the simple or expanded list.

So, and this plays out, that level of variation is just going to sew confusion and distrust every possible which way. So, I invite the hatchet to come to RLE reporting. Any of them could work, just pick one.

DR. HUGHES: So, not a great response, but that certainly is something that we are mindful of at CMS.

All of us that you're seeing here plus the others, including our colleagues in the Office of Minority Health, but across all Medicaid are very much aligned and focused with your, with your comment there.

DR. SCHREIBER: I would only say my guess is that within the next year or so you will see a recommendation for standardized data across HHS that will probably follow what's being done in The Gravity Project and going through USCDI.

So, I think that time is coming but, you are right, it is not here yet.

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52 Race, language, ethnicity

CO-CHAIR SINOPOLI: Well, I want to be respectful of our guests' time and just tell you how much we've appreciated you coming and joining us today and sharing this information. Very exciting, big work. So, we thank you.

And I think we'll adjourn this meeting for the moment. And we're going to take a break now from now till 1 o'clock. And we'll be back at 1:00.

Thank you all.

(Whereupon, at 12:04 p.m., the above-entitled matter went off the record for a luncheon recess, and reconvened at 1:01 p.m., this same day.)

*** Listening Session 3: Linking Performance Measures with Payment and Financial Incentives**

CO-CHAIR HARDIN: Good afternoon and welcome back.

I'm Lauran Hardin, Co-Chair of PTAC. And I'm excited to kick off this next listening session. We've invited three experts who have experience with overseeing implementation of performance measures and supporting measures data sharing with providers.

At this time I ask our presenters to

go ahead and turn your video on, if you haven't already.

After all the presentations, our Committee members will have plenty of time to ask questions.

The full biographies of our panelists can be found on the ASPE PTAC website, along with other materials for today's meeting. So, I'll briefly introduce our guest speakers.

First, we have Dr. Karen Joynt Maddox, who is the practicing cardiologist at Barnes-Jewish Hospital, Associate Professor of Washington University School of Medicine and School of Social Work, and Co-Director at the Center for Advancing Health Services, Policy and Economics Research.

Please go ahead, Karen.

DR. JOYNT MADDOX: Good afternoon, everyone. I am honored to be with you. Lovely to get a chance to be part of this.

It's been wonderful to watch some of the sessions over the last couple days. And I'm excited to spend a little bit of time giving my input into this and, hopefully, generating some conversation.

So, next slide, please. We'll do

obviously just some super brief level setting since this is a group that knows all of this already. But just to be clear, when I mention upside only I'll be talking about the case, you know, in some tracks of MSSP[53] but really not a ton remaining in this space. More high performance can help you win but there's not really downside risk for poor performance.

Two-sided risk, which is some tracks of MSSP, most site-specific ACO or total cost of care programs are moving in that direction, obviously. BPCI[54], BPCI-A[55], and the site-specific value-based payment programs, including MIPS, et cetera, most of which at least have a withhold that could be considered, the potential for downside risk.

And then, of course, the downside only risk. The Hospital Readmissions Reduction Program and the Hospital-Acquired Condition Reduction Program, though that won't be a main focus other than mentioning in passing.

So, next slide, please. The other, I think, element I want you to consider in these models is global versus limited costs included in the model. So, the global or at least near

53 Medicare Shared Savings Program
54 Bundled Payments for Care Improvement
55 BPCI Advanced

global models obviously moving toward the total cost of care was Medicare Shared Savings Program, and the Pioneer Programs, and all of the ACO models.

But we still, I think, have a lot to learn from the limited cost inclusion programs, including Hospital Value-based Purchasing and other site-specific programs that are limited by patient population or by time.

And then BPCI and BPCI-A that are limited very explicitly by time in terms of, in terms of those models' specifications.

Next slide. So, I don't want to spend my time reviewing all of the evidence across the programs because the PTAC team did a great job in doing that already in the preparatory materials. But I thought I'd just put a few up about some of the more prevalent APMs[56], just sort of to anchor us a little bit on the magnitude of costs that we're talking about and the degree of change that we've seen in some of the programs so far.

So, these are data from the Bundled Payments for Care Improvement Advanced Program. And on the left you can see a tiny but technically statistically significant improvement

56 Alternative Payment Models

in cost trends by about $52 per person per quarter on a base of about 27,000. So, statistically significant but maybe not the clinical -- or not the cost improvement we were looking for.

And then on the right side demonstrating no differential change in readmission rates. This is 90-day readmission rates but similar for 30, with a difference-in-difference in trends of 0.01 percent per quarter, which is not statistically significant.

So, just an example from one program where we've seen some cost savings, not much in the way of outcome improvements. But I think given the magnitude of the costs for these episodes, maybe not what we had hoped when seeing these programs roll out.

Next slide, please. And here are some by now classic data on the Medicare Shared Savings Program on the left, showing changes in annual Medicare spending per beneficiary on the order of a few hundred dollars per beneficiary per year. Really driven by those early entrants, the red bars in the top, in the physician group ACO category.

Particularly compared to the hospital-

integrated ACOs where you do see some savings among the early entry but really less so later.

And then a more recent publication over on the right of this slide looking at enrollment in the program, which I would argue is another really key piece in these voluntary programs when you think about their impact.

It's a little bit of a complicated slide. But the idea here is demonstrating that over time the starting dot is the -- is where a cohort enrolls. And then the line is where they go over the years of the program.

So, you can see that the starting dots are moving into the bottom right quadrant. Now all the costs are moving into the bottom right quadrant, which is good. That's the savings per beneficiary per year relative to the region. But you can see that after the introduction of regionalized benchmarks, we saw more ACOs entering who are already low-cost regionally.

And you could imagine why that would be the case with those incentives. Which is really maybe not where we'd want this to focus. For the biggest impact, you'd want to find those high-cost groups relative to the region and help them develop care processes that would lead

towards real transformation.

So, I'll come back to a few of these concepts in a moment.

Next slide, please. And when I was thinking about these comments, I went to this figure that was in NEJM57 in 2021 sort of summarizing a number of the programs out of CMMI over the past decade or so.

And you can see that successes in reducing cost were not obviously driven only by program characteristics, right. So, the types of risk and the included costs vary. So, you know, what I said up at the beginning in terms of those paradigms. But the Maryland All-Payer Model up at the top and the CPC58 Plus all the way at the bottom were pretty comprehensive but at different extremes of savings.

Now, I'll grant that reconciliation payments matter, too. And for voluntary programs, they are part of the mechanism of the program, so they should be included because that's sort of how you incent participation if you're not in a mandatory scenario.

So, I think there's a lot of complexity built into this one slide. But the

57 New England Journal of Medicine
58 Comprehensive Primary Care

main takeaway, for me at least, in thinking through this is the degree to which we cannot predict sort of success in terms of cost savings only by knowing whether or not a program is total cost of care or more limited, or whether it is a more comprehensive or risky in terms of the risk profiles.

So, next slide, please. But I think if we take a step back and sort of think about the why that's buried under that graph, which is really that we want people to be able to live happy and healthy lives with their friends, and their families, and their partners. And while the money is important, it's not all about the money, right. The longer people live, fundamentally the more they cost in the global sense. It's really that health and wellness and productivity.

And so, I think maybe what we need to return to in thinking about the potential for these total cost of care models is the degree to which they could better reflect that health and health care a fundamentally human and personal enterprise, and really about the totality of a person in their life as opposed to only about sort of the metrics that we can get our hands

around easily.

So, to the next slide, please. And we have pretty good data that over the last couple decades that the move towards quality measurement in general has improved processes of care, at least documentation. But I like to believe it's improved real processes of care.

These are data from a few different data sets looking at statin medications, which are highly cost-effective medications to reduce cardiovascular morbidity and mortality. And as a cardiologist, I think everyone should take these.

And we're doing great in this regard, right. We can see real upticks in the degree to which we've gotten these medications to people that need them.

But if we go to the next slide, you can see that if we get closer to measures of health, we see things going the opposite direction. So, on the left you can see obesity among adults rising from 30 percent to 42 percent in two decades.

And among children, in the panel on the right, even among our youngest children, increasing threefold from the 1980s to the present.

So, we, we've done a good job with the processes that we measure, but somehow we're not getting to health.

And if we go to the next slide to look at a health outcome that we've measured, I would argue extensively measured, you would be hard pressed to find any hospital in this country that hasn't started readmission prevention programs, post-discharge clinics, and calling patients, and setting up risk modeling. And we really haven't moved the needle.

You know, my takeaway from this is that it's incredibly hard to reduce readmissions, particularly if you are a hospital. People are very, very sick, there's social complexity, there's food, and housing, and safety needs that come into play here.

And so, while we've done a good job in moving some of the metrics, we really have not moved some of the things where we need to think more broadly.

So, next slide, please. And just briefly, our population-level outcomes would reflect that as well, with really a leveling off of our gain in life expectancy. Not that we should expect Medicare payment policy to change

life expectancy, but to sort of round out the micro to macro approach here, you know, we need to think, we need to think more broadly.

Next slide. I also want to make note that under all of this we have really unacceptable, pervasive, and persistent inequities in health outcomes that we have failed to address.

So, you can see on the left the overlap of poverty, mortality, and minoritized rates in ethnicity where we see the worst health outcomes in the country manyfold higher in terms of this is age standardized cardiovascular mortality.

And on the right, the degree to which our progress in both improving cardiovascular mortality and closing the racial gaps has stalled completely. So, another place that we need to make sure that these models focus if we want to get their maximum effect.

Next slide, please. This has been brought up numerous times, so I won't belabor it. But the administrative costs of doing all this, what we have gotten out of it has become untenable.

So, the administrative costs are not

only untenable in and of themselves but have, I think, works to create sort of a quality industrial complex among the, among the health systems and the insurance companies and everyone who's working very, very hard to collect a lot of information.

And if we go to the next slide, we can see the hospital data as well. This is a tremendous amount of time and energy. And even the highest costs in the claims-based metrics, which was brought up earlier as well, hospitals have literally buildings of people that are reviewing every claim going out to make sure it's quoted as advantageously as possible. And it happens on both sides.

That leads to consolidation and corporatization, but it takes people farther and farther away from the community nature and the trust and the other key elements in medicine that we have to get back to through these models.

Next slide. So, to return to why we do this I thought I'd just highlight a couple brief changes in each of these buckets and then close.

So, at the data collection level,

whether through claims or, optimally, EHRs59, we really need to harmonize the measures.

And if we want to improve access, which I would argue is one of the most important things that we don't include now in many of our measures, we have to measure it. And we have to make that something that's a priority. And we can do that. And we can do that in a low-impact way but it needs to be a priority.

At the measurement level, we need risk adjustment that is made for the purpose for which it's used, so we need to use it to combat risk aversion and promote providing care for high-risk populations.

We need improvements in attribution that promote belonging and relationships as opposed to the avoidance of high-risk patients. We have to outthink the people who are trying to game these, and for whom it's easier to game than it is to make patients healthier.

At the evaluation level we need to rethink benchmarking and avoid the temptation to think that we're good enough at risk adjustment that we can compare clinicians or other small entities directly to each other.

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59 Electronic health records

If you're at a safety net hospital and caring for patients who have years of lived experience with poverty and racism, giving them a transportation voucher is not going to ultimately change their outcomes. You should give them a transportation voucher, but the transportation is a symptom, it's not the cause of the inequity.

And if we continue to expect that hospitals can achieve the same outcomes without recognizing the work it takes, societally the work it takes to make that equitable, then we're failing our safety net hospitals doubly.

And, finally, if any of this is going to drive practice change, it has to be close to home. So, rather than sort of micromanaging what everyone does with their patient population, I would argue that we need to move toward providing those measures and that information.

But instead of creating programs where it's easy to game up and down and choose your favorite measures on MIPS, that we really focus on wellness and trust that clinicians and other groups can use all of that quality information that we should be collecting, or we should be sharing, and we should be publicizing, to make decisions at their own level, at their own

community-based level about how to appropriately use team-based care in relationships to actually keep patients healthier.

Next slide, please. So, I'll end with a final reminder that the "why" is health. And the challenge but also the opportunity in these population-based models is really to think about this, and to name it, and to value it, and to talk about relationships and team-based care and equity as opposed to getting stuck in the details of the metrics.

Again, those are important but they're not the why. And I think we need to very explicitly reframe to get patients and clinicians all pulling in the same direction. And that's toward health.

So, in conclusion, on the next slide, please. Payment reform has improved some measures of costs and quality but it ultimately does not seem to have improved health. And administrative burden has driven consolidation, corporatization, and taken us away from wellness, I would argue.

I think downside risk and global costing matter if they facilitate practice transformation. So, if they free up practices to

bring in team-based care, to think creatively about how to deliver that care.

And that measurements should be simple, targeted, and clear, and focus on public health priorities. Leave some of the details to practices and clinics, and really choose some of the big priorities nationally where we feel like we can move the needle in equity-sensitive ways together, collectively.

So, I will stop there and look forward to the discussion. Thank you very much.

CO-CHAIR HARDIN: Thank you so much, Karen. That was really interesting.

We're going to hold Committee questions until after the third speaker. But just alerting the Committee to be ready with your questions at the end of the third speaker.

So, next we have Dr. Mark Friedberg, who is the Senior Vice President of Performance Measurement and Improvement at Blue Cross Blue Shield of Massachusetts.

Welcome, Mark. Please go ahead.

DR. FRIEDBERG: Thank you very much.

So, I'm going to, I think, echo a few themes that Dr. Joynt Maddox mentioned in her talk from the standpoint of our practitioner-

based total cost of care models.

Let's go to the next slide. So, we have something called the Alternative Quality Contract which is an ACO type model, actually preceded the ACO programs that are coming out of CMS by a couple of years because it went into effect a little bit before the alternat -- before the ACA was passed.

And it has some very familiar components:

A global budget, and covering all medical services for a whole population. It's health status adjusted with shared risk, upside and downside for most, for most organizations of sufficient size.

We have quality incentives that have always been a part of the Alternative Quality Contract. These are long-term contracts, in general three to five years in length. It's been one of the more extensively evaluated Alternative Payment Models out there.

On the right here are some snips of some of the higher profile articles. I think it's the only ones to have been evaluated the full eight years. And that was the most recent article that was published, in 2019.

And I will say -- I'm going to get to this later -- that even though equity wasn't originally an explicit, you know, incentivized set of measures within this contract, there was always a hope that the Alternative Quality Contract would improve health equity.

And that paper down in the bottom left, by Zirui Song in Health Affairs, looking at lower- versus higher-income populations in the Alternative Quality Contract really comes out of that first few years of experience. And there we saw some fortunate stuff.

First-off, equity didn't seem to get worse between our lower- and higher-income populations that were, that were attributed to these groups. But, also, on some process measures inequities narrowed a little bit, which is great. And we didn't stop there, but I just want to say that we didn't see any negative effects in the initial roll-out of these programs.

Let's go to the next slide. In terms of spread, the program started with HMO60 only. I think, a lot of folks don't sort of appreciate that fact, but for several years it was HMO only.

60 Health Maintenance Organization

We added PPO61 around 2015. And then small groups around 2018.

And there are some design differences between an HMO population, mainly having to do with patient attribution, and a PPO population where we can't rely on the members themselves to choose their PCP. Instead, just like the Medicare program, we have to impute the attribution using a, you know, method that's very similar to how the Medicare program does it for Alternative Quality Contracts.

The small group model was part of our desire to extend risk. Now, this is upside only to small groups into organizations that did not want to consolidate to take, you know, or stay in this program. And there are just some important design differences there between both the size of the risk exposure and some of the other quality components. There, again, we focused on the ambulatory measures, for example, instead of both ambulatory and hospital measures.

The quality measures always spanned process, outcomes, and patient experience. And more recently we have added equity measures. And I think we're the only ACO type payment model

61 Preferred Provider Organization

still in the country to have explicitly included racial equity measures within its payment model.

Let's go to the next slide. So, I want to say also that I think that the Alternative Quality Contract, like many payment models, a lot of emphasis is placed on the incentives themselves and the payments, but I think that may underplay the importance of two other components that have always been there.

So, here's what I would call the Alternative Quality Contract triad: it's data, support, and payment. And the data and the support actually precede the payment and, I would say, are necessary to truly having the success that we've seen on the payment side.

So, I'll give an example of how we rolled this out for equity, which was a brand new thing that we rolled out beginning in 2023 as an incentive, but actually in 2021 for data and support.

So, we started by giving all of the Alternative Quality Contracts groups, and these are, you know, large organizations, confidential Equity Reports, stratified by race and ethnicity, on all of their ambulatory measures from the prior years. But we couldn't include hospital

measures because we mainly draw those from hospital compare, which does not stratify by race and ethnicity.

We also gave support to the groups. We have an internal team that provides technical supports on performance improvement, both on quality and cost, but that team even though quality improvement is definitely related to equity improvement, actually didn't have any particular experience or specific experience with improving the racial equity of care.

And so, we contracted with the Institute for Healthcare Improvement, which at the time we contracted with them had about five years of experience, mostly coaching hospitals on how to improve the racial equity of care that they provided to their patients. And we convened what we call an Equity Action Community. All of the Alternative Quality Contract groups participated, and now small groups are also participating.

And that's been in session since November 2021, and continues to this day.

On top of that we made Health Equity Grants over to the IHI, which were then distributed to the groups in the amount of $25

million -- it's one of the larger charitable contributions this company has ever made -- as a down payment on the kinds of equity improving capabilities that we thought the groups would need to make.

And I will say, also, that that grant money definitely helped them feel very comfortable participating in the Equity Action Committee because that, just participating in another improvement group even for a goal as worthy as equity, where, you know, I would say motivation was actually very high among our providers, it takes resources. And we wanted to acknowledge that and give some money up front.

Finally, payment more than a year later came online for the first group. So, this is a financial incentive now. And this is intended to be the sustainment of that down payment that we made back in 2022 and 2023.

So, these are financial incentives on which groups will be paid more if they improve quality in such a way that it lessens racial inequities in care than they would if they improved quality in such a way that it did not lessen racial inequities in care.

And there are some QR codes there with

a lot more detail. We've actually open-sourced all of our technical detail. You can read about it at that second, that second or middle QR code. And there's more detail about how the grant dollars were distributed.

We currently have five Alternative Quality Contract groups, soon to be seven, that are participating in the Alternative Quality Contract. And to Dr. Joynt Maddox's point about measuring what matters, we actually gave the groups a menu of measures from which to choose, what they wanted to work on first for health equity.

And we based that menu on measures where the baseline inequity was big enough and where the minoritized populations were large enough. And that happens to be synonymous with the measures for which we could measure reductions in inequities in a statistically reliable fashion. The math worked out with the intuition, which isn't always the case, but it really did work out this time.

And the measure that was common across all five regional groups was hypertension control. Not a surprise. Huge denominator, disproportionate burden of the condition among

our minoritized communities and large statewide inequities. And those inequities were present within each Alternative Quality Contract group as well.

Let's go to the next slide. So, here's an example on the left. And this is a hypothetical report but quite realistic for a fictional Group X of the performance reports we started giving them back in 2021.

Now, we've always given them that histogram on the left. Just the gray bars. They could always see where they were relative to a blinded set of their peer groups. And this group, Group X, might feel pretty good about their rate of colon cancer screening, which is third from the top, so third from the best. Larger is better on this measure.

What's new with everything else in this report, all the dots representing different races and ethnicities, and the detail around the numerators and denominators, and this Group X actually would find out for this report, for the first time maybe, that they were the third from the bottom among our Black members.

And sure enough, if you look at that middle panel on the right, we did a little math

for them, and they are an outlier on the Black-white inequity among the groups in state.

Some groups already had been tracking inequities internally. Most had not, mainly due to the lack of data and resources. But no group -- and this is where the payers can come in really useful I think -- was able to know how they did relative to their peers on measures of equity. So, that's something we can offer.

On the right is a Public Equity Report that's on our website. And we've now done this three times. Next month we'll have our fourth release of this out there. I think we're still the only health plan in the country to do this where we stratify every measure we are able to stratify by race and ethnicity and put it out there for everybody to see.

And this is intended to be a way of demonstrating a long-term commitment to making improvements in the equity of care that our members receive, and also allowing our members, our accounts, and the broader community to hold us accountable for making those improvements.

It's about so many measures now, including processes, outcomes, and patient experience measures. And I would say this is

quite humbling.

Until we started getting into a systematic and regular set of equity audits in-house, I think we kind of knew we had inequities because there was no reason to believe we didn't, but also it was quite humbling I would say to start to demonstrate that we have these and be tracking them over time.

Next slide. This is how the Alternative Quality Contract groups use the grant money. You'll see there are two broad categories: first, data and infrastructure; and second, starting to work on particular equity improvement targets.

When we started this work, we didn't have our internal race and ethnicity data on the FHIR62 standard, the national standard for exchanging race and ethnicity data. We got that up to snuff right away.

And then when we started rolling this out to the Alternative Quality Contract groups and the Equity Action community, we found that some groups were already on the FHIR standard. Many groups were not. Many groups had many different data standards. Maybe they had 20

62 Fast Healthcare Interoperability Resources

different EHRs and 15 different data standards. And they couldn't exchange race and ethnicity data internally, let alone with us.

It was a major impediment to improving on these new kinds of measures.

So, you see almost all of them did some kind of work on data collection or IT infrastructure to improve the completeness and accuracy of the race and ethnicity data they had in-house.

On the right you'll see the kind of targets that they selected to begin with. Many have to do with chronic disease, diabetes, and blood pressure, as Dr. Joynt Maddox mentioned. But some were more generalized, like giving trainings on how to respond to racism or staff bias.

Let's go to the next slide. So, just some guiding principles going forward. And, again, I feel like Joynt Maddox, Dr. Joynt Maddox and I are sharing a brain here.

Knowing why you're doing this is really important. So, the purpose for our performance-based payment programs is to improve the quality, equity, and affordability of care received by our members.

And with that in mind, the category of a payment model according to, let's say, the HCPLAN63, is much less important. So, in our current models we have some that would be, you know, Category 3B, some that are Category 2 or Category 3A, with only one-sided risk.

But the most important thing is that they would, we hope they would work, and without getting too hung up on getting over to Category 4.

We want to evaluate and refresh the payment models regularly. We do every five years or so a big internal retreat on how to make sure that the Alternative Quality Contract continues to improve and be more effective, not less effective, over time.

We just came out last summer of our third one of those refreshes, and we are making material changes to the program, including making the financial incentives larger relative to fee-for-service. And, also, very importantly, to make the incentives winnable for providers.

It's easy because these programs kind of just roll out the way they were originally designed for the performance targets to get a

63 Health Care Payment Learning and Action Network

little unattainable for some of the providers. And that can be very de-motivating and, therefore, work against the ultimate purpose of these programs. And so, we're working on that as well.

And, of course, to continually improve the quality of the data and the support we provide to provider organizations.

I think much of the time if you're not careful, you can set up a payment program that's too complicated, or too unattainable, or too big in terms of its goals. And it's hard for a provider organization when faced with multiple payers to know what to do.

And we think it's a big part of our mission to make sure not only that we've set up the incentives correctly so that the providers succeed in receiving those incentives, thus fulfilling the purposes of the program.

Thank you very much.

CO-CHAIR HARDIN: It's really exciting work, Mark. I'm sure there are going to be a lot of questions for both you and Karen.

Next, we will go to Nick Frenzer, who is the Population Health and Implementation Executive at Epic. Please go ahead, Nick.

MR. FRENZER: Thank you. And I appreciate the opportunity to speak to you today. To set the stage, at Epic, we're deeply invested in supporting the goal of moving Medicare fee-for-service beneficiaries with Parts A and B coverage in a care relationship to quality and total cost of care by 2030. That also supports the goal of increasing the number of beneficiaries from underserved, including rural communities, that receive care through a value-based payment model by, and this is the key, increasing provider participation and improving health equity.

The topics I'm going to cover today that you can see on the screen are focused on how data collection and sharing service goal and opportunities we have as a country to advance.

Next slide, please. Similar to what Karen showed, we are seeing consistent engagement and increased rates of participation in risk, moving into upside and downside risk in particular. Now, that's a positive direction towards higher-value care. However, we can't get too transparent in improved compensation models without timely and accurate data to support these programs.

Next slide, please. One of the issues we're seeing today is a lack of standardization. Sometimes, more options is not inherently better. So, for example, looking at measure specifications and data transmission requirements across ACOs and MIPS, even when we look at ECQMs and CQMs, the difference in the technology requirements for a provider group or a technology company or anybody in the middle increase exponentially each time we add one of these. We then look at Medicare Advantage contracts and certified HEDIS measures that are often involved, and what happens is you create a necessity for provider groups to invest in multiple pathways from an operational standpoint of how providers provide care, in addition to what is necessary to share that data. And, oftentimes, small tweaks in the measures result in large changes to how both care is provided from clinical practice and to how the technology platforms support that transmission. So we end up, in many cases, with inefficient data ingestion and sharing across programs and expectations of data, the unintended exclusion of rural and specialty providers, which I'll give you an example on in a moment, and then very complex empanelment strategies and

reimbursement logic based on what program someone is in and what data is available.

Now, when I think of the unintended exclusions, some examples revolve around where a patient is provided care by a specialist who is the first and only provider that year to see them. If we're looking at the standard of care that a dermatologist provides, for example, what we're expected to show to that specialist provider and what they're expected to do with that data based on their attribution can be very different based on where that patient is in the ecosystem of how they're being measured and what program they are in. So that leads to a large degree of diversity in how those programs are structured and the investment necessary.

Next slide, please. So from a policy strategy standpoint, we are thrilled to be members of TEFCA64, one of the originating QHINs65, but this gives us a great opportunity to encourage TEFCA participation and adoption through policy initiatives. So, connecting TEFCA and information locking policies, HTI-1, as well as providing funding to rural and safety net

64 Trusted Exchange Framework and Common Agreement
65 Qualified Health Information Networks

providers to be able to join TEFCA, that will allow a much greater clinical data sharing, and I'm going to talk in a minute about some of the downsides of what we see in claims. But the closer we can get to that clinical data source to give providers real-time information about their patient population, that will drive many of the outcomes that we're trying to achieve through this shift to value-based care.

In addition, the need for a FHIR roadmap. FHIR is a wonderful technology that we're deeply invested in. However, the manner in which we use it is going to be absolutely critical, given that, even with FHIR, we have the ability to create multiple different paths that will still require additional investment and can defeat the purpose of standardizing on one data-sharing methodology.

And last, at the bottom here, the clear strategy for reporting electronic quality measures, the difference between engaging with aggregating QRDA66 1s across different sites versus using FHIR is still something that we have to determine as a roadmap, given that there are currently three or four different paths that

66 Quality Reporting Document Architecture

provider groups can follow, and given that there are different sunset dates and different timing for when the roadmap is that these programs will exist. It creates an ambiguity that, from a technology standpoint, we have to invest in multiple paths, and that creates inefficiency, ultimately decreasing our goal of reducing the total cost of care in the United States.

Next slide, please. One thing we have done is, in standing up our QHIN, is supporting customers by linking into direct clinical data sharing and adhering strictly to the standardized file formats and patient matching algorithms. I mentioned patient matching specifically because patient matching is patient safety. Knowing that Nick Frenzer at one organization is the same as Nick Frenzer at another organization can be the difference between a misdiagnosis or identification of a problem that somebody else knew about. But if I don't, I don't inherently know how to act upon that.

That then allows us to deploy quality metric dashboards to providers so they know what they're being measured on and it's synonymous with the clinical care they're providing, so I'm not thinking in terms of equality view and a care

view. Those can be married together and tied directly to the clinic practice. This builds upon care everywhere, which is something that we've been doing at Epic for over 15 years, and that's direct clinical sharing with Epic and non-Epic EMRs[67] to create that network. And the QHIN and TEFCA structure builds upon that.

And then payer platform, which is our product to directly share the appropriate data with providers, excuse me, payers, so that we can reduce the administrative burden, as I think Karen articulated extremely well about necessity to possibly be going back and forth and creating abrasion between the payer and providers. So we think that's a great step, but adhering to as many standards and investing as a country in those standards, as we can together, will ultimately reduce that abrasion.

Next slide, please. One of the gaps of claims data is that it is always lagged 30 to 90 days at a minimum, but it is not a reliable substitute for direct clinical data sharing that drives that clinical acuity. So we use claims today in many cases as table stakes for evaluating what has been documented and sharing

67 Electronic medical records

that information in a standardized format. But claims data, ultimately, that lag is going to decrease our efficacy as we see patients move across different demographic areas, geographies, and health care systems that may be on different EMRs.

The EHR variability, to that point, means that, when we look at ACO transmission for example, despite the certification requirements, there are EHRs that still cannot produce a QRDA-1 for example, which then limits a provider group within an ACO's ability to aggregate that data and meet the requirements to transmit that. And that is something that we're going to have to invest in or determine the accountability structure to make sure that if the requirement is all-payer all-10, for example, within multiple CMS programs, then we're going to need to ensure that, for ECQMs for that example, everybody can provide that information, and the provider group is not left on the hook if somebody cannot provide that for them.

Into rural infrastructure. The investment that is necessary is to make sure certainly things like Wi-Fi and structural needs are in place, but also to ensure that we're

recognizing within these standardized programs what is the accountability structure, what is the attribution structure. For a rural provider, that may be different than somebody that's providing care in a large urban area that has multiple sites, that are seeing that patient and different strategies for caring for them.

And then, with respect to specialist involvement, I think we're very supportive of the CMS call for measures for specialists. That's going to be a key to make sure that what we're expecting of the specialists and what data we're providing them and the outcomes expectations that we're setting are consistent and something they can accomplish. A good example is specialist groups we often work with struggle with the MIPS program. But if you are an orthopedic group, for example, because seeing a diabetic patient during an orthopedic consult, you may be the only provider that's seeing that patient that year, but then that attribution of requirement for caring for that diabetic patient can be very challenging.

Next slide, please. So my takeaways would be: We need to standardize more consistently and assertively; we need to adhere

to those and develop enforcement strategies to make sure that our expectations meet reality, and then determine our support structure for rural participants and specialists within these Alternative Payment Models -- which is really the future of where we're going -- so that we provide them with the right guardrails and right support to be successful. Thank you.

CO-CHAIR HARDIN: Thank you so much, Nick. Again, another really interesting presentation.

I'm going to turn it to the Committee now. If you have a question, please tip your name tent up. We have a lot of ground to cover here and some really interesting opportunity to access these experts. So who would like to go first? Jen, please go ahead.

DR. WILER: Thanks to our experts. It's been wonderful presentations, and there's many questions to ask, but I think I'm going to go to Nick. We've talked a lot about access to data and why it's so critically important to improving performance, and then we've talked about should there be financial incentives or not, infrastructure costs, et cetera.

But I'm actually going to give you a

chance to talk about something else, and that's around utilizing electronic data for making decisions, so clinical decision support, for instance. Can you talk a little bit about how your organization or on behalf of other vendors in this space are thinking about helping to support work that is evidence-based beyond just data and reporting? Because we know leveraging protocols, pathways, and, ultimately, creating algorithms through AI have a lot of potential to help us improve outcomes in a patient-centered way. So can you talk a little bit about that?

And then, ultimately, the follow-up question will be how can payment incent more quickly implementation of what you're talking about?

MR. FRENZER: Certainly. Thank you for the question. The goal that we need to strive for is real-time exchange of clinical data elements that are agreed upon within FHIR or other standards so that we are measuring to the same pathway. One thing I've observed is there can be a perception that quality measurements that are often built into CPGs, clinical practice guidelines, are going to be what provider groups are going to use. That is not the reality.

There is generally a difference in how a provider group is going to measure that performance.

So, in many cases, if you look at Care Everywhere, other data-sharing platforms in the QHIN structure, we have the mechanisms to share the real-time data, but we do not often see adherence to what that standard will be. So, ultimately, Epic and other vendors, I can't speak for them, but I will say that we all have the engine to derive that clinical practice based on what that provider group is expecting them to be, but we're not seeing consistency, especially as compared to the quality measures that we are measuring, such as HEDIS for example.

Now, ultimately, when we look at reimbursement models, the key needs to be, in my opinion, what specifically is the outcome that we're going to look at down to a measurement level, and is there an agreed-upon standard that is the expectation for are we measuring a patient, are we measuring an encounter year, what does that look like, because providers will, in my opinion, act upon when we create for them a workflow that is very effective in caring for that patient, but the consistencies are what can be frustrating. And from a technology

standpoint, that investment becomes an overinvestment, and we have to create five different ways to do a breast cancer screening across a health system because of those disparities.

So, to summarize, it is -- the data-sharing mechanisms exist. We do not have consistency in how they are applied. And I think that, at least our customers would be hungry and open to that standardization if we can agree on how they're going to be measured, and then it can be built into clinical practice.

CO-CHAIR HARDIN: Thank you, Nick. Angelo.

CO-CHAIR SINOPOLI: Yes. My question is directed mostly to Karen, but I'd actually like to hear what everybody else thinks, too. And so, Karen, I really enjoyed your presentation, and my question would be, so I agree that we're not really focused on health, and we're obsessed with checking the boxes for a lot of metrics, so how would you think about influencing those underlying behaviors that actually drive health or poor health, and how would you measure that, what metrics would you migrate to?

DR. JOYNT MADDOX: Thanks for the question. A nice easy one to just run with. So, you know, I think we know how and with what people we can deliver care that meets patients better where they are. Pharmacists are better at med titration for hypertension and diabetes than doctors are. Nurses and nurse practitioners are better at follow-up for a lot of sort of chronic disease management stuff than doctors are. Community health workers are better at behavior change than doctors are. And behavioral health specialists are much better at behavior change than non-behavioral health specialists. Yet, the way that we pay for these things and the way that we arrange our care still expects that patients are going to sort of come into the mother ship, right, in these very sort of archaic approaches to care delivery, and part of it is because big clinical groups can't change a plane while they're flying it, right.

Care transformation is really hard, and I think it requires the kind of up-front investment and team-based care explicitly to try to think about how to spread tasks and spread relationship around a group. I don't think that it's the individual quality measures that will

get us there. I think it's more like what Mark was talking about and actually Nick, too, where we're talking about sort of like investing and all going in the same direction, and then you think about delivering the care differently with different groups of people and different sort of patient-centered nature, and that's a bigger lift than just designing more measures. It's much more philosophical.

You know, I think probably emergency department visits and hospital admissions are always going to be a good measure of when things go wrong. But they're way too far down the line, right, and people are quite sick by the time we get there, and we've missed opportunity. So I think hypertension and diabetes and those sorts of things up-front of where we should be focusing with the idea that we will always use those utilization measures as sort of, I don't know, a check, I guess. But it's far too late to be relying on those as our ultimate measure of health.

CO-CHAIR SINOPOLI: So, what would be a good measure of health, before we move on to the others?

DR. JOYNT MADDOX: So, it depends a

little bit on life stage. I think, for younger people, just having hypertension and diabetes under control will get you much of the way there because that's much of what leads to the sort of early onset of cardiovascular disease and stroke, and that's why I think we should focus on those.

In older age and in people with disabilities, I think we underutilize functional status and frailty. We can get that out of claims, we can get it out of EMRs. There's way to kind of understand those, and I don't know that those are good outcome measures. Again, I think we shouldn't be paying on all the things that we measure, but I think integrating those into what you can see in your EMR and what you're measuring in your patient population are another place that's not quite as tough as a patient-reported outcome measure but gets to some of that more global sort of health.

So, for young people who are mostly healthy, I think hypertension, diabetes, gets you much of the way there. For older people where you need more of a holistic measure, I think thinking more about frailty and functional status and how we can try to improve those is a good move.

CO-CHAIR SINOPOLI: Perfect. Mark.

DR. FRIEDBERG: I don't have too much to add to what Dr. Joynt Maddox mentioned. I think there are, you know, some pretty well-established outcomes measures out there, like the SF-12, that have been used in research studies for a long time. You know, they haven't been operationalized as quality measures because they are so distal to the care that's being delivered and, therefore, kind of hard to, like, by giving you a financial incentive to improve your patient's SF-12, I don't know where, as a practicing doctor, I would start with that. I have some ideas, but I think it could be very frustrating from a contract perspective to be waiting years and years and years to see if I'm moving the needle on that kind of, ultimately, really important measure but hard to influence in the short term.

So, there's a balancing act between what you can measure upstream relatively quickly and with high validity and reliability versus measures that are more inherently important, like the SF-12 and related health outcome scales.

CO-CHAIR SINOPOLI: Thank you. Nick.

MR. FRENZER: Thank you. I'm not the

right person to speak to the specific quality measures that are most appropriate, but I will say that the variety of different risk adjustment methods and different measures make it very hard to even start to begin that guidance. So I think, from a technology standpoint, we're more than willing and able to help support that, but we need consistency and leadership on what those measures and what those outcomes should be, and then we can certainly help to enable providers to act upon them.

CO-CHAIR SINOPOLI: Thank you.

CO-CHAIR HARDIN: Let's go to Larry next.

DR. KOSINSKI: My question is for Nick, and I'm going to add a few more letters to the TEFCA, QRDA, QHIN, FHIR. A subject that has come up several times yesterday and earlier today are PROMs[68]. So, where is Epic with respect to patient-reported outcome measures? When will you make it easy for our providers to obtain these? Not to pin you down but --

MR. FRENZER: Not at all. So with respect to information that we gather from patients, we do that through MyChart today, which

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has well over 200 million patients in the U.S. using it. And, ultimately, it comes down to workflow. It comes down to where can we enable the patient to provide information that helps drive that provider's workflow?

So, our strategy is to use the patient portal and use when we have a patient in front of us, and then the challenge is not can we build that into the provider's workflow as a trusted data source. It's a question of when do we obtain that information and what does that mean for a patient in an underserved socioeconomic area and their ability to access technology to do that.

So I think it's incumbent on us to look at every opportunity we have to engage that patient, but taking patient-reported outcomes is bread and butter to what we do today.

DR. KOSINSKI: Proactively. Can you obtain them proactively?

MR. FRENZER: Yes. We can reach out to the patient to ask them for information at any point in time. One really good example of this is we do what are called campaigns, and we can look at all of the diabetic patients within the patient population that the health care system is

looking for and do advanced notification to reach out to them and try to pull in that information. We can query when they've been seen at other places and pull in patient-reported information from those sites. So we do have the ability and often see groups doing proactive outreach to obtain that patient-reported outcome and then build it in.

So, I'd be happy to explore further, but that absolutely has to be the strategy of bringing the patient in to the story and not just the receiver of questions when they're roomed.

CO-CHAIR HARDIN: Lee.

DR. MILLS: Sure. I guess this is for Karen and Mark. I really appreciate the clarity talking about the relative impacts of certain interventions over time and watching those track on those graphs. Would you comment more and unpack a little bit more what difference in quality improvement has the research shown in terms of upside only versus two-tailed risk models? And if there is a consistent difference, which I'm not sure I'm familiar with in tracking literature, but, if there is, how big an impact do you see in the one-sided versus two-sided risk models?

DR. JOYNT MADDOX: I'm not sure there's a clear difference because of the degree to which the programs vary on so many axes at once, right. So the mandatory programs have been weaker. Some have been upside and downside, some have been downside only, but they've been weaker because they're mandatory programs, to some degree. So they've been little bites of, you know, a percent here or half a percent there or a very small multiplier here and there, so it's hard to extrapolate, I think, from what all that does.

I think the move towards things like ACO REACH and some of the other programs where you start seeing practices that are really ready for care transformation would suggest that there is a degree to which more risk means more flexibility, and that's really sort of the thing where you get action. I think, at the back end, it doesn't move too much based on up or down or what.

The voluntary programs are different because you have to protect people. To get people to join, you have to protect them from risk, so then you get all caught up in what those payments and what those reconciliation formulas

are, which have been a little tricky, I think, because of the opportunity to basically sort of, I don't know, arbitrage some of the programs of a voluntary nature because of the availability of data. So I think it's really tricky.

Behavioral economists will tell you that penalties are much more powerful than bonuses, which is a double-edged sword, right. You think back to the VA and the wait list sort of thing; if a penalty is put in place, and it is quite frightening, it makes you act. Now, whether that action is good or bad depends on which of the two things is easier to do. So, I think penalties tend to be more powerful; but until you get out to real risk that also means real investment, I don't think you see true transformation.

DR. FRIEDBERG: I'll just agree. I haven't seen a study that gives convincing evidence one way or the other on upside-only versus upside and downside effectiveness of payment models. I think there's far more heterogeneity within each of those categories than there is between them. It reminds me of studies that are looking at, you know, are doctors or nurse practitioners better or are

specialists or PCPs[69] better for certain conditions. And I think those studies that focus on the means of really wide distributions are very misleading. It's really important to look at the overlap, which is most of the story.

CO-CHAIR HARDIN: Jim, let's go to you next.

DR. WALTON: Thank you. I wanted to respond a little bit to Mark's presentation and kind of dig into that just a little bit, Mark. Thank you for showing us this.

One of the questions I had really was, in your incentive program, were you able to discern particular groups within Massachusetts that have actually leveraged the rewards, so to speak, the opportunity for the reward to move and close disparity gaps that were identified? And could you comment on that?

And then a second thing, and this is going to be for all three of the folks on the call, this whole idea of collecting, where to collect race, language, and ethnicity data and the standardization of that because, obviously, Mark, you're one system, you know, you're one insurer, but there's a lot of disparity, I think,

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in just the collection of that information. I know the Epic executive on the call should be able to comment on that, as well, because you cross all these different systems. And, Karen, I'd be interested in yours, as well. So I'll hush and let you all talk.

DR. FRIEDBERG: So, it's a great question. I'll have to say stay tuned. So we actually don't know the answer to your question yet. The question, just to rephrase it and make sure I have it right, is have we seen any groups move the needle as a consequence of these incentives or any of the other support or data that we've been able to share as part of our introduction of equity into the Alternative Quality Contract.

There's been one full year of the whole program in place for five groups. Hypertension, as it turns out, takes a while to settle because it's a clinical measure that requires clinical data exchange. And we have a system in place that we've had for many years, but it won't be until late summer that we have a sense of final adjudicated performance data. And then, you know, I think we'll make some kind of announcement of what we've seen so far, but we

don't have it for you today.

I can say, qualitatively, the groups have really worked at it, in general. In fact, I know they worked at it because they've complained a little bit about how hard they were working and how hard it was to move these gaps, and my response was, good, this isn't supposed to be super easy, and there's a lot of money at stake. And what we're really trying to do, and acknowledging this is a new area of emphasis, is make it easier for the chief financial officer of one of these systems to sign off on an equity-improving incentive because we've created a return on investment that's, more or less, guaranteed if they achieve a measurable improvement that wasn't there previously. So they might have signed off on, you know, certain things before, but we want to make it more likely they'll sign off on bigger equity-improving investments. And if those prove effective, then the reward will follow.

On the point about data, really important. So I could talk about this for a very long time. Maybe I'll put in the chat -- actually, if you email me, I can send you some slides. We have a lot of material on what we've

encountered with data.

So, first off, we're collecting a lot of data ourselves directly from our members. We've got it for about 25 percent of our in-state members voluntarily collected through our app, through a short survey. They're not representative of all of our members; we know that. There's non-response bias there, just as there is in any survey. But we have been able to validate that those data are highly accurate relative to, like, data that's collected by CAHPS survey where we've been able to do a member match, and CAHPS surveys have very high item response on race and ethnicity items, conditional on responding to the survey in the first place.

What they open the box to is checking the accuracy of data in EHRs on race and ethnicity, and it turns out that varies widely. Some provider groups have incredibly accurate data. We have the same degree of jitter in the data that we have between us and some groups as we have with CAHPs or just people, you know, you ask them the same question twice, they're not always going to answer exactly the same way.

Some groups, it's very different where, you know, the thing that we see the most

commonly is a dramatic undercounting of our members who self-identify as Hispanic ethnicity. We don't know why that's the case, but it's there, and it's a common finding, it turns out, in demography. When you're not sure where your data are coming from, there tends to be a problem of undercounting people who self-identify as Hispanic.

MR. FRENZER: So, my mind goes back to during COVID when this became a very rapid race to make sure that we could map values like race and ethnicity across geographic areas that, historically, were inconsistent. Our first attempt was to see, well, can we standardize those? Can we get everybody to agree on what are the list of values, you know, speaking from a technology standpoint that are appropriate, that was not successful.

So, instead, looking at a mapping exercise to know that different geographies, different states, different provider health care systems, or payers for that matter, may have a different manner of listing them out. But having standardized mapping methodologies, such as the HL7 Gravity standards, has been very successful. So we have built the ability as a part of that

from all Epic sites to aggregate up race, ethnicity, gender, veteran status, those types of elements, so that we can do analysis and research on them.

But I would say recognize that it may not be necessary to have everyone agree on the same 20 values. We've tried that; it doesn't always work. But, instead, can we agree on what the mapped values are that we're going to look at when we're looking to change and impact health equity outcomes? That would be our perspective on what has worked best.

DR. JOYNT MADDOX: Now, I'll add that most of what we do relies on the Medicare data, and that is inadequate for really being able to assess race or ethnicity. You can't be both. There's no listing of groups that are, you know, of sort of growing demographic importance in the country, and, obviously, it stopped being collected by Social Security at some point. So, on the federal level, it's problematic, and I think the EHRs and the practices and the insurers that are actually much closer to the patients are probably collecting it, you know, maybe differently from time to time but in a much more real-time way than the Medicare data, which is

decades old, many decades old in many cases, and pretty problematic.

CO-CHAIR HARDIN: Is Chinni or Josh on? Okay. Committee members, next question. Go ahead, Walter.

DR. LIN: So, I have a question for Karen and Mark. Karen, the overview of the results from the last 10 years of value-based programs that you presented at the beginning of your presentation was quite underwhelming, you know, in terms of the magnitude of the results at least. And, yet, Mark, my sense is the Alternative Quality Contract has produced some very good results in terms of its value-based purchasing outcomes.

And so, I'm just wondering if there's something that's done differently in the ACQ than the other programs that were reviewed by Karen. Is it something that we measure differently? Is it the incentives are bigger? Is it that the data was more timely? Is there something that kind of generated the differential results?

DR. JOYNT MADDOX: I'll give you my philosophical response to that and then let Mark give the response for his scenario. So, you know, I think part of the reality of health is

that health care is only a small part of health, right. So when we think about health care, the idea that we could sort of magically move the needle, I think, is a bit of hubris. There's the impact of poverty and pollution and education and income, and all of those things just so far outweighs moving us on the needle from 85 percent to 90 percent on getting someone a statin.

So to some degree, it's almost preordained that we're not going to be able to make some of the changes that we wish to as long we focus on the individual person. We have to be thinking public health to think about really moving the needle on these things. So it's a bit of an unfair straw person that I set up, right, to make this point exactly, which is that focusing on this bit is not going to get us there, and we have to think much more broadly. And the degree to which we can harmonize and go big, I think, gets us closer to the public health.

That said, I do not want to say that the individual stuff doesn't matter, and, where we can improve, we should improve, and we need systems that help us improve in real-time, as opposed to penalties that tell us later that we

did badly on patients we no longer remember and can't figure out who they are anyways.

So it's both things at once, which is that we need a broader approach to really impact health and that's public health and that's coordination and rowing in the same direction; and there are places that have been quite successful in moving on the individual patient. I will say my current market is not one of them, right. It's not just one individual thing, it's a culture change, and that is very different in different parts of the country right now.

DR. FRIEDBERG: I can't comment too much on, you know, payment models that have been developed by others, other than, you know, in my prior life at RAND, doing some evaluations of CMMI initiatives. I mean, the challenge is we have the luxury in Massachusetts of having a pretty small market where we're the largest commercial insurer, and so we have quite a bit of the patient panel share for most providers, which helps, I think, with making the business case to change how the investments are made in a meaningful way. We're not spread too thin either, especially on technical assistance. These aren't, like, webinars where you maybe have

hundreds of practices or hundreds of organizations around the country attending and getting, more or less, the same message. You know, we have a team of folks who maybe have three Alternative Quality Contract groups each and get to know their staff quite well and are able to answer questions they may have about data or savings opportunities on the fly. I think that's some of the distinguishing features of a smaller local program.

DR. LIN: So I guess, Mark, maybe a follow-up question would be, you know, from what Karen said about health care being a very small part of the effect on overall health, and it's something I agree with. Is your sense kind of the same, and has the ACQ been able to affect kind of the broader contributors to health more than health care?

DR. FRIEDBERG: We've only been measuring, you know, costs, quality, and equity, and equity being stratified quality measures. So none of those are inherently important to outcomes. I mean, blood pressure is like an intermediate outcome. You know, it's not something that's inherently important. It's only important insofar as it prevents strokes, heart

attacks, kidney disease, and the like. So I think we can start to look at that, but we haven't really ever had the data necessary to follow our members into the distant future to see what the ultimate health outcomes look like, and to do that also for comparison groups. We have some kind of credible counterfactual. So, unfortunately, I think it's a bit of an unknown on ultimate health outcomes.

DR. JOYNT MADDOX: And sorry to jump back in. This is exactly why the government exists, right. The private insurers are always going to have people who come and go, and they cannot be driving in each their own direction because we, as the people, are paying for all of us forever. Right? We all, God willing, will end up using government health care. That's the way we've set up our society.

And so, therefore, there's a very clear need to actually be the entity that can say hypertension matters, diabetes matters. I don't care if you can't see your needle move in three months. Like, this is what we are doing because, collectively, it's what we need later. And we're not just going to tell you to go from 140/80 to 130/70 by bringing someone in and giving them a

cup of tea. We're going to say go find your 220s. They are out there. It's half of the emergency department that I round in, right? Go find them. Access -- like, go find them and make their blood pressure better.

And a private company is not going to do that on its own. That doesn't make any sense for their bottom line, unless you make it make sense by setting priorities that then sort of drive that broader sense.

So, the degree to which health care only touches a little bit is, to some degree, expandable, if you think about it from a public health lens, and you think about what's driving blood pressure. You bring in all that other stuff sort of into our lane where we can at least talk about it and acknowledge it and try to push on it collectively.

CO-CHAIR HARDIN: Committee members, any other questions? Go ahead, Lindsay.

DR. BOTSFORD: I'll ask one, and I don't know, Karen, if you have any comments, because I think one of your comments made me think about it but open to others, as well.

I think you alluded to the fact that health is beyond just health care, and a lot of

our measures look at the provider level, sometimes the system level of something that's delivered in the health care space. I'm wondering, as we think about transformation and total cost of care, what gap there is in looking at the health of the system, whether that be on the payer side, on the system side. And to what extent do we need to be thinking about measures that measure the health of the system that can drive health more specifically than just the health care experience? We've heard access mentioned in other places. We hear about friction and efficiency and other measures that might have been considered more practice management measures, but I think, to the degree that we think health is more than just health care and as a measure of a highly-functioning system, what gaps are there and what opportunities are there in leveraging EMRs, leveraging payer data, to think more broadly about what we think of as quality and health?

DR. JOYNT MADDOX: That's a great question, and I would say that the biggest gap is that we have no idea how to define a system. Like, we don't have a health care system. We've got economic adventures happening, right,

wherever they happen.

I'll share a brief anecdote because I think it's actually illustrative of how data and community thinking can come together. So I do not, I am paid nothing by Epic. We are all on Epic in the St. Louis market, and thank goodness because we can actually see where people go. And so we have a gun violence reduction collaborative called Life Outside of Violence. We're working on some sort of substance use and housing intersection with serious mental illness work. You cannot do that by yourself. You have to do it in community.

And so maybe you don't want, like -- I shouldn't be saying any of this -- you don't want, like, Barnes to compete with Ascension to compete with Mercy in some sense, right. Well, you do economically, but you want them to work together. And because we don't have a system defined us such, there's underinvestment in the kind of things that is a collective action problem. And so things like accountable health communities, things that really move in that direction, I think, are very positive. You know, here, it's grown out of a real recognition by the community, by the clinician community, of this

real unmet need around gun violence, around serious mental illness and housing instability. I suspect those are pretty common to one degree or another in different places.

So that's a collective action problem. We don't have a definition of a system, and we don't have a good way to think about that community action, but I would love to see that. Again, this is sort of what government is for, right, to think about these things and to think about nonprofit status and what people are engaging in and how we can use the organizing capacity of some of these ways of thinking about payment and some of these ways of thinking about Medicare and Medicaid and all the ways in which the public dollar goes that we could think about some of those broader questions.

CO-CHAIR HARDIN: So you've touched on this a little bit, but I'd love to hear more from each of you. When you think about the investments or the incentives that are needed or that have worked to help under-resourced organizations and communities come to the table with data collection and data sharing, what would you recommend, what do you think is most important in relation to those investments or

incentives? I'd love to hear from each of you.

Nick, do you want to start?

MR. FRENZER: Absolutely. It's an incentive to provide better care. My mind, as you lay the question out, goes to the safety net hospitals we work with that are often deeply invested in underserved communities and health equity. And for them, they see it as an organizational imperative to do that kind of work.

As compared to a group that's very focused on commercial fee-for-service care, when we see the business model shift into why it is more beneficial for the patient community to look at that downside risk, which we do see greater operationalization and investment in, that is where we start to see that shift. So I would push our energy into the further we can go into incenting folks to provide the care. And to Karen's point, when we see organizations collaborate on this from a care management standpoint, getting people in food deserts into food pantries, that type of work, that all comes in together and supports that type of effort.

So from a reimbursement and quality standpoint, the more we can incent people to work

together and provide those types of things, by saying that that patient's outcome is how we are going to incent you, I think that's where we need to go. The technology supports it. There's a lot of ways we can incent private industry to help align to that. But right now, if you're on five disparate programs, if you're not the type of organization that has this in your mission statement as number one or number two, it then is going to come under something else. And that's the difference that we see when we enable the technology for different types of groups.

CO-CHAIR HARDIN: Karen or Mark, would love to hear from you, as well.

DR. JOYNT MADDOX: Sure. I mean, I'll agree with Nick in that it's not that the technology doesn't exist or even that most safety net hospitals don't have some sort of technological infrastructure and even, you know, FQHCs70 have technological infrastructure. It's that the incentives remain to find your highest-paying patients and go do good things for them. And so until that changes and that's part how much we pay for Medicaid, it's how we think about the safety net, it's where the money is, that's

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where people go. So it's not that it's an unsolvable problem. I have a good friend who is in venture capital in D.C. I've asked him, like, why don't you go invest in, like, you know, really getting into communities that really need you? He's like put the money there, we'll go, we don't care. But there's no money, so why would I go there? I can't do that. That is the issue.

So if you want there to be real change in where we see inequities in this country and where we see really just stunning intergenerational, entrenched adverse health outcomes, you have to put money into those communities intentionally, explicitly, and again and again and again.

And I don't think the technology is actually the barrier. I think it's a potentially incredible enabler because it has kind of gotten commoditized now, like everyone knows how to use the basic technology. So it's a function of getting people to go and use it to do the thing, as opposed to the technology itself being the insurmountable barrier, I think.

DR. FRIEDBERG: I agree with both Nick and Karen. I'll just add that one thing we focused on that was actually a very different way

we constructed pay-for-equity, and now we're going back to our quality programs and adopting this, as well, is to address the concern by safety net providers that their communities are different, and it's unfair to compare them to anybody else who is not surveying that demographic. What we did is we're not comparing them anymore to anybody else in pay-for-equity. They're only compared to themselves in the past and being rewarded for improvements over time. I think that's really important to getting buy-in and making the resources that are attached to the incentive seem achievable. And then there's just an up-front investment that has to be made, and what that investment amount is and what it should go into, you know, we negotiate that with the groups. And we have the ability to do that because we're local and we know them pretty well.

CO-CHAIR HARDIN: One more opportunity for the Committee for any final questions or comments. All right. Then I'm going to just open it up to you experts with one final question. Are there any additional insights you'd like to share about performance measurement and population-based total cost of care models or what financial incentives actually move this work

forward? Anything we didn't ask you about that you'd like to share?

DR. JOYNT MADDOX: I thought the questions were fantastic and sort of covered the waterfront, but I'll take the opportunity to summarize that we need, and I would hat-tip to the CMS folks, for really pushing quality strategy because it gives us an opportunity to say collectively, nationally, societally, what are the things that we want to focus on and how can we be very intentional about that in a way that is centered on equity, recognizes the challenges that people face in their day-to-day life achieving health. And I do believe that the total cost of care and population-based thinking is what needs to get us there. So it's just how we can leverage that with being very explicit about what we want to do and not thinking we can be all things to all people but that we can really push people in a direction of trying to improve broader population health.

DR. FRIEDBERG: Great questions. I would just add the importance of measure alignment across payers from the provider perspective. Absolutely critical. We've had a great experience in Massachusetts. There's a

measure alignment task force here that's been around for more than five years now. Alignment is voluntary, but there's a lot of peer pressure.

People are quite aligned, especially the local payers, in Mass health. The payer is not aligned with Medicare actually because the hard thing for the way Medicare currently does the quality measures is there's alignment within and hopefully better alignment within the programs going forward due to recent changes CMS has made in that regard, but it's still a national uniform data set. And these efforts at alignment tend to happen at the state level. Massachusetts is not the only state that does this. And that might require the Medicare program to adopt local data and quality measure sets, rather than kind of being flexible across states. That's a real hindrance to participating in multi-payer programs from the payer perspective and I think for providers, as well.

MR. FRENZER: Very well said, Mark and Karen. For me, it comes down to convergence. Where CMS leads, everyone follows. And, right now, there are so many paths that we can go down, the closer we can get to as few paths as we can follow so we converge on what's right for

patients, what's right for providers, then I think private industry will absolutely support that. But it will help us be more successful by following a more limited set of measures, of paths, and heading towards value-based care. Thank you.

CO-CHAIR HARDIN: I want to thank each of you for these very valuable insights and for taking the time to be part of this meeting. It was a really, really deep discussion and really informed, as well.

I know we're a little bit early. Amy, can we go to the public comment or do we need to take a break? Take a break. Okay. So we will take a short break until 2:30 p.m. when we have an opportunity for public comment before we close for the day. We want to encourage you to stay on, and, again, thank you so much for sharing your expertise. And we'll be back at 2:30 p.m.

(Whereupon, the above-entitled matter went off the record at 2:18 p.m. and then went back on the record at 2:27 p.m.)

*** Public Comment Period**

CO-CHAIR SINOPOLI: Welcome back, everybody. I believe that we do have a public commenter that's ready to make some comments. If

I can introduce Jennifer Gasperini, who is the Director of Regulatory and Quality Affairs at the National Association of ACOs or NAACOs. Jennifer?

MS. GASPERINI: Thanks. Can you hear me?

CO-CHAIR SINOPOLI: Yes, we can.

MS. GASPERINI: Okay. Great. Well, I wanted to thank first PTAC for the important discussions over the last two days. Quality assessments are critical to value-based care work, and getting those quality approaches right is really important to clinician engagement and the success of these models.

So we heard a lot -- can you hear me?

CO-CHAIR SINOPOLI: Yes. I think we have some technical difficulties.

(Whereupon, the above-entitled matter went off the record at 2:28 p.m. and then went back on the record at 2:32 p.m.)

MS. GASPERINI: I think I left off right around talking about what we've heard today, so that's where I'll jump back in. And we heard a lot today during the discussions about alignment efforts, and I wanted to speak to that. Alignment is crucial to reducing administrative

burdens and freeing up practices and clinicians to care for patients in new ways in value-based care models. But aligning to the right group is equally important.

So, right now, CMS is aligning, for example, MSSP ACO quality requirements with MIPS requirements, which, as you know, are very focused on providing care in the fee-for-service environment, so this really creates issues when you're trying to apply those measures with the same reporting rules that are, you know, being applied equally, regardless of the type of provider when you're applying this in the total cost of care context like for MSSP ACOs.

Instead, we believe it's critical that we start looking at the next generation of measures for population health models, which, as it has been mentioned throughout the meeting, should focus on things like accountability across the system and not with an individual provider, focus on things like care coordination and team-based care, access, and other population health goals that make sense to evaluate at the ACO level and less so at the individual clinician level, for example.

And there's been a lot of discussion

also today around digital quality measurement and interoperability. And moving to more digital measures and reporting methods will reduce the administrative burdens and allow us to really get closer to receiving real-time data that can be used at the point of care to improve care for patients.

However, we also have to have realistic goals for our timelines to move in this direction and take caution to not move forward with requirements before industry is capable of supporting that work. Right now, we're not currently where we need to be in regards to interoperability to transition to fully-digital measures in the next year. What we do need is clear direction from CMS and ONC on what that digital quality future is that we're striving for. If it's FHIR APIs to support digital quality measure, or dQM, reporting, then we need to focus on that goal and not hold ACOs and other value models accountable for different requirements that also require investments in the interim.

And that's really what's happening right now with MSSP ACOs. They're currently struggling with making investments for those

interim requirements that are not really fully aligned with the digital future state that CMS and ONC are ultimately working toward. So we don't want to see the system have to invest now in interim technology and work only to have reinvest in the mapping and infrastructure that will be required, for FHIR APIs for example, in the near future.

So those are just a couple of things that we wanted to touch on today. We have lots of additional thoughts on this topic, and we're happy to follow up. Thanks again for your focus on this topic.

CO-CHAIR SINOPOLI: Thank you, Jennifer. Those were excellent comments, and we appreciate you taking the time to reach out and share those with us. So thank you.

*** Committee Discussion**

I think now we'll move in to our Committee discussions. That was the only public commenter, right?

Yesterday, at the end of the day, we spent a great deal of time talking about what we had heard through the day yesterday. And so, today, we just want to take a few minutes and have some time to re-discuss that and add any

comments from the subject matter experts that we heard from today. So I'm going to open it up to the Committee members to make some comments about what we've heard. All right. Jennifer.

DR. WILER: Thank you, Mr. Chairman, for the opportunity. Without going over what we discussed yesterday, I thought the panelists today were phenomenal and, again, want to thank our PTAC staff, ASPE, NORC staff for putting together a really wonderful meeting and exceptional group of experts.

I heard a number of things today that are takeaways that I think are important for us when we're thinking about our summary report. The first is acknowledging the heavy lift and significant importance of our federal agencies working together to focus on creating a data infrastructure that allows for fundamental data sharing and aggregation through simplification processes which are easy to say and really hard to do and creating this digital platform where data, as we've talked about in the past, is a utility, and then we heard today that tech is the commodity. I think we're really poised to make sure that, if financial incentives are necessary beyond will, that this is critical to the success

of any focus on quality outcomes that we want to achieve.

Secondly, I think we continue to hear there has to be a business case for change, and there's a very different business case for voluntary programs versus mandatory programs. Voluntary programs need high incentives, and it needs to be moderated with an appropriate level of risk. And there's ways to moderate that risk, but one thing that we continue to hear is that payer alignment or all-payer participation, in addition to the simplification of measures that are of high priority, is one critical component of that.

Next, I think we heard about this idea around a balanced scorecard approach, and I think my takeaway is that that has to be at the, quote, system level, although we heard what's the definition of a system? But let's assume that that's known from a population perspective. And I think it really comes back, to me, to that value equation of quality, safety, patient experience, equity, over cost and efficiency. And if we think about measures that really focus back to those fundamental areas of value using

the rubric that our PCDT71 group put together, I think that's a nice place to think about how we pick measures under this simplified and prioritized process.

The next thing I heard was around data, that, again, data and information change performance and outcomes, so why that is so critically important, and that anything we can do to encourage sharing of data or decreasing the friction associated with that is really important.

And so when thinking about drivers, we heard in the first panel around this idea of -- my takeaway was whoever has the data needs to be forced to share it, and whoever is the accountable entity shouldn't be the only one responsible for having to pull it. And so creating some incentives for that sharing, financial or not, is important because that data, again, has to be actionable, it needs to be specific. It can't be aggregated. And what we heard today a lot was around a couple of simple measures, and I know I'll put that in quotes because we heard about even blood pressure being not a simple metric. But, again, a lot of really

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smart, talented people are thinking about this, and there's a way that, we heard from our Epic colleague, if we can all just agree on what the definition is, it can be executed on.

So although data sharing of information is fundamental, critical, and essentially difficult for us to move forward, I also heard that, ideally, each of our accountable practices would like to have insights also. So if there was a possibility to have a version two, insights would be ideal.

And whatever we can do to necessitate, regulate, or pay for this information sharing, and maybe it has to be very tactical. We heard about paying for consultation notes to be shared, so a way to engage our specialists, which we've talked about in the past as being a challenge. Paying for inpatient hospitalization discharge summaries. You can get very tactical very quickly, but I do think those incremental components of important data actually is a place for us to explore.

Then last but not least, we heard a lot about timeliness of care and access as a metric for both quality and safety. And it sounds like there's an opportunity to get a nice

list of those timeliness metrics around things that maybe are intuitive. What we heard was a diagnosis of cancer and then seeing a specialist. It would be nice to have a list of those timeliness metrics that, if they're not ready to be leveraged within CMMI or a CMS model, maybe within the other payer programs or communities, those could start to be used and tested. But we kept hearing over and over what an important outcome, what an important essentially process measure for quality and safety they could be. Thank you.

CO-CHAIR SINOPOLI: Excellent comments. So anything to add to that, Walter?

DR. LIN: You know, it's always very hard to follow Jennifer because she does a thorough job of summarizing.

CO-CHAIR SINOPOLI: That's why I call on her first.

DR. LIN: In addition to the thanks that she gave to the staff, I also wanted to thank the PCDT team, as well, for putting together an excellent two-day public session. I thought we heard from multiple very different perspectives, from a small, essentially solo practice in the middle of Kentucky to mid-sized

practices to very large integrated health plan practices, like Geisinger, to health plans and academic practices. So it was a valuable perspective to hear from all different levels.

You know, I won't repeat what Jennifer said. I think it's very thorough. But I will just maybe ruminate a bit about the last session we heard about where we were reminded how little impact health care has on health, you know. And I think that's pretty well documented in the literature and health economics and other disciplines, as well. And this reminded me of a conversation that we, as most of the Committee was there actually last night at dinner, and, Angelo, you were there, too, where the really interesting idea was brought up why shouldn't we maybe think about having more federal interagency cooperation to address some of these social determinants of health, you know. And so just to name a few, for instance, housing, right. Housing is a big social determinant of health, can we maybe somehow get HUD72 involved? Or food insecurity, is there some way we can kind of think about getting USDA73 involved? Education.

72 Department of Housing and Urban Development
73 U.S. Department of Agriculture

So the list goes on, and it was probably very unrealistic wild idea, but something I was thinking about during Karen's presentation today maybe we should look outside of CMS to help with some of these SDOH74 issues. Big, big challenges that are very hard to solve and, kind of in the climate of growing inequality in our country, I would say very important to solve and, I think, has the attention of not just those in health care but those outside, as well, in some ways. That's it.

CO-CHAIR SINOPOLI: Thank you. Great additions. Jim.

DR. WALTON: I agree with Walter. The only thing I would say just to strengthen his comment would be I think it's our responsibility for the health, the common, so to speak, as physicians, as a profession, to do that. And I think our conversation with CMS physicians, I thought, was very powerful because there's a certain degree of solidarity in the profession that we need to speak into this space to call out more thoughtful action around social determinants of health, investment. We heard a number of times different kinds of investments that are

74 Social determinants of health

needed, so that the next generation can have something more to work with and maybe accelerate what we've been doing over the last few years.

CO-CHAIR SINOPOLI: Thank you for that. Lindsay.

DR. BOTSFORD: Yes. Thanks, Angelo. You know, I think we heard in a variety of our presenters the idea that, you know, and we went into this kind of knowing it, but that our current measures don't really account for everything that we're going to need in evaluating total cost of care. We heard alignment that ER75 and admission rates are certainly good ones that need to be included but might be too late for really showing some of the things we need to show along the way as we think about how we evaluate total cost of care.

I think we heard that access to care, population health measures, mental health, and things like language are probably things that we need to look at as we're looking at evaluation of total cost of care models. Resonating back from yesterday's conversation, the idea that, as we think about looking at more patient-reported measures, patient experience measures, that some

75 Emergency room

of the existing surveys and tools might not meet the needs of all populations, so high-needs populations and how can we make it easier to collect the data that we know is important.

Reflecting from today, I think we heard themes that we heard in our last meeting, too, about how much up-front investment in team-based care is important when it comes to building the teams that are able to succeed in some of these population health-focused activities.

I think the final concept I heard today was, and maybe it's more of a warning or a caution, as we move forward, to thinking about new measures, was the phrase quality industrial complex. And I think that does echo some of the fears here around, as we talk about all the new types of measurement needed, a word of caution as to how we think about who is developing these, where the data comes from, and how can we get ahead of making sure that that data does not become proprietary or having to rely on certain people that maybe have adverse financial incentives being the ones to help innovate in this space?

And I think the final thing from the last presentation was just when it looked at one

of the lessons learned about promoting equity in measurement is when we heard from Dr. Friedberg the idea of, when you're introducing equity measures, to think about just comparing, not comparing to others and just showing improvement, kind the all boats rise concept and that you don't have to be better than the one around you. And the idea, as we think about encouraging equity and encouraging improvement at the population level, how can we just slowly nudge along and encourage that one-percent better, as opposed to having to be above a certain threshold. It takes time and it takes money, and that investment is needed to nudge things along.

CO-CHAIR SINOPOLI: Thank you. Lee.

DR. MILLS: I agree with my colleagues. Perhaps after another two years of practice here at PTAC, I'll be as comprehensive and clear-headed in my remarks as Jen is already. It seems unlikely, but I'm willing to go for it.

I heard a couple of themes. Well, first of all, I want to say, just the recency effect, I thought the very last panel we had, all three members were remarkably clear-headed and clear-spoken. I think maybe the single best listening panel, conversation panel we've had in

two years, so I would, to staff, recommend we think about ways to program them and invite them back at future meetings.

So we heard themes, as Lindsay said, themes that have gone meeting to meeting, year to year. The first was data, data, data. You know, information is the lifeblood of any effective population health, public health perspective and approach, and it's still, incredibly, the data infrastructure of the country is incredibly archaic and incredibly siloed. You know, it's better now than four years ago; and, yet, still the data burden is falling on the physicians and practices to generate the data the entire system is operating on. So it's like those least able to bear the cost and with the least expertise in generating it are the ones that are responsible for doing it all for the benefit of the entire population, which just seems miscalibrated to me.

So we heard an outcry for, you know, essentially health data utility approach, and routine data aggregation for quality measures were certainly on that path towards moving to ECQMs. A really clear appeal from the provider in Kentucky about just why is he having to report on things that, you know, it's not just Medicare,

that payers already know, and there's got to be a way to aggregate that and share that back in a combined denominator, as opposed to relying on the physician directly.

We certainly heard, again, about the need for risk adjustment. I think we haven't talked about this much that, you know, programs in retrospective data review, actuarial studies often are using prospective for comparing effectiveness, quality change provider to provider; and, yet, what the providers need to actually affect change at the individual or group level is concurrent risk adjustment in an ongoing fashion, and they're two different things and that's not widely talked about.

Certainly heard an appeal for moving away from care process measures that are not, you know, more directly tied to outcomes, moving towards patient-oriented measures. I think those, of course, raise a whole level of just operational tactical complexity because you can't administer them at a practice collection level. It's got to go directly to the patient and how does that work? It raises a whole series of questions that we don't have answers for right now.

Let's see. One speaker spoke to a fundamental problem. It's not new, it's been ongoing. I certainly faced it in my work with the provider-owned plan. It's just that CMS is leading the way, and, I think, doing great work in many fronts to point the direction and provide leadership in this. And the rising sea does lift all boats; but, to that point, every private health plan is getting the benefit of CMS' leadership without contributing the additional investments because every health system and practice can't operate differently for this payer versus that payer, and so you build your operation to produce consistent results and every patient gets the benefit, which speaks to a fundamental inequity and a fundamental kind of a systematic lack of the adequate investment we're going to need to really change operations for population health.

I heard a clear call for a multiyear glide path to where we're going, especially around PROMs and health equity. I think there's a real role that CMS has the ability to step into with a transitional plan, much like they've done in other venues, saying, okay, well, we're going to put it out there that 20, you know, proposed

rulemaking in 2027, we're going to switch 25 percent to a prospective population-based PMPM[76] payment and 75 percent current system and transition it over four years or six years, whatever it is. Just get something out there for people to start getting their minds around it's really coming after talking about it for 20 years.

I'm struck again by the quality industrial complex. I don't know what that means to me, but it's really kind of off-putting and scary. It means a lot. And then my final comment is really, really struck by that health care is only a very small part of health, and so this belief that we can rejigger the incentives around health care being, you know, call it 20 percent of health outcomes, and we're going to see dramatic changes in health was hubristic from the start; and, yet, here we are, that's what we do, and those are the tools we're paying attention to. But it does speak to a need for a broader conversation involving a public health approach to health, that it doesn't rely on practices. So thank you.

CO-CHAIR SINOPOLI: Thank you, Lee.

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Lauran.

CO-CHAIR HARDIN: So in addition to all the excellent comments, just one thing I'd like to call out. So people made it very clear. One statement that was made that I thought was really powerful was winnable measures and the ability to have some input into what those look like. People were consistent around calling out the cost for building the analytics, building the ability to understand the data and collect it. And I thought Mark's example from a payer perspective was a great example of how things could be a glide path towards incentivizing and helping people to change.

So the payer provided a dashboard, actionable data, things that helped informed the providers. Then that was partnered with the learning community, so people could come together and learn with each other. And then that was tied to a grant program, so that they could choose a way that they wanted to invest and learn and change. And once that was built, then incentive-based outcome measures were put into play. I thought that was a really brilliant pathway to share.

*** Closing Remarks**

CO-CHAIR SINOPOLI: Perfect. Thank you. So before I close out, Audrey, are there any other questions or comments that you want to have?

Okay. Well, I want to thank everybody for participating today, our expert presenters, panelists, my PTAC colleagues, particularly my PTAC colleagues. This has been a very intense couple of days with great, great information and very engaged PTAC members. I want to particularly thank the PCDT team for a really excellent presentation that I know took you all a lot of work to put together.

So we explored a lot of different facets regarding improving performance measures and development and implementation of the population health total cost of care models. We'll continue to gather information through a request for input on our topic. We're pushing it on the ASPE PTAC website and sending it out through the PTAC listserv. If you can offer your input on our questions by April the 26th, it would be appreciated. The Committee will work to issue a report to the Secretary with our recommendations from this public meeting.

*** Adjourn**

And with that, we'll end this session. Thank you.

(Whereupon, the above-entitled matter went off the record at 2:58 p.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

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Before: PTAC

Date: 03-26-24

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate complete record of the proceedings.

Neal R Gross

Court Reporter