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, September 17, 2024

PTAC MEMBERS PRESENT

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

PTAC MEMBER IN PARTIAL ATTENDANCE

JOSHUA M. LIAO, MD, MSc*

STAFF PRESENT

LISA SHATS, Designated Federal Officer (DFO), Office of the Assistant Secretary for Planning and Evaluation (ASPE)
STEVE SHEINGOLD, PhD, ASPE
RACHAEL ZUCKERMAN, PhD, ASPE

*Present via Zoom

A-G-E-N-D-A

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

9:03 a.m.

* CO-CHAIR SINOPOLI: Good morning and welcome to day two of this public meeting of the Physician-Focused Payment Model Technical Advisory Committee, known as PTAC.

* **Welcome and Co-Chair Update - Identifying a Pathway Toward Maximizing Participation in Population-Based Total Cost of Care (PB-TCOC) Models Day 2**

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

Yesterday we began our day with opening remarks from Dr. Liz Fowler, the CMS[1] Deputy Administrator and CMMI[2] Director.

She provided some insight on the Innovation Center's vision to achieve the goal of having all beneficiaries in accountable care relationships by 2030.

We also had several expert panelists and presenters share their various perspectives

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

on identifying a pathway toward maximizing participation in population-based total cost of care models.

Today, we have a great lineup of experts for three listening sessions. We have worked 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 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 prior to the 2:40 p.m. public comment period today.

Again, that's ptacregistration@norc.org.

Then, the Committee will discuss our comments for the report to the Secretary of HHS[3] that will be -- that we'll issue on identifying

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[3] Health and Human Services

a path toward maximizing participation in population-based total cost to care models.

Because we might have some new folks online who weren’t able to join yesterday, I’d like the Committee members to please introduce themselves again today.

*** PTAC Member Introductions**

Please share your name and your organization, and if you would like, you can tell us about your experience with our topic.

I will cue each of you as we move around the table. I will start. I’m Angelo Sinopoli. I’m a pulmonary critical care physician by training. I’ve had many years of experience in population health, network management, and enable company development.

And presently, I’m the Executive Vice President for Value-Based Care at Cone Health in North Carolina.

First, let’s go to our PTAC members joining us by Zoom. Larry, are you there?

DR. KOSINSKI: Yes, I am, Angelo, thank you.

CO-CHAIR SINOPOLI: Go ahead.

DR. KOSINSKI: I am Dr. Larry

Kosinski. I'm a gastroenterologist by training, and I practiced for 35 years in the Chicagoland area in private practice.

The last 10 years of my life has been devoted to value-based care, specifically attempting to develop solutions for specialists caring for patients with chronic disease.

I am the founder of SonarMD, a value-based care company that was launched following its successful approval by PTAC back in 2017.

So, I have been on this Committee now for three years and look forward to the discussion today.

CO-CHAIR SINOPOLI: Next is Jay.

DR. FELDSTEIN: Hi, my name's Jay Feldstein. I'm trained in board and emergency medicine. I practiced emergency medicine for 10 years and then was in the health insurance world for 15 as a medical director, and also running health plans in both the commercial and government space.

And for the last 10 years, have been the President at Philadelphia College of Osteopathic Medicine, trying to educate our future workforce in our new world of value-based care.

And, anxious for today’s presentations and discussions.

Thank you.

CO-CHAIR SINOPOLI: So, we’ll go around the table now. I’ll start with Jim.

DR. WALTON: Good morning, my name’s Jim Walton. I’m from Dallas, Texas. I'm trained in internal medicine. I practiced in Waxahatchee, Texas, at the beginning of my career developing some Rural Health Centers and helped lead a multi-specialty primary care group.

I moved my practice to Dallas, Texas, leading the Community Health Strategy for Baylor Health Care System and was their Chief Health Equity Officer.

I finished my career as an executive leader for a large IPA[4], primary care and specialty care IPA, and that developed an ACO[5] engaging in APM[6] contracts with CMS, Medicaid, and commercial and Medicare Advantage.

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[4] Independent Physician Association
[5] Accountable Care Organization
[6] Alternative Payment Model

And, I currently serve as an independent health care consultant.

DR. MILLS: Good morning, I’m Lee Mills. I’m a family physician in Tulsa, Oklahoma. I have worked in multi-specialty medical group and health system leadership.

I've practiced, operated, or helped lead five different CMMI models over the years, and been executive leader in two different ACOs.

And then spent four years as chief medical officer of a regional, provider-owned health plan, working in commercial and individual exchange, and Medicare Advantage space.

Thank you.

DR. BOTSFORD: Good morning. I’m Lindsay Botsford. I’m a practicing family physician and PCP[7] in Houston, Texas, with Amazon One Medical where I also serve as our medical director for the Midwest and Texas.

I’m currently the chair of the governing body of Iora Health Network, which is

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[7] Primary care physician

our ACO REACH[8] ACO.

That's it.

DR. WILER: Good morning, I'm Jennifer Wiler, tenured professor at the University of Colorado School of Medicine, and practicing emergency physician.

I'm a co-founder of a health -- large health system's care innovation center where we partner with digital health companies to grow and scale their solutions to improve high-value care.

I'm a co-developer. I have an Alternative Payment Model that was evaluated and endorsed by this Committee, and have over 10 years of experience in group practice and delivery side hospital leadership.

DR. LIN: Good morning, everyone, Walter Lin, founder of Generation Clinical Partners.

We are a group of providers in the Greater St. Louis area, passionate about the care of the -- for elderly living in senior living. Those with serious illness and complex chronic conditions.

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[8] Realizing Equity, Access, and Community Health

We work with a number of different value-based programs, including specialized ACOs, institutional special needs plans, and PACE[9] programs.

DR. PULLURU: Good morning. Chinni Pulluru, I’m a family physician by trade, practiced for 15 years.

I spent 20 years in the value-based care space, first at Duly Health and Care, which is a multi-physician group, multi-specialty physician group, as well as its subsidiary MSO[10] that covered 5,000 physicians implementing value-based care platforms end-to-end at scale, with industry-leading quality and financial outcomes.

After that, left and was Chief Clinical Executive at Walmart Health.

Excited to be here, fourth year in PTAC, just starting.

CO-CHAIR HARDIN: Good morning, I’m Lauran Hardin. I’m a nurse by training and Chief Integration Officer for HC2 Strategies where we partner with communities, states,

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[9] Program for All-Inclusive Care for the Elderly

[10] Management services organization

health systems on building connected communities of care for complex and underserved populations.

I’m deeply involved in implementation of the Medicaid waiver in California and other states and have a background in leading care management and next-gen MSSP[11] and BPCI[12], designing a complex care model that is all-payer, all populations that is scaled to multiple states.

And then, was part of the team that founded the National Center for Complex Health and Social Needs, and spent 10 years partnering with communities, states, health systems, payers, on designing interventions and models for complex and underserved populations.

Excited to be here today.

CO-CHAIR SINOPOLI: Thank you, Lauran. And, we have one of our members, Dr. Josh Liao, who is unable to attend this morning, but he’ll join us for the afternoon session.

So now I'm going to turn things back

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[11] Medicare Shared Savings Program

[12] Bundled Payments for Care Improvement

over to Lauran to lead the next listening session.

So, Lauran?

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

CO-CHAIR HARDIN: Thank you so much, Angelo. We’re really pleased to welcome four experts to our listening session today, who will present on organizational structure, payment, and financial incentives for supporting accountable care relationships.

At this time, I ask our presenters to go ahead and turn on your video if you haven’t already.

All four experts will present and then our Committee members will have plenty of time to ask questions. So, begin preparing those as you hear the speakers.

The full biographies of our presenters can be found on the ASPE[13] PTAC website, along with other materials for today’s meeting.

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[13] Assistant Secretary for Planning and Evaluation

So, I'll briefly introduce our guests. Presenting first, we are welcoming back Dr. Alice Chen, who is the Vice Dean for Research and Associate Professor at the University of Southern California.

Alice, please go ahead.

DR. CHEN: Hi everyone, it's great to have the opportunity to talk to you again. Thanks for having me here.

Next slide, please.

So, when thinking about how to incentivize participation in these advanced payment models, I think it's first helpful to have a lay of the land.

And, I want to perhaps state the obvious, which is that if you are not participating in advanced payment model, you're more than likely going to be facing fee-for-service payment rates. So, something to keep note of is over time, the relative attractiveness of fee-for-service payments have been changing.

In particular, fee-for-service payments have been falling. Cumulatively between 2021 and 2024, there's been a 7.8

percent fee reduction, and there’s proposed fee reductions of 2.8 percent in 2025.

And you would think that this would incentivize participation in APMs, but at the same time, the bonus participation payments for the APMs have also been falling. They will be zero in performance year 2025, so I think we want to keep that in mind.

Next slide.

When looking at ACO participation, I want to focus on the MSSP program, the largest Medicare ACO program that we have.

And what you can see from this graph is that over time, participation, in particular since 2019, has been flat. You can see that in the green line.

But it really isn’t because we haven't had new entrants, it’s really because the number of entrants have equated, essentially, the number of dropouts, which prompts the question of, who is entering and why aren’t people staying?

Next slide.

And, you know, one thing when you look at this a little bit more carefully is, what you can see is each successive ACO cohort has looked a little bit different. And, the ACOs that stay in the program look a little bit different than the ones that leave. In particular, because this is a voluntary program, what we've been seeing is that participation has been skewed towards ACOs with lower baseline spending.

And what this graph is showing you is, essentially, each successive ACO cohort has started to have spending per beneficiary at a level that's lower than the regional average. And over time, the ACOs that remain in the program are those, again, with lower spending relative to their regional average.

And, this is problematic for two reasons. The first is that we know that ACOs with high-risk adjusted spending actually lower spending more than the ACOs with originally low spending.

And in addition to that, it is efficient for the high-spending ACOs to participate in the program. Those are precisely the ACOs and provider groups that we want to be able to incentivize more efficient spending behavior.

Next slide.

So, when we look at the incentives for participation, I don’t want to spend too much time on what’s already been done, but I definitely think that there have been large improvements, in particular, since I last talked to this Committee on the design of the MSSP program.

New this year, they have incorporated a prior savings adjustment which will mitigate the rebasing ratchet effects.

They have added an administrative component in the benchmark growth, which will ensure that there is a wedge that is there between fee-for-service expenditures and ACO savings.

And in addition to that, they’ve limited benchmark reductions due to the regional blending. And this last point in particular, affects the incentives for ACOs with higher than regional spending to participate. So, they’ve capped the adjustments at negative 1.5 percent for ACOs who have higher than regional spending.

Next slide.

So, as a result of the new policy changes, what we see now is that benchmarks are updated using what is -- what they've called a term the three blended -- three-way blended factor, which includes the national trend, the regional trend, adjusted for some of the factors that I mentioned on the previous slide. Previous savings.

And, they've introduced an administrative component into this. And, this three-way blend makes me wonder if this is sufficient to incentivize entry and reduce drop-out.

It's also become quite complicated reading through all of this documentation, and figuring out how benchmarks are actually being updated over time.

And, to offer some ideas on a roadmap for how to simplify this process, and also get us to a point where we might be able to encourage more participation, you know, I think what I would propose is that we have the initial benchmark set at ACOs' own historical spending as it is currently done.

And over time, have a regional convergence phase where essentially benchmarks are updated at an annually projected rate of the fee-for-service expenditures, minus a savings rate, which will differ depending on the ACO spending relative to the region.

And, one thing I would mention here is that I would just caution that these, you know, changes in movement toward regional convergence be gradual.

As we’ve seen, ACOs that face large benchmark changes tend to drop out at pretty high rates.

Once convergence has been achieved, I think we can then move to just annual updates based on a combination of risk adjusted regional rates with a benchmark bump, or even an administrative trend.

And, I think you heard yesterday that the spending at the rate of inflation was proposed.

And, I think, you know, setting the administrative trend at the rate of inflation is certainly a possibility, though we want to take into account changes in health care technology both on the services and the pharmaceutical side, which will increase spending. And that isn’t going to be reflected in just inflation.

Next slide.

What else can be done other than looking at benchmarks? I think there are other financial levers that can be pulled here.

You can make non-participation less attractive. So for example, enforcing site-neutral payments to providers that don’t participate, or make participation in 340(b) drug pricing programs conditional on participating in an APM.

On the flipside, you could also make participation in the APMs more attractive, including increasing the bonus payments for participation, and increasing the shared savings rates, which really will allow providers to be able to capitalize on their investments of participating in an APM.

Next slide.

So, I want to sort of add a little bit more nuance here in thinking about, you know, what again, what are the types of participate -- providers that are participating.

And, I want to talk a little bit about the smaller organizations. There have been again, recent implemented changes to encourage participation amongst smaller, low-revenue ACOs, including slowing down the on ramp to downside risk, and providing some up-front capital investments.

I think what we want to think about here is, can we get even smaller, more PCP-centric groups to participate?

And one viable path forward is to create a track that includes only primary care spending in the risk contract, and have a contract that's based essentially on capitation.

For these smaller groups, allow them to receive some participation bonus, which they're currently not doing.

And consider capping their losses. And for groups with small revenues, you want to cap losses based more on their revenues than their benchmarks, which might far exceed their low revenues.

Next slide.

So to close out here, you know, I offered some ideas on how to improve participation through reexamining benchmarks, through increasing financial incentives for participation, through things like bonuses and increased shared savings rates, and through creating a track for smaller PCP-centric groups.

But I want to leave off with just a few quick pointers here of things just to not forget about.

The first is risk adjustment. It’s the same approach that’s been used in the Medicare Advantage program. It suffers from gaming through coding and insufficient adjustments because it takes the status quo spending as the appropriate level of spending.

I think if we increase beneficiary participation, we will see improvements in an ACO’s ability to change care, and that will also make participation more attractive.

And finally, when thinking about how do the incentives trickle down from the organization level to the physician level, I want to say that restructuring physician financial incentives, there’s a long literature showing that it will affect physician behavior.

But there are a lot of non-financial impacts here. In particular, organizational norms and behavioral economics suggest that physicians will change their behavior depending on practice norms.

I have recent research showing that when physicians are forced to move from one practice to the other because the department closed and they move within less than a 10-mile radius, it turns out that their service intensity really changes from, to match the new practice that they are joining.

But these are just some of my thoughts. I think I’m out of time, and I look forward to a great discussion with my fellow panelists and the Committee.

CO-CHAIR HARDIN: Thank you so much, Alice. And Committee members, please be capturing your questions. I know you’re going to be very interested to dive in on this session.

Next, we’re excited to have Dr.

Michael, Mr. Michael Meng, Chief Executive Officer, and co-founder at Stellar Health.

Welcome, Michael. Please go ahead.

MR. MENG: Thank you.

Good morning, everyone and appreciate you all having me here today.

Next slide.

Just a quick background on myself. I’m the co-founder and CEO of Stellar Health. I will come to that in a second but prior to that, I spent 10 years at a private equity firm investing in all sorts of different health care companies and physician groups.

Today, I sit on the board of three different physician groups across the country ranging from 10 docs in size, to 50 docs in size, to 150 doctors in size.

I’m very proud of the fact that too, I actually get placed on the compensation committee, despite not being a physician, which I think is an honor that I have earned with these colleagues.

One last thing to note, too, is I do sit on the board of the CUNY School of Public Health. I’ve always cared about not only health care in a business sense, but also policy sense as a whole.

So, thank you again for having me today.

Next slide, please.

Just a quick snapshot on who is Stellar Health today. We serve over one million patient lives that we manage in value-based care, or Alternative Payment Models as a whole.

We have almost 14,000 providers onboarded that use Stellar daily. And as a whole, we think of things in two ways. One is how much in reward dollars are we paying to all these providers and their staff monthly.

You can see we paid tens of millions of dollars out, monthly, to these providers for doing the right work.

And, we’re approaching almost a million healthy actions being completed in a year, which we’re very proud of.

We think of healthy actions as these building blocks of achieving in value-based care, or an APM.

I have a quote here that I’d like to

highlight, too, from an actual staff member, office manager of one of our practices.

And, what I like to highlight is the, her statement that the solution not only rewards you, but gives you an immediate sense of accomplishment.

I think this is a really important piece of what is missing in value-based care today, and we'll come upon that in a second.

Next slide, please.

So, I want to follow the start for a second and just think about did you have coffee this morning? And, why?

And, what I contend to you is, it is a very common feedback and habit loop. I, myself, had coffee this morning. I wake up, need a little bit of wake-up coffee.

Act on the behavior and then I'm much more, much, much, much better prepared for the day once I've had that coffee.

We all live in these different feedback loops on a regular basis. Whether it is brushing our teeth to feel clean as we head towards the day, making our beds.

Whatever it may be, these habits are

important and very powerful in how we actually carry out our day.

Next slide, please.

And so, when we think about value-based care performance, we think a lot that the ultimate performance is a lot defined by these primary care and provider workflows.

In addition to that, in order to improve the performance, we're going to require a lot of behavior change. We need these providers and their staffs to do things differently than before.

I tell you that just participating in an APM or a value-based care arrangement does not in itself mean you are achieving in population health or value-based care.

That ultimately, you must do things somewhat differently than before in order to manage that care, those patients' care at higher value, lower cost, and maintain very high quality as a whole.

And ultimately, all these feedback loops and behavior change require real time incentives to the people responsible for work.

I think ultimately, one of the

biggest problems we face in value-based care as a country, is you have two problems, ultimately, that remain.

The first is you have delayed gratification, right? So, the way all these models work, you might do work in it as a participating provider or staff member. And ultimately, at best, you see the reward 18 to 24 months later.

Can you imagine if I told you that your entire salary was instead, going to be paid 18-24 months later?

So, the idea of this delayed of gratification, I think makes it very difficult for people to really want to jump on in, into these and succeed.

A second problem that we also face is shared accountability. For those of you who have led and managed larger organizations, you will find that having the confusion of multiple people responsible for the same thing does not lead to great outcomes.

That we end up with a tragedy of the commons if we do not have clear lines of ownership of who needs to do what.

I think in value-based care because you have to manage a population as a whole, you end up with a situation in which providers sometimes ask themselves well even if I do all these things, what about the rest of the ACO?

If the rest of my providers don't also achieve four stars, or if they also don't do the transition of care visits, do we achieve the results collectively?

So you have this problem of shared responsibility, which I think makes it difficult.

Next slide, please.

And I want to highlight one more thing that's really important, which is from my perspective today, I think we see that value-based care penetration is a little bit misstated out in the real world.

That, in terms of the penetration, a lot of the focus still stays with larger organizations, and the centralized organization at the top.

And the reality that I see is on the ground, it's really the attributed physicians and the staff, the medical assistants, nurses, front desk staff that work with those physicians, that really drive value-based care action and change.

And that one of our other biggest problems is we need to penetrate value-based care and the change, down to those people who do it.

And you'll see here an inverse arrow that points out that the importance of the delivery, the actual doers of the work, the people on the front lines, are actually down at the bottom.

But I ask you, how many of those dollars in value-based care, those bonuses, have flowed to these people down here?

If they don't see the dollars, where is the feedback loop that matters to them?

Next slide, please.

So, one of the things that Stellar does, and I think that any successful program needs to do, is you need to be embedded in the workflow and highlight at the right time, the exact actions that help drive value-based care.

Whether it is doing a mammogram, a diabetic eye exam, addressing a condition, doing a transition of care visit, making the right referral. Any of these actions are what really happens day-to-day.

We all know in this room that these actions drive tremendous value for the system when done right.

So, the real question is, how can we create the feedback loops that train all these providers and staff to do things slightly differently to achieve these outcomes instead?

How can we reward in a way that ties the exact action that we wanted to the outcome that we really need?

Next slide.

And it’s also important to note when I talk to providers and staff carrying out value-based care in the real world, that we sometimes at the top trivialize what it takes to actually get some of this stuff done.

That in order to achieve value-based care on some of the toughest patients, it actually requires more than just an open gap turning to closed gap.

That it actually requires getting the patient on the phone, or engaged. Getting that patient in. You're scheduling the patient maybe with another doctor, like a GI[14].

And then also making sure the patient goes for their colonoscopy and shows up. And ultimately, closing that out with full, full credit all around.

The point here that I'm making is, this stuff is not straightforward, not easy. And we sometimes look at it as just a binary one or zero, open or closed when in reality in the real world, it's a series of workflows that go right, that end up leading to better patient care.

So I ask you today to think about what are all those workflows, and why should they be rewarded to make sure again, we achieve the outcomes that we're looking for?

Next slide, please.

Finally, we think about this a lot at Stellar Health and again, I ask that you all think about it in a similar fashion, which is, there is a feedback loop that ultimately happens to why a provider or their staff may embrace more and more of the value-based care

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[14] Gastrointestinal

and success in it, or not.

The first thing they have to do is have the patients come in and see these patients. Already happens out there, but an important piece in the step.

It is also important to prep these patients in step 4, right? Prep for these patients.

Make sure they understand what are the additional value-based care actions that may be required to truly address the patient today.

Step 5, you have to actually see the patient and carry out these additional actions that is not part of your normal day.

Suzy may have come in for a sick visit, normal sick visit with the flu, but there are other things that you may want to get done to manage her as part of the population.

You really want to use technology to update what has happened. Whether it’s in your EMR[15] or in some other technology, you have to actually note that this, this got done and follow that patient along.

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[15] Electronic medical record

And finally to close the loop, we find it is very important to reward, something we call here Stellar Value Units, or SVUs, for when a practice does the right things in near-term.

By doing this, we change the paradigm to near-term reward, an immediate feeling of the satisfaction of what we accomplished, as well as direct individual accountability to that care team and not the group as a whole, in general.

Ultimately, I think sometimes we ask ourselves why is it that in fee-for-service, we have providers and groups maximizing their RVUs[16]?

And I say it's because that's the way we designed it, right? And instead, if we design the system to maximize the value-based care actions, we will also see providers and the staff carry that out.

Ultimately, I'll leave you with one last story, which is in one of my, in my working with one of the national carriers, I was once with one of the market CEOs.

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[16] Relative value units

And he said to me, it’s so interesting, Mike, you’re saying if we just pay the providers to do the things we want them to do in value-based care, they’ll actually do it.

And, I thought it was such an interesting simple statement that perhaps what we have done is made it so complicated that it isn’t clear what you want me, as a provider to do, and how to go achieve.

And if we can make that incredibly clear, establish the feedback loops, we will see this take off as a whole.

Thank you for your time today.

CO-CHAIR HARDIN: Thank you so much, Michael, can’t wait to ask you questions about that. Next up we have Dr. Steve Furr. We are happy to welcome him as the President of the American Academy of Family Physicians.

AAFP is also a previous submitter to PTAC with the Advanced Primary Care: A Foundational Alternative Payment Model for Delivering Patient-Centered, Longitudinal, and Coordinated Care proposal. Welcome, Steve, and please go ahead.

DR. FURR: Good morning, and glad to

be with you. Michael, by the way, I don't drink coffee at all, so we'll see how this goes.

So I'm Steve Furr, and when I'm not on the road as the president of the American Academy of Family Physicians, I'm a practicing family physician in Jackson, Alabama. So coordination of care is very important to me. Team-based care from a family medicine perspective.

Specifically I want to look at the extent to which formal clinical integration is needed to achieve care coordination and team-based care in the context of population-based total cost of care payment models.

Next slide. So we look at this and things we want to emphasize. Primary care is at the center of care coordination. And care coordination encompasses both physical and mental health. As we're learning, mental health is a huge component of what we do with our patients each and every day.

It is a team sport, and it's led by the primary care physician. And that's the one that coordinates all the care. This care coordination encompasses both health care and entities. Also community-based organizations to help address health-related social needs. So this is where we’re at in trying to address those social needs that our patients are experiencing each and every day.

Next slide. So things to look at. Clinical integration is a spectrum regardless of how formal or informal it is. The name -- the aim of the clinical integration is to improve coordination of patient care across their conditions, their providers, their settings and across time.

So clinical integration is a spectrum. And it can stretch from very informal arrangements to collaborative agreements, to full blown legal entities known as clinically integrated networks.

Some of the more formal clinical integrations involves an integrated platform enabling access to the patient clinical data for all providers. Collection of data on cost, program utilization and participation, as well as clinical outcomes, retrospective and predictive analysis, ongoing collaboration, and communication between in and outpatient providers. Including primary care physicians and specialists.

This should include information on the setting of care, the delivery, the assessments, and treatments given, and the treatment plan going forward. So coordination and management of complex issues between providers and disease management programs.

And in some cases, even having case managers assigned to each complex or chronic patient to make sure they get the care they need and the follow-up that they should.

Next slide. So some points we want to emphasize here. Clear communication is essential. Expectations should be set proactively and clearly understood. PCPs and specialists need to have aligned incentives and must be mutually accountable. And patient preferences and incentives need to be aligned so that everybody understands where they're at and that they're on the same page.

Next slide. While not required for optimal care coordination, formal clinical integration can help. Other things that can help facilitate optimal care coordination include communication, as we mentioned before, technology, and reduced administrative burden.

You know, in all this high-tech world that we have, and I spent all day yesterday upgrading all my Apple devices from my Mac to my iPads, to my iPhone to get the latest Apple updates. Sometimes it’s the simple thing in communication that makes the biggest difference.

I can tell you, two of the most important people on my care team is a vascular surgeon and a breast surgeon that I use. And why do I use them? They always give me information about my patients and get it back, but most of the time I don’t have to even wait until I get formal consult letter back, often they call me directly from the operating room and tell me what went on.

In that two-minute conversation, I know exactly what happened to the patient, I know what the plan is, I know this patient with breast cancer, they’re planning on doing chemotherapy and radiation, in the order in which they’re going to do it. That two-minute phone call will save me 10 to 15 minutes of trying to go through their patient’s records and actually figuring out what is going on.

So that care coordination is so important that sometimes it’s the simple things. Just the phone call, the red flags that will let you know what's going on with a patient and what you need.

Next slide. So primary care physicians are the quarterback of care coordination. This is a team sport with everybody working together. And as long as everybody does their part in the system, it works well.

But it’s so important that everybody also is willing to realize when things aren’t going right or if something’s wrong that they’re willing to make a difference and step up when some kind of data comes through the system that it's not, shows there is an abnormality that needs to be addressed, somebody needs to make sure that’s taken care of.

Just to give an example of the other day, I had a patient who had a chest CT that was markedly abnormal. Nobody in radiology bothered to pick up the phone and call, they just assumed somebody would look at their report that was sent back electronically. And because of that, this patient's care was delayed for a couple of days. Wound up being in a ICU[17] bed on a ventilator. That might have been prevented if somebody had just picked up the phone and called.

So particularly when we coordinate our care, it's so important for our patients that when there is that red flag, the thing that really stands out, that in all the sea of normal lab and lab data, and lab information, something's abnormal that somebody says, that's a trigger, we need to address this, we need to deal with it. So that is clear effective communication.

And I can't emphasize how important it is through coordination between the different specialists. You know I think so many of the specialists now are trained in these vertically integrative systems, and they assume everybody in the world is on Epic, so they all

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17 Intensive care unit

have access to the same information.

So I have some specialists that rarely send me a letter back, even though I send them a patient down, they're not in my network anymore because I no longer send them any patients. Because as a two-way street, I learned about what they've done for my patient, but they also educated me about how they're taking care of these problems. The people who need surgery, who don't need surgery, who treat different.

So I think it's fully important that we continue to train our physicians, that it's important that they continue to communicate back and forth, and that's a two-way street, that our patients get the best care possible.

Next slide. So financial risk needs to be the level above that of the individual physician. Financial incentives need to be aligned among all involved, including the patient.

Value-based insurance design, including coverage consistent with patient-centered care plan, can help align the patient incentives. And the patient's primary care provider needs to be the ultimate owner of the integrated patient-centered care plan covering the multiple touch points across the continuum of care.

Next slide. Some key takeaways. Optimal care coordination does not depend on formal clinical integration but can benefit from formalized accountability. Effective care coordination starts with promoting proactive longitudinal primary care. And those relationships between the primary care specialists and the specialty care need to be communicated and facilitated by clear communications, effective data sharing, and alignment of patient preferences.

And so much comes from the clear communications, not depending on hoping somebody is going to read an email sent through or they're going to read data that was put in there, but that communication needs to be sure the follow-up on the patient, when something is abnormal, somebody is addressing that and making sure that's taken care of right at the point of care.

So appreciate your time and look

forward to the other presenters and answering questions. Thank you.

CO-CHAIR HARDIN: Thank you so much, Steve. Really interesting presentation.

Next, we'd like to welcome Ms. Jenny Reed, the Senior Executive Officer of Southwestern Health Resources. Welcome, Jenny, please go ahead.

MS. REED: Thank you. Good morning, everyone. It's nice to be back with you. My name is Jenny Reed. As it said on the introduction, I'm a licensed clinical social worker. I've spent the last decade-plus in value-based care but came to it through a role of coordinating care for the most complex patients that we took care of in our health care system, so I speak a lot from that point of view and finding places we can coordinate better.

Southwestern Health Resources, if you'll go to the next slide. Just to give you a little bit of background about who we are and what we do. We're located in Dallas-Fort Worth. We are a combination of two large health care systems. One being Texas Health

Resources, which is a large community-based health care system, acute care hospitals, and specialty care hospitals, ambulatory surgery centers, standalone imaging, et cetera.

And UT Southwestern, which is a large academic medical center here in Dallas-Fort Worth that does a lot of teaching and has depth and breadth and specialty services, as well as physicians in our community hospital, Parkland Healthcare System and Children's Health. The physicians from the UT Southwestern serve both of those community resources as well.

So in 2016 these two organizations came together to work collaboratively on value-based care initiatives and form a clinically integrated network. And what you see on the timeline below, I won't read all of the points to you, but what you'll see is a journey from forming as an organization, having already started to put, UT Southwestern had already started to participate in Medicare shared savings upside-only program.

And in 2017 we moved into a Next Generation ACO. We participated in Next Gen until the time that it was sunset and moved into ACO REACH, where we are currently participating in the Global and Professional Direct Contracting model. And we'll be moving into PCP Cap in 2024.

So we have generated $223 million in savings. We've shown lots of success in this model.

And on the subsequent slides, what I will do to explain how we can get specialists more involved is kind of give you a real-world example of what we experience, or what a Medicare member might experience in the DFW market.

Next slide please. So this is a different point of view of our network. 1,500-plus primary care physicians. That's the largest primary care physician aggregation in the DFW market.

Four months ago, and last time I spoke to PTAC, I worked for Baylor Scott and White Quality Alliance, which is the other not-for-profit ACO in this DFW market. We there were the top performing Medicare Shared Savings Program. Southwestern Health Resources is among the top ACO REACH performers. And like I said, the largest aggregation of primary care in the market.

You see that very large specialist number, those are heads. Not necessarily FTEs[18]. As I mentioned, UT Southwestern is a large academic health care system, and so a lot of those physicians wear a couple of hats in teaching research and actually seeing patients.

But also in that number is a large amount of community-based, independent specialists that we work with. And, you know, we really, our goal, in both the primary care and specialist space is to help independent physicians stay independent if they can and make these models accessible to them in a way that they can continue their practice, despite the financial pressures that we're all experiencing in health care today. So when you look at that specialist number those are academic-employed and independent medical, surgical, and hospital-based specialists.

On the next slide is a little bit more detail about how patients and specialists

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[18] Full-time equivalents

might experience our ACO. But just as an example of what I think happens across the country to specialty care providers and facilities who are trying to deal with these Medicare advanced payment models.

So as I mentioned, we’re one of the largest ACOs nationally. We have 125,000 lives attributed in our ACO REACH. So you see that in green on this line across the top. In the pink is our total attributed Medicare Advantage lives attributed to our primary care physicians in our Accountable Care Organization.

And then the rest of the lines, the red and the blue, are the rest of the Medicare lives that we’re serving in our clinically integrated network. And those are being seen by our specialists and in our hospitals and not attributed to our ACOs.

So the point of having all of the different logos that you see across the bottom is to illustrate that most of the organizations, in fact, almost all of the ones pictured here, have their own accountable care relationship with CMS. And we’re all accessing the same resources in terms of specialists and hospitals.

So when we look at primary care attribution, I think it’s really hard for specialists to figure out how they relate, and to really get involved in a meaningful way with all of the various organizations. And what they might deem their requirements to be or their preferences to be.

So I have a few suggestions about how we can fix that. Wanted to show one more example on the next slide. Using our SWHR data, again, 125,000 covered lives, one of the largest ACOs in the country, we got some shadow bundle data based on our 125,000 lives.

And my arrows aren’t quite lining up as they should, but if we look at major joint replacements, that’s 1,850 total qualifying bundles. You can imagine for some of the smaller ACOs that maybe have 30,000 lives, that number is going to be a whole lot smaller.

But even for us, across 12 months, and probably 200, 250 orthopedic surgeons that perform this procedure, it’s not a meaningful number or a number that providers can feel like really is evidence of what work that they do.

Statistically significant work being done. It's also a scheduled elective procedure which is very different than folks who are admitted with a fracture. Which usually is the result of trauma.

And you can see again 35 across 12 months and 125,000 lives. When you look at taking action on that in an ACO that’s more average size, 30,000 lives or so, the numbers just don’t accumulate in a way that it can be meaningful to specialists for participation.

So, and those are surgical specialists. When we talk about medical subspecialists, I think it’s a different ball game because oftentimes they are managing chronic disease. And I know we’ve done some innovation on oncology and ESRD[19] as far as helping, helping those physicians that are managing as the primary provider of care, even though not typically PCP.

But there are more in, you know, ulcerative colitis and Crohn’s disease. Probably that’s a GI physician, et cetera.

So on the left, just some more notes

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[19] End-stage renal disease

of what I’m describing. It's sample sizes too small to be useful in a nested episode in most ACOs. The logic doesn’t follow what's clinically expected.

Again, scheduled elective procedures ought to be a whole lot easier and probably very different to manage. When you look at the shadow bundle of an inpatient fracture, that’s a trauma. And the majority of the spend there is the patient sitting, non-weight bearing and a SNF[20].

So the amount of time assigned to a nested bundle ought to be based on clinical course, not just the standard that we’ve assigned a number to. Earned incentives are delayed and small. I agree with, what I think Michael said earlier, paying doctors 18 months after they do a behavior is not consistent with behavioral economics or just human nature.

The calculations are opaque. How do I understand? We participated in BPCI advanced when I was at Baylor Scott and White. And I think paid reconciliations for three years after. Again, I don’t know that that really

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[20] Skilled nursing facility

links what I did for a surgeon or any physician, what did I do with how did I earn or not earn a reward.

And so specialists lose interest and the program loses relevance. And then we just go back to, do you get to receive my referrals or not based on whatever I define as behaviors I want to see in a specialist. And I think that is a way, but it's not a meaningful way to really engage the hearts and minds of physicians in participating in these programs.

So I've listed some potential solutions on the right. Aligning ACO and facility to encourage collaboration. So if we think back to the slide I had up previously, there are hospital, or health care system sponsored clinically integrated networks.

But how would we encourage primary care-only ACOs to connect to both specialists and facilities to mutually create value and participate in the value that's created? Including quality and cost metrics relative to care setting and provider. As I mentioned before, these episodes, and specialists are all, are not created equally.

Reward transitions back to the community provider. So that’s a simple way of saying what I think was said right before is, you know, if you give the information on what happened to my patient back to me maybe there is a reward for that. And that starts to get us more integrated and coordinated.

Allow ACOs to opt into nested bundles rather than requiring. So using this data on the left, maybe I would opt into the first two, but obviously the last one, 35 encounters over a year, maybe not as exciting a risk venture for me to take right out of the gate.

Include clinically relevant providers and timeframes. This is a, health care is a team sport. And then establishing low volume threshold. So those are some potential solutions for nested bundles.

On the next slide, a little bit more about specialists’ participation in general. Sharing all relevant data to, all data relevant to the use case. What I mean there is, CMS has data, longitudinal data, or provider-based data across how they’ve provided care to all of their lives, Medicare lives.

The only thing that ACOs can see is how a specialist has provided care to their specific attributed lives. What that does for specialists is can unfairly represent what, how they're providing care.

So in a similar way to what we do to primary care when we attribute lives to them, maybe there is a way that we can create specialist datasets that say, here is how this particular surgeon does surgery on a broader, more statistically significant look rather than just, you know, the few episodes that happen to occur within your ACO.

Give episode data with national and regional benchmarks. Maybe something with stars, et cetera, to inform patient choice. Use standard definitions that are transparent and relevant to the clinical scenario. And like I said before, ensure sufficient sample size.

Aligning program design elements, so eCQM[21] and MIPS[22] should remain aligned to broad

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[21] Electronic clinical quality measures

[22] Merit-based Incentive Payment System

outcomes created by all providers. Again, this is a team sport. Not taking it to specific metrics that aren't, wouldn't be significant or represent the course of care for a patient longitudinally.

QP[23] bonuses today penalize ACOs who include unattributable providers. Let me pause here for a second.

So because of the way the QP bonuses work and the percentage of revenue that's involved in an APM, for what you see typically is that health care system CINs[24] include specialists, and primary care independent ACOs include primary care. When you add specialists, you have to look at their entire book of Medicare business.

And what percentage of that is involved in an Alternative Payment Model, regardless of what I already said. Not all of those patients are attributable to the ACO. So you create a disincentive to include specialists in the ACO because of the way that that math works.

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[23] Quality payment
[24] Clinically integrated network

So said differently, if I include an orthopedic surgeon, I'll just use them because we talked about knees earlier, in my ACO, and they see a hundred Medicare patients but only 20 of them are involved in my ACO, or any ACO and APM. Now I've got 80 patients who count against me in my percent of Medicare revenue for my providers that are coming through an advanced payment model. And that jeopardizes my ACO's ability to earn a QP bonus.

And that, that in and of itself is a disincentive for ACOs to go out to the community and include providers. Specialist providers for that reason. So that has to be something that is fixed if we want to include specialists.

I think specialists probably need to be able to participate in multiple ACOs, just given the data that I shared on my first slide. There are lots of community, there are lots of ACOs in the community.

Tighter alignment benefits patients, so allowing them to count theirs across multiple ACOs would be helpful. Updating attribution logic to include a greater number of specialist panels for those medical subspecialists that are the provider of record because they’re managing a complex disease.

They should be able to get credit for driving that care. Similar to how we’ve done oncology and ESRD. And then make advance payment option available to all ACOs regardless of revenue.

We talked earlier, one of the speakers talked about low-revenue ACOs. I’m a little bit on the advocacy, I’m a lot on the advocacy side of high-revenue ACOs because I think we get sometimes a bad name.

But because we are including all these specialists and facilities, there is a longitudinal care element that I truly believe is part of the solution for value-based care. We have to include all the providers of care. All of us have to work together to create value. And we shouldn’t be penalized for taking on a broader swath of care.

And so I think that the revenue, high-revenue, low-revenue can disincentivize both small providers who don’t have a lot of capital access to join these programs, as well as high-revenue providers who really are trying to coordinate a more complex set of participants.

So those are my thoughts there. And I think I have one more slide. That is about patient involvement. And I believe it was our first presenter who said, the patients need to have an incentive to participate.

I couldn’t agree with that more. There is a lot of, there are a lot of elements for patient choice, and to protect beneficiaries from exploitation that can occur in these kinds of programs. And I totally agree and support that.

However, the patient involvement is key to success. Without incentivizing them to understand what they’re participating in, to understand their choices and to make smart choices about how they can participate in their own health, we are still going to be a paternalistic health care system speaking at people instead of working with people, and we have to fix that.

So I have a couple of bullet points here. Redesigning, sorry, I’ll just go through them real quick. Redesign notification so that beneficiaries hear what they want to know, not what, you know, legally we think we should tell them. Allow ACOs to customize so that they can combine with other communications that they're giving that may get the patient's attention better. And increase flexibility to provide beneficiary incentives.

On the last slide is just a conclusion. Again, make it easy to understand for specialists to participate, make it easy to understand and join, allow advance payment options and broader participation, and incentivize patients to participate. Thank you for your time.

CO-CHAIR HARDIN: Thank you so much, Jenny. Really interesting presentations. So we're going to go to questions from Committee members next. If you have a question, please tip your table tent up. If you're on Zoom, please raise your hand.

And I'm going to take the opportunity to ask the first question while you're warming up. So we know, in focusing on achieving care coordination, the recommendation is really looking at multidisciplinary team-based care that's longitudinal to really have holistic care coordination. So I'd love to hear from each of you what roles or disciplines you've seen as most essential and successful in achieving the care coordination outcomes that we want to see in Alternative Payment Models? That's the first level of the question.

And then the second level is, what are the financial incentives that actually result in growth of those roles in achieving the outcomes that we want to see?

So open that up to whoever wants to start first, but definitely would love to hear from each of you. And if you don't jump in, I'm going to go to Michael first.

MR. MENG: Sure, I'll take that one. So in my experience I don't necessarily think there's a role that is special or makes the difference. And it's not because I don't think it's important, it's that I think in every practice, it's someone different sometimes, and the role can be called different things.

So in a large group you might have nurse care coordinators, right, that are absolutely essential to this. I think what I find is that your five doc groups though, smaller group, it might be the front desk staff. So I don’t necessarily say it’s this title or this role that makes that difference, I think what it actually makes a difference is the work they do.

So, and the work we can all agree on is kind of the same. It’s making sure patients navigate to the right place, it’s making sure that when they’re out there in the wind, we get them in and all these different things, right? So I think we can all agree on that.

Again, I don’t have a title that I like to use. I think in different groups there is different ones. For me though, to your point, it’s all about making sure they’re rewarded.

And what I find absolutely fascinating, right, is a lot of these people, if you actually look at what they make per hour, we’re not talking about a lot, right? They’re competing against the, people hiring, employing them are competing against IHOP down the street. That’s a real story by the way of losing these people to IHOP who are offering $25 an hour when inflation really hit.

And so for me the really interesting thing is, how can we just pay them a little bit more? And oftentimes I find it's not so much that they care so much about the money, right, it's also about the thank you, the gratitude that that represents when you ask them to do more work than they're actually rewarded for.

So I think the most important piece of this is, they're very much the backbone of our health care system. Not that providers are absolutely important too, but I think we share some portion of the dollars to these people, and they will step up and do a lot more of this work.

CO-CHAIR HARDIN: That's great, Michael. And have you seen the incentives in your model actually result in an increase in those roles, or is more just increase in their payment?

MR. MENG: No, we, actually, it resulted in an increase in a couple different ways. So one, we actually did see groups start adding more of this role over time.

Now some of our larger groups, they're earning hundreds of thousands of dollars, maybe up to millions. And to me that's actually the ROI[25] machine.

And forgive me for being a bit of a finance student here which is, I think in order to make this work, the provider side needs to see a return on their investment first, and then they can invest that back into these people and hire more of these people who generate more return on that investment again. And that's how this ultimately results.

But the second thing I will also highlight, and we did this study with Healthy Arkansas, which is a lot of the larger health systems there which we are implemented in, and we also found that patients who, the care coordinators and staff members who receive this small extra dollars actually scored about 10 points higher on their employee engagement survey.

So much so that the health systems were perplexed at a time when it was hard to retain these people, what was it that was so

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[25] Return on investment

different about this. And a lot of the comments were, it feels like you guys actually appreciate the extra work. When you ask me to stay late till 7:00 p.m. to do this extra call for a patient that I actually, you appreciated it versus just expecting me to do more to burnout.

So I highlight that. It's employee satisfaction, as well as the fact that we could actually add more of that capability.

CO-CHAIR HARDIN: That's great. Thank you so much. Steve, would you like to comment?

DR. FURR: Yes. I think one of the most important things is who actually is in charge when something in the system breaks down. I think that ultimately goes back to the primary care physician because when the system does break down, you need to know why it broke down and how do you fix it, these problems still don't continue to go on.

So for example, when home health sends a patient to the ER[26] without calling me first, and it's something I could easily could

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[26] Emergency room

have handled over the phone or brought them into the office. I don't need home health to send them to the ER. I need them to communicate with me what needs to be done.

Or as I mentioned the CT scan the other day, nobody called me the results that could have been taken care of. So ultimately, I think the family physicians got to make sure, the primary care physician has got to make sure when things do break down why did it break down.

When your subspecialist doesn't give you a call back or he doesn't send you a consult note, you say, I've got to get me another specialist here on the team. So I think ultimately that's important.

I think addition of financial incentives, I think everybody on the team is excited when you see you made a difference in a patient's life. That you saved that diabetic leg, that you kept that patient from going dialysis. So I think sharing those wins, not only when things break down but when things work really well, my people get really excited about that, and they know they made a difference.

And ultimately, we all went into medicine because we want to make a difference in our patients’ lives. So I think that makes a huge difference.

But financial incentives do help. And I think positive incentives help. I don’t think negative incentives really drive physician behavior.

I think we have a history of having a really weak care and a strong stick, and I don’t think that helps physicians. I think the reason they’ve steered away from a lot of these models is that they see they have to do a lot of work to get a two percent gain, but if they don’t do it, they take a seven percent loss. And that doesn’t encourage anybody to participate.

CO-CHAIR HARDIN: So helpful. Thank you so much. Jenny or Alice, would you like to comment? Jenny.

MS. REED: Sure. so I think that the roles that we have seen be the most helpful are really, the biggest, the most important one, I guess, is risk stratification because the role of a nurse is more important for a complex patient who doesn’t understand what's wrong with them or what they should do next, whereas I think the gross majority of people just don’t understand how to access health care.

And that advocacy and navigator role that Michael mentioned has been super helpful. Not only to make sure that we generate our outcomes but also, to Steve’s point, to take some of the burden off of the physician. We found that even depression questions were hard to add to the physician’s plate, but when we could say, hey, if you, your PHQ[27]-2 comes out positive, we have the social worker that’s going to do the nine.

And that’s also going to address the issues that are discovered in that process. Okay, well then, that’s a little bit of what happens to my day.

As far as the what happens to my pay, I think we have designed incentives that are aligned with overall outcomes. So there's an annual goal or target set of goals that we

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[27] Patient Health Questionnaire

meet. That we need to meet.

And when we do, we reward all the way down to the frontline staff. We don't reward on an individual activity basis, but I do believe in changing the economic model.

I think the more these programs can change the economics of fee-for-service to value, the better. What I think we have to be careful not to do is create another production model, or just another RVU, and make sure that we, I feel pretty strongly about connecting to outcomes as much as possible because all those dollars come from somewhere. And they're being spent on a patient today. So we have to make sure that it's not needed for that patient tomorrow in order to connect those incentives correctly.

CO-CHAIR HARDIN: That's a great point, thank you, Jenny. Alice, please go ahead.

DR. CHEN: Yes, you know, I think from what you've heard from the panelist, my interpretation from what everyone has said is essentially there is a variety of different disciplines and roles that are maybe specific to a given organization. And I just want to mention the health hot-spotters randomized clinical trial.

I'm not sure if the panel is familiar with that trial, but essentially in Camden, a team of nurses, social workers, community health workers all went to coordinate care for some of the highest-risk patients with this idea that surely there will be savings. And there wasn't.

And I think that was a surprise to everyone. And I think part of the challenge here is knowing that organizations, not all organizations are the same, they're all different.

And so being able to pinpoint a certain title, a role, a person that would be most successful in a given organization, across all organizations I think is not a, it's not something one can identify or answer really well. But definitely agree with the need to make financial incentives, you know, at least present for the people who are doing the role.

CO-CHAIR HARDIN: Wonderful, thank you. Larry, let's go to you.

DR. KOSINSKI: Great session. I always enjoy listening to speakers that are on the ground dealing with this every day. And all of you are in that space.

As a specialist, I typically bring up the specialty focus issues. And although my question is going to be focused towards Jenny, any of you can participate in it.

You mentioned that you are attempting to bring in value-based payment programs for medical specialists. And you specifically mentioned oncology and gastroenterology. And I am a gastroenterologist.

So much of the work that we, the care that we provide today requires extensive pharmaceuticals. So my first question is, are you including in total cost of care models for your ACO pharma medical, as well as pharma based spend, and if you are, how does that, how are you utilizing that to make sure that the specialists are providing the right drug to the right patient at the right time for the right reason?

MS. REED: I would love to tell you

that we have cracked that nut.

(Laughter.)

MS. REED: I will tell you that we are committed to furthering that. Yes, we do include pharmacy and medication. We also own a Medicare Advantage plan, so we’ve had some successes. And to be real honest with you, some failures because of the headwinds of pharmaceuticals and all of the other legislative changes that have occurred.

But we do see wins in things like medication selection is one. So making sure that we understand all the bio-similars and are they really similar. But also site of service delivery for those medications and where we can do that in the least restrictive environment. And then patient adherence to those. Because we know what costs can occur without proper adherence.

But yes, to your point, those are going to continue to be some headwinds that we have to work through. But including the medical specialist in the conversation is the first step to get that solved. And how much time and expense is part of the workup and the what's wrong that we could potentially take out and make better for the patient.

So I don’t know if that totally answers your question. I think it’s, we’re on the beginning side of that.

And I think CMS, with the ESRD model and the oncology model, has done some experimentation there too that’s helpful. I think they should include GIs. I think you need to be a part of it, I think, you know, pulmonary physicians need to be a part of it for COPD[28], cardiologists for those complicated heart failure patients.

You know, we penalize hospitals for readmitting them, the heart failure patients, but where is the incentive for the cardiologist who really managed those patients? In some cases, they can be attributed, in a lot of cases, they’re not.

So it’s a combination, I think, of designing the right program. And then clinically, if that medication is required, negotiating the right price and allowing for the treatment to occur that prevents the

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[28] Chronic obstructive pulmonary disease

disease from progressing.

DR. KOSINSKI: Thank you. Great answer.

CO-CHAIR HARDIN: Any of the other presenters --

MR. MENG: A little bit on it.

CO-CHAIR HARDIN: -- want to comment? Please go ahead, Michael.

MR. MENG: Yes. Well Larry, that we actually recently were commissioned by a large national payer to drive value-based care in specialists. So this is a very important topic to them.

They actually looked at a number of specialists, including GI, that almost act as primary care, right? Again, we sometimes only think about Medicare but don’t forget that for women aged 20 to 40, your OB/GYN actually might be your primary care physician essentially.

So we looked at about five or six of these specialists that essentially are being used as a primary care quarterback. And we’re actually going after them in the same way to try and drive these things.

Now you bring up the pharmacy side

of things, and we have a couple clinics that are very high in HIV for example. And that is incredibly difficult. We've never been able to get a value-based care contract or APM setup properly there because that spend is just so different. And neither payer or us can figure out how to do that in a way that is meaningful.

But again, I will say, I think the tide is starting to turn. That specialists are being included. Especially those who really direct a lot of the care for these patients. And I'm pretty encouraged by that.

CO-CHAIR HARDIN: Anyone else? And as presenters, I want to encourage you as well to comment on each other's comments. The dialogue amongst you is very valuable. We appreciate all of your expert opinions. So we'll go next to Lee.

DR. MILLS: Thanks. This is mainly for Alice, but others will have comments, I'm sure. I'm fascinated by your third slide just showing that participation of ACOs has been strongly skewed towards those better performing at baseline with benchmarks spending less than their regional average. Obviously conceptionally the greatest aggregate gain will be those moving from terrible to average, not good to great necessarily.

So focusing in on that specifically, why do you think that is?

I think for me, it’s more about culture of those lower-performing ACOs perhaps in leadership vision than economics, right?

I would just love your insight to why you think that is, and then that leads to next follow-up question, what could we do to change incentives or models to get the higher-preforming aggregates of doctors and ACOs or worser performing to actually engage in this journey?

DR. CHEN: That’s a great question. I think what we’ve seen is, essentially over time the ACOs that are entering are becoming the better performing ACOs, right? Those that, as you said, have already low spending relative to their regional average.

And part of this is because 2019 when we introduced pathways, we started penalizing ACOs with higher spending than regional average. We started putting into their benchmark essentially a stricter updating factor that required them to do, you know, to have larger savings in order to be able to have any incentives, right, to be able to have any dollars back, paid back, bonus payments back, relative to the ACOs that were already spending less relative to their region, right?

So that was a mouthful. All that to say, we made it harder for ACOs with higher than regional spending to participate because we made their benchmarks harder to meet.

And I think that is something that we should really pay attention to. And that's in part why I think that the blending of the regional benchmark should be done at a very gradual pace because those are the high spenders are the ones that we want in the program.

CO-CHAIR HARDIN: Anyone else want to comment?

MS. REED: Just going to add. Can you hear me, I'm having trouble coming off mute?

I was going to add, the converse of that is also true, Alice, right? So the high spenders end up exiting because they’re higher than regional benchmark.

And the ones that were low spenders now have a delta that they were never able to achieve before, and so their willingness and ability to take risk increased in 2019 when they kind of got credit for regional benchmark because performing against yourself, when you’re already performing really well, is not a place where you want to place your bets. So I think that’s where you saw those high-performing ones kind of double down and the lower-performing exit.

DR. CHEN: Yes, absolutely. And I think part of this is also, Jenny, as you mentioned, essentially this rebasing and this ratchet effect we want to make sure that we definitely protect against.

MR. MENG: I’ll add one more comment too –

CO-CHAIR HARDIN: Great.

MR. MENG: -- and we have this in MSSP ACO, so I do think about this a lot in terms of, I think the issue is also that, don’t forget that we’re asking these groups to take insurance risk, right, essentially? And when you're doing that, one of the things I think is maybe understated is the potential risk of ruin.

So the idea that something can go so upside down that it could blow up the ACO as a whole I think is not fully accounted for. And so, I think if we want people to take the risk on the higher cost patient, I think we want to make the risk corridor more aligned to that so that they are willing to take such a risk.

I think as someone who runs an ACO, it's easier to say, I'd rather my consistent clear performance than to maybe take a chance on something like that. So that might be a part of it too.

CO-CHAIR HARDIN: Thank you, Michael. Let's go next to Jim.

DR. WALTON: Thank you. Thank you all for your excellent presentations. Michael, I'd like to direct this question. You were commenting, and I was struck by the perspective of incenting through proximity of reward toward the activity to the strategic value unit. I think you called it SVU. I like that.

I wondered, and I saw in your example kind of how you do that, and I was wondering what other elements do you reward, and for example, and do you measure the code, you know, like the reward for, let’s say coding accuracy, and it produces a unit of work, and there is a unit of reward attached to it, do you have the same thing for your providers relative to care management, then what percent of the reward systems are structured so therefore coding versus care management?

I’m thinking care management like referral completion and the patient made it to the specialists in a timely way. Completion of health-related social needs screening and addressing the actual gap in the social need. Is that part of the activity? Okay, that’s question part one.

Then the second one talked a little bit about the rewards, and I got the impression that they were provider-based rewards. And I was curious about, because of some of the work that I do identifies really staffing and labor issues as one of the top issues inside the ambulatory space. And I was curious about how the rewards are actually allocated. Are they all provider-based rewards, or do you have staff rewards as a percent of contribution?

And the same question would be for the specialist. Are they, or do you have a percent of the reward system for the specialist that are participating and helping make the value of the outcome in the value chain?

MR. MENG: Great question. So the first one I'll say, we're very proud of this, that we architected ourselves in a way in which anything you would want to incentivize, your heart's desire in value-based care, we write up actions for and then incentivize. So to your point, transition of care can be important. To your point, referrals can be important.

We're actually testing something right now on switching to ambulatory surgery centers, right, which is a really hard one to do by the way. The point being here that, absolutely, care coordination is a big piece of it.

I'm also pretty proud that we're partnering with some of the 1115 waiver in New York, because we also have sufficient density of providers here where we're going to actually be the ones administering the social determinants dollar rewards for those specific activities.

So you're absolutely right, that's an important piece of it. We're not trying to just incentivize coding or one thing.

And so I think I think of it as, I'm not the expert on what do we want to drive, I think you all are. My job is to make it so that you can incentivize it and drive it so when we partner with someone like you to set up a program, you actually have your say on that.

And I'll add that the SVUs is dynamic. So one of the things I am a little frustrated with that you all know well, is that the physician fee schedule in RVUs is actually updated once a year. It's fairly fixed. So once you're done that, it's stuck.

Stellar, or SVUs, are actually dynamic. We can change it down to monthly or weekly, or daily if we wanted to. We don't do that because that would throw people a little bit, but we can. And that's important because you want to change in different parts of the year, or different populations, the amount that you're rewarding for different things.

What we've actually found too with providers is, as long as what you see is what you get up-front, the no overapplied, underapplied, overpayments, all these other things, providers actually are okay with the changing amounts as long as it's clear up-front what they would have earned for it. So all that is to say, you're absolutely right about the direction that these are going, and we want to partner with folks who know what they want to drive to go drive it. We're not experts ourselves necessarily in the different things in your population.

And specialists, I will say that we don't actually have, and have fully figured out yet today, and I'll come to that in a second.

And then on the staff, you hit the nail on the head. Which is, we actually encourage sharing about 20 percent of the earnings with the staff member who logged in and actually did the work to tee it up for you. We find that ratio to be a pretty solid ratio.

It can rain. We let every medical group choose for themselves in the end, but we have found that when you share 20 percent, oftentimes it results in a staff member earning about 300 to $500 extra per month. And that amount goes a really long way for them while also driving significantly better results for the group.

So yes, absolutely. Exactly how we think about it is how you stated it. And that has actually been, I think, a big key to success.

DR. WALTON: Lauren, can I follow on? And, Jenny, I'd be remiss. We have history. It goes all the way back to Baylor 20 something years ago.

I'd be remiss not to ask you the same question. I had a couple, I'm going to tee it up a little bit. So I'm just pleased with hearing the success of this SWHR organization in its scale.

I think that, you know, and I watched this while I was in the system working in the Dallas-Fort Worth Metropolitan area watching the competitive nature of what was happening in the consolidation around, consolidating physicians around value-based movement is really quite remarkable. And it is a study in itself. And it's really informative.

And I think the scale that you've all reached, and its marketplace lessons that it has to teach us is incredible, so thank you for bringing those statistics and helping us see that.

The potential for positive and negative, what we're seeing in our work is, the potential for positive and negatives for, at any scale, is something that we're trying to harvest. And particularly around the topic of cost, quality, and equity.

And so, and I know that's something near and dear to your heart, and that's kind of what we worked on when we were working together. So I'm curious about this idea of improving quality and improving equity while saving money through engagement of specialists.

There is 5,900 specialists in your network. Some of them are probably community-based specialists with one of your JV[29] partners. And I'm curious, are they being rewarded with the large amount of savings that

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[29] Joint venture

the ACO has made over the course of its four or five years, you know, you started with, well, you're now in ACO REACH, and are you rewarding the staff because they're helping make the value, making these rewards?

I'm just, I'm just trying to understand how large organizations do this and how instructive that might be for us to as we think about endorsing, you know, significant models.

MS. REED: Sure. So hi, Jim, nice to see you again. So I would love to tell you again that we have it all figured out.

Here's what we have done with ACO REACH so far. As far as, well, let me start with incorporating, cost and quality, sorry, quality and equity into total cost of care to me is an easy connection to make.

I don't know that the lines are always, it is a process that has to start, that has a little bit of a delay reward, but once it starts being rewarded it's easy to see how the dollars invested in improving quality of care and access create overall savings in the DFW market because of the massive amounts of growth we have experienced.

We don’t have enough houses, and we also don’t have enough hospital beds. So there is a value proposition, I think maybe a little bit unique to our market that it’s a needs-based value-based care, as well as a reason, you know, an incentive aligned to creating more value.

We also don’t have enough places to take care of people. So being more proactive and creating less demand on our limited health care systems is positive in two ways. Because of the value it creates and because it frees up space for those who really need it.

So we’re trying to capitalize on that as much as we can. And really take advantage of the opportunity to better manage Medicare patients.

In the specialist space, we are at the beginning of designing how we use our ACO REACH prepayment dollars, which ought to be available to more than just ACO REACH as we think about what we continue with, and how we limit the participation of high-revenue ACOs.

I applied at Baylor Scott and White

Health for ACO REACH and was denied, despite being the number one performing ACO in the country. Because, well, we weren't given an explanation. My suspicion is because we were a high-revenue ACO.

But being here at SWHR, what that is going to afford me to do is create economics with specialists in the market that incentivize them to work on costs and quality the same way primary care is. And that's what we're looking forward to doing.

I haven't done specialist yet, but have done post-acute care, Jim. So we've contracted in our APO[30] network with skilled nursing facilities, rehabs home health for a rate different than what they would have gotten from fee-for-service Medicare, and a withhold and a payback earn back for quality and total cost of care performance.

So length of stay, readmissions, those types of metrics rewarded in the funding pool that's created by the advanced payment contracting option, the APO option that we took advantage of. Experimental better with

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[30] Adjusted Plan Option

facilities than individual, independent physicians in a very competitive market like DFW.

But the plan and goal is to now go to specialist and create the same so that we can figure out, like I said, right now the market is basically, if you want to continue to be in the network, like Steve said, if you want to be one of my specialists on my list, I need you to do these certain things. And we're doing those types of arrangements. You know, certain criteria to be able to, to be eligible to participate. But if we don't change the economics, those won't, those incentives won't last alone.

And then I think the last part of our question was about staff-level incentives. Because we are part of large health care systems we have, to this point, and I've been at SWHR for three months so maybe this is different next time we talk, but right now we've adopted the health systems practice of setting annual KPIs[31]. And the staff, all the way down to frontline staff, is rewarded for

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[31] Key performance indicator

those.

And those are based on outcomes like total cost of care, savings in our CMMI, emergency department utilization reduction, avoidable admissions, and chronic disease. The same metrics that CMS is measuring us on. We tell the staff if we all, if we succeed in those measures, we'll all succeed together.

And that has been incentivized so far. But I also noted that Stellar Health is located in Grand Prairie, Texas, so maybe we brainstorm together, Michael and I, and we figure out, I don't know, something, some way of working together.

I am just a little bit cautious, again, because in primary care, or physician-only ACOs, the dollars created are often created by creating costs in another part of the health care system. Whether it's extending length of stay or forcing certain options in post-acute care.

And I think the better service to our collective industry is to figure out how all members of the team, hospitals, post-acutes, specialists, primary care nurses, social workers get to create value together and then participate in the value that’s been created. As long as we create winners and losers, we’re not going to have a sustainable health care system that serves all comers at varying degrees of need.

CO-CHAIR HARDIN: Thank you so much. We’ve got about five more minutes left. And, Chinni, I’m going to go to Walter, and then Chinni and then Jay, then we’ll wrap up.

DR. LIN: Thanks. Fascinating presentations, thanks for being with us. Just a few quick follow-up questions on Stellar Health’s model with Michael.

You know, this idea of quick feedback for desired behaviors is interesting. It appears to me, Michael, that most of the examples you brought up were rewards for a process-related metrics. You know, like calling patients, ordering mammograms, diabetic eye exam, that kind of thing.

Couple questions here. Does Stellar Health reward for outcomes, you know, like you have a certain hemoglobin A1C or certain level of blood pressure control?

And then secondly, there seems to be kind of a bright line, perhaps, where it becomes really uncomfortable for rewards. So for example, the Stellar Health reward for prescribing generic drugs instead of brand name drugs, right?

Or does Stellar Health reward for using a certain type of less costly orthopedic implant compared to a more expensive one? I mean, there might be some kind of anti-kickback ramifications.

And the last question is, we heard a lot about beneficiary engagement over these last couple days. Does Stellar Health ever reward patients for, you know, certain healthy behaviors or even just showing up for their appointments?

MR. MENG: Yes, great question. So on the first one, and I'll try to keep it a little bit tight here. On the first one, we do reward for the outcomes that you refer to, so controlled HVA1C hypertension control. Any of the ones that are normal HEDIS[32] measures absolutely.

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[32] Healthcare Effectiveness Data and Information Set

Now the thing I’m actually a little cautious about when we talk about this though is, I think when we thrust upon larger grander outcomes on providers, that’s where it gets a little unfair, right? So controlling that patient’s A1C, reasonable.

And then asking that we hope that we reach four stars when we don’t know the cutoff for HVA1C as a population of the whole, harder for them to track individually, right?

And so what I think we need to do is say you can control what you can, mister physician, or miss physician, in that moment but then outside of that, the whole population is being managed by our technology. So what we actually do is, we track the conversion rates of all those different steps to see if it actually resulted in the outcomes we wanted.

And that’s how we actually price the things we’re talking about. So if you want a bunch of transition to care visits done, not everyone is going to get done right away. What we do is reward for them, and we see what the conversion rate for that provider may be and adjust accordingly to educate them that all transitions of care, you want to do as many as possible ultimately.

My point to you is, that the outcomes, when we try and make them really grand for an individual provider, I think get really hard to track across all their lines of businesses, Medicare versus Medicaid versus different payers. I think that's where technology should do the work as a whole.

And then in terms of, your second question was around, sorry, remind me?

DR. LIN: Kind of rewarding certain types of clinical decisions. Like prescribing generic drugs instead of –

MR. MENG: Oh, right, right. So similar to my answer earlier, what we try to do is form in those situations, a clinical committee that decides that they want a certain clinical protocol such as referring to a certain place within, maybe the clinical integrated network, or prescribing a certain formulary or drug. And what our job is, using incentives, is to drive the whole group of providers to adhere to what that clinical committee decided.

So we don’t really directly make these clinical decisions ever. We do not practice corporate practice of medicine. But what we’re trying to do is say, you all physicians came up with what you think is the right standard, let’s actually reward people for sticking and adhering to that standard instead of maybe following their informal golf buddy’s recommendation for that specialist, right?

So those are kind of the ways we really focused on this. Again, I’m not the expert on what the clinical intervention should be, you all are. But what we can do is drive the whole group to follow what you suggested in the first place.

DR. LIN: And then the last one was beneficiaries. Do you ever like reward patients themselves?

MR. MENG: Yes, great question. I get asked this question all the time. And what I found personally is, I don’t see the full ROI or benefit of doing so.

And I may be wrong about this but when I, for example, I don’t know if any of you guys have ever done a gym bet with your friends, right, like oh, let’s all commit to go to the gym four times a week and, you know, whoever does it all the time at the end gets the reward, and those who don’t lose, right? I found actually that I didn’t do any more or any less of it as an individual human.

I don’t know why that is. I just find that the patient rewards do not seem to move the needle, whereas when it’s part of a workflow and work, they seem to work. I don’t know why that is B to B versus B to C, but I do, will highlight, I get asked this question, we test it every so often, but again, I haven’t seen kind of convincing evidence that it really moves the needle.

CO-CHAIR HARDIN: Thank you, Michael. Jay, let’s go to you next quickly, we’ve got just a couple more minutes.

DR. FELDSTEIN: Well, it is a quick one. It’s for everybody, but, Dr. Furr, you kind of pushed me this direction. To what extent are you using e-consults to increase specialist access or to increase specialist communication because specialty access is a real issue nationally?

DR. FURR: It is. And we're in a rural area so it's even more so. So we're having some of specialists particularly use it for their follow-up visits, for their post-op or where they've already had their initial consultation with the patient in person, and then do their follow-up visits.

It's been particularly for mental health. Even our GI guys and our cardiologists are using that to some extent. So it has been helpful.

The rate limiting factor for some of our patients is still the technology. In our areas, a lot of them do not still have broadband, so that's why it's really important for us. So we keep pushing for payment for audio, only telehealth because we do, just some patients that don't have the high-tech capabilities. But it has been a tremendous help for us.

CO-CHAIR HARDIN: And, Jay, you're muted but Jay wanted to hear from each of you about e-consults.

MS. REED: We also heavily use e-consults despite the number of specialists you saw there. Partly for access, to solve access problems, and partly for timing. So we use this a lot.

DR. CHEN: I can’t say because I don’t participate in a specific practice, but I will say that the MSSP did start to reimburse for telehealth consults as an incentive for participation. And I think that’s a good step in the right direction.

DR. FELDSTEIN: Thank you.

CO-CHAIR HARDIN: We want to thank each of you for all of your expert presentations and the tremendous knowledge that you’ve brought to the table today. We’ve covered a lot of ground during this session. And you’re welcome to stay and listen to as much of the rest of the meeting as you can.

At this time, we have a short break until 10:50 Eastern. Please join us then for a listening session on developing a balance portfolio of performance measures for total cost of care models. Thank you for joining.

(Whereupon, the above-entitled matter went off the record at 10:42 a.m. and resumed at 10:52 a.m.)

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

CO-CHAIR SINOPOLI: Welcome back. I’m Angelo Sinopoli. I’m one of the Co-Chairs of PTAC. We have invited four guest experts with unique perspectives to share on developing a balanced portfolio of performance measures for TCOC models.

You can find their full biographies and slides posted on the ASPE PTAC website, along with other materials for today’s meetings. I will now turn it over to Committee member Jen Wiler to introduce our presenters and facilitate this listening session.

DR. WILER: Thank you, Angelo. At this time, I am excited to welcome four guest experts for our listening session who will present on developing a balanced portfolio of performance measures for TCOC models. At this time, I ask our presenters to go ahead and turn on video if you haven’t already.

After all four experts have presented, our Committee members will have plenty of time to ask questions. The full biographies of our presenters, along with other materials for today's meeting, can be found on the ASPE PTAC website.

So, I'll briefly introduce our guests. Presenting first, we have Ms. Lisa Schilling, the Chief Quality, and Integration Officer of Contra Costa Health. Lisa, please go ahead.

MS. SCHILLING: Good morning. First, I want to thank you for the invitation to present today. It's an honor to be able to speak with this Committee. If we go to the next slide?

First, I just want to acknowledge that I am currently Contra Costa Health's Chief Quality Officer as one of my clients, and I will be speaking to their experience in health care today. Next slide?

My perspective comes from being an executive in quality and population health in several health care organizations in the United States. I've either been an executive in these organizations or on the board. So, I want to speak to a little bit about infrastructure, how these organizations learn, and then their ability to measure the outcomes that they're trying to achieve.

On the left side, these organizations are really structured to focus on clinical acuity and have sophisticated ways to evaluate population outcomes, the care trajectory, and episode treatments.

On the right side, these are safety net systems, Federally Qualified Health Centers, and they are structured more to focus on the social acuity with the clinical interventions, and perhaps one of the more interesting ones in this group is Contra Costa Health because they have much of the infrastructure that you see to the left side, but they have accountabilities and structures that support the social acuity on the right side.

So, I'm going to speak to a little bit about the characteristics of the measures, some organizational infrastructure needed to succeed with total cost of care incentives, and then perhaps some opportunities for incentives to get more providers to participate in these programs. The next slide, please?

First, I want to speak to the way we measure inside health care organizations and how these programs can incentivize the use of these methods to improve performance over time. First, this is no surprise to any of you, but we really do need to measure what matters and reduce the overall numbers. Even 100 measures is a lot of effort to put into measuring, evaluating, and performing, and it takes away from the resources that can go into clinical care.

I also know that sometimes we say we’re using the same measures, for example, as CMS core measures, but then when the incentive programs come out, they say oh, no, I want to focus on this population, which requires the doubling of efforts and resources to be able to gather and evaluate that performance, so it becomes more burdensome when we don’t use the same operational definitions.

To perform over time, it really is establishing improvement targets for year over year performance, so if I’m 50 percent of the way on the trajectory of performance outcomes that I'm trying to achieve, then I need to go 25 percent better one year and then the next year to achieve my goal over three years.

But they also need real-time data reporting, and we know that a lot of the programs at the CMS level have older data for good reason, but how do these organizations have data real-time to know is that patient getting the care they need today or are we performing year over year, month over month in the direction we want to perform? So, that's going to take infrastructure.

The next slide will talk about certain measures that are already existing. I'm simple about this. Safe, timely, equitable, effective, efficient, and patient-centered measures matter. They're already out there in the space that providers use.

Perhaps some of the ones that are most interesting to me are things like misuse. If I have an ambulatory sensitive condition, can I understand whether that patient is using the ED[33] or getting admitted to the hospital?

Also, we do need episode of care

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[33] Emergency department

data, right? We need to understand are we improving the journey of care for patients who have either high-value conditions or high-volume conditions, right? Are we improving the journey and the outcomes of the patient?

One thing I wanted to mention is that there are a couple of measures that aren't here that are really important, and they're under development. The first is inpatient safety for ambulatory care. There are structural measures available for diagnostic reliability.

I believe that we need to understand when a person has a symptom, that we have the right diagnostic testing and then we give them the right care very early on, and we really don't have good measures of that over time for our patient populations, so that's one to watch.

The others are around patient-reported experience. There is a new set of measures. Sorry, if we go forward one? There's a new set of measures being tested right now around the Community Trust Index. I find it interesting because that measures patient trust in health care.

I like it because it hits on three different types of measures. One is about the experience of care. If I trust my provider, then I’m having a good experience. The second is quality and safety. If I feel like I’m getting quality care, I’m going to trust my provider. And the third is equity. If I trust my provider, I feel like I’m getting equitable care. So, I’m watching that set of measures because that’s a very interesting development, and I think we should embrace that.

The next slide will talk about provider versus group-level measures. So, we all know this, right? If an individual provider is in an incentive program, they want to know what am I doing today that’s impacting the outcomes for the patient? They don’t want to be responsible for the social supports or even transportation to the clinic because they don’t feel like they can manage that.

So, process measures, and intermediate outcome measures, and care experience measures are what they value the most. I do believe the high performers and the low performers for outliers in populations also can be either positively incented or penalized for their performance.

It really does take though the grouping system to be able to have episode of care and population-based risk-adjusted outcomes, and that's why there needs to be infrastructure, so that we can see how we learn. I've heard other presenters today talk about getting specialists involved. If you have a group or you have a larger system, they're going to have specialists as part of the system, and therefore, we can monitor and manage the population outcomes.

So, the next slide is going to talk a little bit about what does it take then to be able to work at a group level? I call this the Goldilocks Equation, so not so big that you lose the essence of the frontline care provider, and not so small that you don't have the ability to manage in the way we're talking about. So, the least structure necessary to maintain what I call a clinical operating system is what's needed.

The first four things on this slide,

I think, are absolutely necessary to perform against these type of incentive programs. One is a large enough population cohort so that we can learn together.

That’s why I believe Contra Costa is a very interesting case, because they have 300to 350,000 people that they’re managing with the insurance plan, with the delivery system in the hospital, and then the social supports. It’s enough of a cohort to learn, but it’s also enough to know, at the frontline of care every day, you know what you’re doing.

Some way to have enterprise data, both clinical data and operational data, so we understand what are we doing in care, and how is it -- what is it costing, and can we risk stratify the population to learn more? These organizations that I’ve mentioned before have a very strong ability to do this.

Of course, financial data and cost accounting if it’s available, and then finally, how do they structure safety and learning systems to adopt these evidence-based practices?

The last slide is really a little

bit about my thoughts around what kind of incentives might help individual providers of small groups participate and then become part of a network if you will. The first is structural incentives. They’re out there.

They’re very helpful if you want to over time group into populations and provide supporting infrastructure. These could be incentives for public organizations like state health departments or private organizations to become these cohorts of populations and help the providers learn as we’ve talked about.

The second is to get those individual providers involved. Pay for performance is a really popular way for them to engage because it seems very simple and very much an upside, and state-based initiatives do this already.

And finally, maybe one step towards total cost of care measures would be looking at some of the things that are underway right now. For example, I’ve outlined what California is doing with some of their APM models. The idea of reducing reliance on RVU-based payment, fee-for-service, and moving more towards per member per month payments.

So, what they’re testing now is a base encounter payment from the health plan and an up-front per member per month wrap, and thinking about the gate and the ladder approach, which is hey, if you’ve done what you’ve needed to do to manage the population, you can continue to get those per member per month payments, but over time, we’re going to reduce the RVU burden, we’re going to reduce the fee-for-service and move more into the per member per month payment system.

So, I think these types of considerations are essential for providers and groups to participate in the total cost of care program, and I appreciate the time that you’ve given me today to speak with you. Thank you.

DR. WILER: Lisa, thank you so much. We are saving all questions from the Committee until the end of the presentations, but I know there will be a number of questions. Thank you. Next, we’re excited to welcome back Dr. Robert Phillips here with us today in person. Bob is the Executive Director of the Center for Professionalism and Value in

Health Care. Welcome, Bob. Please go ahead.

DR. PHILLIPS: Dr. Wiler, thank you for the introduction. In addition to being the Executive Director of the Center, I'm also the Director of the country's largest qualified clinical data registry for primary care where we do a lot of our measure development and testing work.

And I'm also a practicing family physician. I work about 12 miles west of here and have been in the same practice for the last 22 years. So, the work we're doing in this space applies very much, or I wish it would apply more to where I'm taking care of patients. If I can advance?

Barbara Starfield, a number of years ago in talking about primary care, came up with a set of functions and measures of primary care. They've delivered well and produced great outcomes. They had to do with first contact. Usually, we talk about that these days as access, but she also talked about continuity and comprehensiveness, and as we heard last hour about care coordination.

So, we've developed measures or

adopted measures around continuity and comprehensiveness, and I’ll talk about continuity specifically in a moment, but we’ve also developed some of the patient-reported outcome measures like the person-centered primary care measure, actually developed by the Larry Green Center, but in working with us to test those in our registry and to turn them into a now CMS-endorsed measure.

And I was interested in the last speaker, Ms. Schilling, about trust, because we’ve adopted the Wakefield Trust Measure, which was validated more than 30 years ago, and are testing it in our registry now as well.

We think these fit the criteria, the rubric that came from crossing the quality chasm that Ms. Schilling mentioned, but we also want to point to the NASEM[34] report for primary care that came out in 2021 that said that measures for primary care should be meaningfully parsimonious, they should be fit for purpose, they should be aligned to the internal and the external motivations of the actors, and they should support primary care

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[34] National Academies of Science, Engineering, and Medicine

value functions, and there’s a whole chapter in that report about measures and their alignment with total cost of care that might be useful to the Committee. Next, please? Well, actually, I’m advancing.

So, continuity has been used in the U.S. for decades and in many other countries as well, and we actually published a bibliography of all of the studies done about continuity showing that it’s associated with lower total costs with lower hospitalizations, emergency department visits, overuse of health care generally, and also with reductions in mortality.

It’s significantly more highly associated with cancer screening, child and health screenings, vaccinations, medication adherence, early disease diagnosis, and both patient and physician satisfaction. So, it has many of the things you would hope that we would include in total cost of care, and it may be, as some surmise, maybe one of the explanations why other countries have better health outcomes than we do.

I’m interested in noting that the

proposed rule that came out in July for physician payment from CMS mentioned continuity 54 times, it mentioned longitudinality, which is continuity over time, 36 times, and it mentioned relationships 104 times, but continuity is not a measure used as an outcome or as an evaluation even though it is a requirement that people taking on the APCM[35] commit to continuity.

The Norwegians have some of the best studies around mortality and other outcomes, so here we're looking at emergency services, hospital admissions, and mortality. The blue bar is continuity over one year, the green bar is continuity over 15 years or more, and showing that there's a dose effect.

There's a reduction in all three of them, with mortality being reduced by 25 percent for people who have a relationship with a primary care clinician for at least 15 years, so longitudinality really matters.

Now I'm getting to some of the questions that you all gave us, less about measures and more about adjustment. So, we

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[35] Advanced Primary Care Management

have focused a lot over the last 10 years on how to increase resources to practices caring for the underserved, and one of the ways that we have talked about doing that is using small Area Deprivation Indices, using neighborhood-level metrics as a proxy for the individual.

Two of these we have tested now with U.S. Census Bureau. We’ve gone into the federal statistical research data centers and linked patient data with IRS[36], with Census data, and demonstrated that eight -- of the eight deprivation indices in common use, two of them have the lowest ecologic fallacy risk.

The neighborhood is very, very highly correlated with the individual. So, we’re getting closer to saying, you know, if you’re going to choose one, which one should you choose?

In a series of workshops that we did, one of the questions that kept recurring is, how much do you need to adjust payments in order to meet the social needs that you find in clinical practice, and with Sanjay Basu and others across the country, we’ve found that it

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[36] Internal Revenue Service

takes about $60 per member per month for the average practice.

It ranges between 60 and $93. For FQHCs[37], it's about 115, and that is if you get everyone who is eligible for SNAP[38] on SNAP, and everyone eligible for HUD[39] support into those programs, so it's in addition to the social services that are already available and eligible there.

So, my question is, if you're going to start to do this, as CMMI has done across eight of its programs, are you going to give on one side, on the payment side, and then take away on the quality side?

It seems a little unfair to do that, so we've actually proposed, and others have agreed, that it would be helpful to adjust payments and also potentially to adjust the quality scores so that you're comparing apples to apples, not hiding poor care for poor people, but understanding where your quality is based on the risks of the population you're serving, and so you can start to understand are

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37 Federally Qualified Health Centers
38 Supplemental Nutrition Assistance Program
39 Housing and Urban Development

you doing better than expected, and are you demonstrating improvement over time?

In our series of workshops, which had a lot of stakeholders in them, we came to the strong conclusion you do need more resource into practices taking care of underserved patients, that it should be adjusted sufficiently to address the social needs that you find. Otherwise, you have underfunded mandates, that you need to make sure, as I think in the last hour we heard a few times, that the resources actually reach the clinic and the patients they're designed to reach, not just sit up in the health system, and that your policy targets should be about improving health outcomes and equity, not just overall savings.

At the same time, we said, you know, you should need to reduce burden. Basing payments on the data you collect about the patients you're seeing 18 to 24 months in the future, as was said earlier, is too long, and it creates a real burden for clinicians to collect those data. There's also a lot of incentive for gaming if you're trying to capture those data from the patients, and we've seen that happen with other risk scores.

There’s the need to titrate the funding to address the social needs, and we think that that’s done best in this way because you don’t always see the patients who don’t come in, and so you’re actually getting resources to take care of that population and can move care to them.

And then it does create the ability to create accountability for addressing social needs. Are the resources you’re getting for your total population actually reaching the patient and making a difference?

So again, we think the small Area Deprivation Indicies, they have no burden. You can attach them to the patient based on their address. We have an increasing reliability around them so that you can lower the risk or the concern about geographic fallacy.

You’re talking about the whole patient, not just those who come to see you. It’s more reliable because we know patient-level social needs vary throughout the year, particularly for the folks who have the worst social risks. They lose their housing this month, they get it back three months later, and you don’t know that because they haven’t seen you this entire year.

And it does help align our payments with our measures in what I’ve called a virtual cycle here where you adjust the payments. It gives you the incentive and the resources to meet the patient’s social risk assessments.

You can actually address the social need either in your clinic or moving those funds out into the community-based organizations, and you’re improving accountability because you can start to look at, based on the risks of my patient population, am I doing better than expected or doing better than I did last year? Thank you very much.

DR. WILER: Bob, thank you so much. Next, we’re happy to welcome Dr. Barbara McAneny, who is the Chief Executive Officer of New Mexico Oncology Hematology Consultants and former President to the American Medical Association. Dr. McAneny is also a previous submitter to PTAC with the MASON model, Making Accountable Sustainable Oncology Networks proposal.

Welcome, Barbara. Please, go ahead.

DR. McANENY: Thank you very much for inviting me to do this. I have great respect for what you are trying to do, and was an advocate for the Affordable Care Act from the AMA and an early adopter of some of these issues, but I'm going to tell you a bit about some concerns I have, and I hope that you can take these comments in the spirit in which they are intended in terms of doing a better job for the patients we serve. Next slide, please?

So, I'm concerned about whether or not we are indeed meeting that mission of improving quality, improving health, and lowering costs, and unfortunately, I think the cost changes have been minimal, the quality has been minimally improved, but only on specific things, and one unintended consequence is the increased consolidation.

I remind people that as a physician fee schedule practice, if I sold my practice to a hospital and saw the same patient the next day in the same office, in the same exam room, did the same things, under the hospital outpatient, it would cost double, so consolidation is a major driver of costs that has to be considered. Next slide?

So, we've looked at all of these models, and I'm not listing all of them. I'm just listing some selected ones because I think they were very well-intended, but I don't think that they have achieved the goal of improving care and saving money at the same time.

And I will remind people that as a physician, my main goal is to improve care. Saving the health care system money is a secondary consideration for me as a cancer doctor. My first is to give the patients the treatment they need. Next slide?

So, in 2012, I received the COME HOME Award, 19.8 million dollars, and COME HOME was a very successful model. I'll show you some data in a minute. What it did, it was not a payment model. It was how to do a practice.

And so, with apologies to pediatrics and primary care, we created the Community Oncology Medical Home, which is what COME HOME stands for, and we were able to figure out what patients cared about, which is staying out of the hospital, spending more time in their home with their family, having better health.

We worked it by having people – we figured out what would be the earliest indicator that a hospitalization was on the way, stepped back two steps, intervene then with an office visit rather than emergency department or hospitalization, and we discovered along the way that not only were patients healthier and happier about it, but we saved a lot of money.

This went then into the Oncology Care Model, which added a lot of data collection and added risk, wanting to put the practices at risk for cost of care, and now it’s moved into the Enhancing Oncology Model.

I participated in the Oncology Care Model and did very well with that. I declined to participate in the Enhancing Oncology Model because of the way the data was collected. I take care of a lot of Native American population with my clinic in Gallup, and I asked my patients what they thought about my submitting their data to Medicare, who they see as the government, and I would have lost the 17 years of trust that I have built in giving cancer care on the reservation had I submitted all of that data, so I elected not to go into EOM. Next slide?

So, COME HOME, it did use IT systems. We did do a lot of data provision, but it was also based on that ongoing relationship with the cancer doctor, and it was physician-led, team-based care, with financial counselors, navigation done not as nurses to navigate, because frankly, that’s too expensive.

My nurses are sitting on the triage pathways getting patients in when they need to be seen, not when it’s convenient for me to see them, and we still do 15 to 20 same-day visits every day, which results in having a hospitalization rate that, all the way through the Oncology Care Model, was about two-thirds of the OCM average, so we still do that. I still think that the best way to prevent a readmission is to prevent an admission, and we did a lot of patient education with that.

The other thing that was part of COME HOME with my practice and the six others that participated is that we provided them funds to build the infrastructure of triage pathways, nurses doing triage on the telephone, people navigating as appointment secretaries, et cetera, helping with the financial costs of having cancer.

And we were able to do this because we offered a very nice carrot to all of the practices in terms of payment for doing these things and in terms of giving them the resources. COME HOME worked because we made it easy to do the right thing and we gave people tools to do the right thing. Next slide?

So, this is one high level from NORC that shows what we managed to save on average, overall $673 per patient, which is actually better than most of the other models that have been in CMMI. However, you'll notice that this was not a model intended to save money, and there was no risk in this model.

We just did what we did, we did it better, we took care of patients better, and that is what saved money, and to me, that was the huge part. And we also found that we could save a lot of money at the end of life because we had built that trust that the previous two speakers have talked about as well. Next slide?

So, ACOs, I had great hopes for ACOs when they started and watched a lot of them, but I have some concerns about what has evolved with ACOs. Next slide?

We were hoping that ACOs would be able to improve primary care access, because as a cancer doctor, I’m not very good at managing peoples’ diabetes and hypertension. It’s not what I do. But I find there’s very few primary care doctors out there for me to partner with in taking care of these patients.

And the alarming statistics coming out of the AMA worry me considerably, with the burnout rate being so high, and the number of residents in primary care who are in practice as opposed to being hospitalists or doing other things. Next slide?

So, my take on ACOs -- and actually on most of the CMMI projects we’ve done -- is that there are minimal savings there. It did teach these systems, particularly the ones that had a hospital involved, how to cherry-pick and find what I call the Winnebago seniors, and avoid cancer patients and other sick people.

In my attempts to work with ACOs, cancer was always carved out, so as soon as someone got sick enough to need specialty care, they were out of the model, and so what that meant was that the success of the model was really based on patient selection and not on better management of sick people, and we went to school to take care of sick people.

The inadequate rewards for physicians, I had a primary care physician in my network talk about their dissatisfaction with trying to work in value-based care models because the value tends to go to the payer, and for the doctors, it's a race to the bottom. We can’t have that because we’ll lose the infrastructure of care.

And it focused so much on population health that when somebody said, I’m sick today, will you see me today, there was no process in place to manage that. And I’ve already spoken to the consolidation, which is, I think, the worst thing that ACOs have contributed to, and I think that’s a significant problem.

And it also morphed into what I fondly call Medicare Disadvantage, and you all know what Congress is looking at in terms of the increased payments to these programs. I call them Disadvantage because I find that cancer patients who sign on with one can't participate in clinical trials.

When they need to have any Part B drugs or anything like that, they discover they can't afford them on this plan, and there is a lot less money delivered to be able to deliver these services. So, I'm exceedingly disappointed and have great hopes that you at PTAC will advise CMMI to take a second look. Next slide?

So, we focus so much on risk and on putting physicians at risk, and I think that is a mistake. So, we've developed all of these models. We've switched to carrots that are shrinking every year and sticks that are getting bigger and bigger.

And unfortunately, physicians do not respond well to sticks, but they do respond well to being given a carrot and being given the tools that they need to do what they are supposed to be doing, which is delivering quality care.

So, if I got to do quality measures -- and we do quality measures. We do well on them. I call it documenting for dollars because none of the quality measures I do for MIPS make any difference in how I manage patients.

I would look at the days from the first phone call to when I get them in, when I have an appointment. That tells me access. That's what patients care about, the days from the first visit to when they are on treatment, because that's the other thing cancer patients care about, and that also gives you an idea of the efficiency. Am I doing the staging workup, getting the port in? All of those things.

I want to know that people are doing same-day visits. Treat the patient when they wish to be treated, and that is what cuts down on emergency department visits, and that you have – is your team working at the top of your license? Our mid-level practitioners, those practitioners and PAs[40] are not determining

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[40] Physician assistants

oncology treatment plans, but they are seeing the same-day visits, and then you can look at the hospitalization and usage.

However, if CMS really wanted to save money, they would look strongly at the site of service because that is the biggest variation, and even this year with a 2.9 percent cut to the physician fee schedule and a 2.6 percent increase to the hospital outpatient perspective payment system, we are just widening that gap and that needs to be addressed.

For outcomes, I really put quality measures into two buckets. One is the clinical quality, the technical quality. Do I know what I'm doing? Am I treating the patient with the right drug or the right treatment? And to me, the easy answer with that is pathways. We're working with the Dana-Farber Pathways.

I think that we should direct academic institutions to create pathways for more than just oncology so that we can use those. I put that in MASON. Robert Carlson, who was the head of NCCN[41] at that time,

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[41] National Comprehensive Cancer Network

suggested 80 percent is the right answer. Not everybody is going to be compliant, but you need to have a thoughtful reason why you're not on a pathway.

And then we need to look at risk assessment. As the other speakers have said, it takes more money for me to manage patients who have fewer resources of their own, yet our current system penalizes people who are in rural areas or poor areas by basing the GPCI[42]-adjusted payment to apartment rent and non-farm labor, and that does not account for the social determinants. And the other part of quality is the customer service part. It's the access. It's patient satisfaction. Next slide, please?

So, here is my message to CMMI and to PTAC as the conduit to CMMI. We need to rethink about putting practices at risk. It hasn't worked. We've been doing this now for the last 12 years, and we are not going in the direction we want to go.

So, if you've been doing something that long and it isn't working, maybe it's time to think about other things. Do we really want

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[42] Geographic practice cost index

to put practices at risk of going out of business? Do we really want them consolidated into hospital-based systems?

The other thing that happened in OCM to a great degree was that I would find that if I chose what I thought was the best drug for the patient, it would be the worst drug for the practice. So, let me talk a bit about drugs as the total cost of care issue that is most affected by oncologists.

So, the way we are paid, for example, to infuse a drug, that fee schedule has not changed since 2005. Since that period of time, we've added little expense items like EMRs, USP[43] 800-compliant pharmacies, pharmacists, oncology-trained nurses, et cetera, et cetera, yet the payment has not changed, and we make up for that on the drug margin.

And I will freely admit, and I don't like it a bit, that we run our practices based on the drug margin. And that drives CMS crazy, frankly, because they're afraid that I'm choosing drugs based on that. I will tell you

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[43] U.S. Pharmacopeia

that if there are a drug that does a better outcome for a patient, we’re going to choose that, and pathways will let us know about that.

But if in the case, for example, of biosimilars, where there are two drugs that are absolutely equivalent, I’m going to choose the one that puts more money in the practice because I have to pay for the shortfall of Medicaid and Medicare patients. I have to take care of the infusion.

I have to do the social workers and everything else, and there is no money for that. So, am I going to put my making payroll next week over the nebulous idea that in six months, I’ll get some payment that may or may not help me with that? I’m picking the payroll.

And if there is the concern of, am I cutting down health care costs for the system or am I making payroll and keeping my practice alive and able to take care of patients, you know which one I’m picking. I’m picking the practice.

So, if you want us to not base our financial well-being on the drug margin and get the drugs out of total costs of care, I think you ought to look again at the MASON project, because we took that money out of drugs, and we put it into infusion, into the doctor’s time to be able to explain the treatment plan to a patient, into all of the support systems, et cetera, that is necessary to do a good job taking care of a cancer patient, and pulled it out of the drug margin, but we can’t just put the drug margin to zero and expect the practices to somehow magically find money to cover all of the things that the drug margin was taking care of.

The surgical fees, as we add surgeons to the practice, this is a problem. I cannot afford to hire a surgeon, to try to keep them in New Mexico because, you know, 85 percent of the payment for the operation goes to the hospital and not to the surgeon.

And my advice to CMMI would be, one size is not going to fit all. What works in oncology may not work in primary care, may not work in psych, may not work in OB. We need to do a thousand pilot projects and then figure out which ones work, because there are a lot of doctors out there who have really good ideas about where there is waste and what would do a better job.

And the other thing is, I do not believe -- you can go to the next slide -- that we are going to be able to save money in health care until we actually know what it costs to deliver care. Cancer is getting increasingly granular, but the lumping together of all of these patients into one bucket that is an at-risk bucket is completely opposed to the idea that care is very, very granular.

When I wrote the MASON project, Making Accountable Sustainable Oncology Networks, we found that in the COME HOME data, we could find clusters of payment, and then we could figure out why was this patient more expensive than that, and was it something that the physician could control or was it something that was patient-related?

Total costs of care should be minimized to going into total costs of cancer care for a cancer program. If my patient gets hit by a bus on the way to the clinic, and they end up in the ICU for two months, I would be accused of delivering lousy cancer care because my total costs of care would be very, very high. To me, that makes absolutely no sense.

And so, I think in this day of data sciences, we should be able to take the massive amount of claims data that Medicare has, work with groups of practices who are interested in doing this, and be able to say okay, why is this patient more expensive than that other one?

We found, for example, that patients who had stage IV pancreatic cancer, if they had peritoneal mets, they would cost the system four times as much as those who just had metastasis to their liver, but there was nothing I could do about who is going to get their metastasis to the liver only or the peritoneum.

So, if I got more patients with peritoneal disease, I flunk, and I’m a bad doctor. If I got all of my patients with liver only, I’m a genius, and I make extra money. That is not the right way to do this.

We really need to use data science to really determine what is the optimal cost of optimal pathway-driven care so that we know what we’re paying for, and then we can look at how much money are we spending that’s over and above what we should be paying in health care.

And I think that I would switch the GPCIs around 180 degrees, and I would pay more for the rural patients, the disadvantaged patients, the people who have no resources to take care of themselves, because the practice or the system is getting increased expense to try to get the same outcomes on that. I think that’s my last slide, but thank you very much for listening to me, and I hope that we reconsider this.

DR. WILER: Barbara, thank you so much, and I am sure there will be lots of questions on your presentation. Thank you.

Next, we have Dr. Sarah Hudson Scholle, who is a Principal with Leavitt Partners, and here with us in person. Welcome, Sarah.

DR. SCHOLLE: Thank you so much. I really appreciate the opportunity to talk with you today and to introduce to you the Alliance for Person-Centered Care, which is a multistakeholder group that has come together to address and facilitate the collection and use of patient-reported data in clinical care and in quality programs.

And the Alliance formed because it believes that person-centered care should be the benchmark for quality, and that effective use of the patient-reported data can enable person-centered care.

So, why the focus on patient-reported data? And all of our members are coming from having experience either as people with lived experience or people working in different health care settings who are interested in how we put at the forefront of our health care system what matters most to each individual patient.

And we know from the research that there are many benefits from having this conversation, from understanding what matters to people. It shows up in better shared decision-making. It allows for care plans that address what the patient’s goals are rather than what health care has to offer exclusively. It helps people understand their condition, to have expectations about their care, to be involved in monitoring and supporting their own recovery.

It can facilitate communication with patient partners that are members of the Alliance, and one of our patient partners said this is the way that we have a common language, that we understand what we’re doing together.

And we know that you can enhance treatment and reduce disparities as well, because by focusing on what matters, and focusing on patient-reported data and these outcomes, we can identify where there are variations, and we can focus efforts to reduce those gaps in that way.

So, how do we actually make patient-reported data, patient-reported outcomes part of our set of measures that we use and work on them day by day? Well, it depends on having an entire system to support the use of this information, and that’s a big change in how health care is provided today.

It means that patients need to feel empowered. In our research that I did when I was at the National Committee for Quality

Assurance, I had people say, I’ve never been asked what’s important to me. I’ve never been asked what my goals are. So, we’re actually asking people to serve in a different role in relation to their health care team.

Clinical teams need to be brought in. That means they need to know what to do with the data and have the support to do it. They need tools that make it easy and equitable to collect and use data over time. Policy needs to support this, and the investments need to show value.

And so, our Alliance is really about taking this belief system and then saying here is how we put it into practice. Because we know some places are doing it, but it’s really hard.

So, these are the members of the Alliance for Person-Centered Care, and as you can see, it represents a whole array of perspectives, including people with lived experience and different kinds of providers and systems.

I did want to define terms because I was asked to speak about patient-reported outcomes today, and so a patient-reported outcome is what we're measuring. It's the question. It's the concept we're trying to get at, whether it's functioning, or depression symptoms, or trust.

There's a tool that we use to measure that. It could be the PHQ. It could be a PROMIS[44] tool. It could be one of those trust instruments that my colleagues have mentioned. And then there's the performance measure. That's how we determine whether there's improvement or an average performance.

And so, I think as I've been working on this for the past few decades, I know that these terms are unfamiliar to many in clinical care, and they get confused. In our Alliance, we think about patient -- we use the term patient-reported data because actually, it's not an outcome until you've constructed the outcome measure.

But we do think that there are a number of topics that patients can report on that are relevant to their clinical care, and some of those are listed here, from goals,

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[44] Patient-Reported Outcomes Measurement Information System

well-being, relationships, preferences, health-related social needs.

These are all things where the individual, whether it’s the patient, sometimes a family or proxy, who is talking about what they believe, what their experience is without interpretation of a response by a clinician or someone else.

So, the Alliance formed because we realize that there are a number of issues that get in the way of patient-reported data being used today, and we’re working on deliverables that relate to policy, data and infrastructure, and implementation.

And our first deliverable is really about, what are the principles that should govern the use of patient-reported data? And we actually developed these principles this year and used them to develop a comment letter that was submitted to CMS in response to questions in the physician fee schedule.

And just to summarize our key points, which I’ll walk you through, it’s about starting with what matters to patients, rebalancing the set of measures that we have so that we focus on value, equity, and innovation, and really reduce the burden on clinical organizations today, the burden of quality measurement, and then investing in sustainable implementation and improvement. And so, let me walk through and explain how we got to these principles and what's coming forward.

So, there's ample research, and especially if we look in academic settings, if we look to other countries. We see that the use of patient-reported data and these performance measures that are based on the data can be impactful, but it really requires changes in how care is delivered.

It changes workflow. It changes the culture. It changes the relationship of the conversation if you're asking patients about their goals, and that means wait, it's not really consistent with the care plan I would typically use, so actually doing this, it's not easy.

And one of the things that our Alliance really believes is that the way to determine what are the right measures that should be in a set of measures for this type of model is to start by asking patients and families who are in that target population what are the measures that matter? How should you collect the data? How can we make this more feasible for the entire system? Because often, patients and families have simpler solutions than a health care team that might be at fault thinking that they need to have a research project in order to do it.

But we've found that actually having relevant and actionable data for the particular condition or the particular population is important, and you've heard today from my colleagues about how that might differ depending on the group, so with Barbara talking about in oncology, what's important there, and Bob talking about trust and others in those settings.

So, what does it mean to rebalance measures? Well, the measures that are used in these programs need to generate data and insight that will affect outcomes, and so we're looking at outcomes that really make a difference and that clinicians and patients believe is important to work on. That means that you really have to remove the measures that bring less information and value.

Now, one of the key issues that shows up here is, well, does that mean that every group has a different set of measures, and that we have to have only specific measures? We don't think that's true. We think there are generic measures that could be used often across different populations that allow for comparison and support, but there are some cases where specific measures are needed.

For example, for people with intellectual and development disabilities, we don't have measures that have really addressed those – the concerns of that population. That's why it's important to have patients and families from each group to say yes, will this work, or is there something new we need? And of course, these should be considering disparities.

This means that we have to make way for new types of measures, and so we see within our Alliance a number of groups are working on new measures that can be added to programs instead of saying we've got a set, and we're just going to choose from the ones we have.

I think one of the biggest challenges that we've heard and that I've experienced when I was at NCQA, I helped to develop a set of measures around depression remission and response, and I was really excited. I thought this is great. We've actually turned -- for mental health, we've moved away from just measuring visits to looking at whether people are getting better, but those measures have not taken off. They're really hard to implement.

They're hard to implement because it means that you have to collect information over time, and many places don't have a way to do that in a seamless way for patients that don't come back. It's hard because clinicians might not know what to do if people aren't getting better, which is the whole point of measuring is to see what do you do?

It's hard because it's hard to understand who within your panel of patients is getting better. Which of your doctors or therapists are doing a good job? Where should we focus our attention? What other services should we offer besides medication? Where do we get the therapy? How do we address the social needs?

So, actually pulling in measures like this require an entire workflow, and I think back to one of the speakers from the previous session who talked about, you have to think about everyone along the pathway who’s involved in using this information, and what is their response? How did they know what to do with it?

How do you even talk with individuals about why you’re asking the questions and where are the data coming, and do people who are reporting on these important things that they believe or experience, do they get that information back? Hey, you know what? I noticed your symptoms aren’t getting better. What’s going on? How can we do something about it?

So, all of those, that structure needs to be in place. Otherwise, it’s just a measurement for measurement’s sake. It’s not actually helping patients.

And what I’ve heard from the members

of the Alliance and from others, there are cases where patient-reported outcome measures are being dropped into models or dropped into payment models, and they've become just can we get the data, not how is this really changing care.

And so that's where our Alliance is really looking at -- and I'm going to go back a couple of slides -- just to say as we think about adding patient-reported measures into care, we think it's going to make a big change. We need to start with what matters to patients.

We need to rebalance the set of measures so that we account for all of the work that's going to be required for these measures, but also removing measures that -- the potential value and equity that you can address with these patient-reported data, and then invest in the implementation that's going to help us improve and actually meet our goals on reducing costs and improving population health.

DR. WILER: Wonderful, Sarah. Thank you so much.

At this time, I'm looking to my co-panelists. I know you have a number of questions, so please tilt your tent cards, and we'll start first with Chinni.

DR. PULLURU: This is directed to Sarah, but I would love to hear all of the panelists opine on it. So, one of the concerns we have as we kind of take a step back to measures is attribution.

So, for example, Sarah, you know, patient-reported measures are only as good as who they recognize as their physician, right, in group, and so how do you see us balancing patient choice with being able to get attribution to a point where these measures are actually relevant?

DR. SCHOLLE: So, I think the issue here, you know, if you think about, where are the data collected? How are the data used? And if these data are collected and available in the clinical setting, which is part of our, the Alliance's goal, right, is that it's not --

The attribution issue actually shows up because you're being asked this question because your clinical team member says look, we would like to know about how your symptoms are evolving over time. Or we would like to understand what your goals are, and that becomes part of the clinical care plan.

So, this is not a model where you take a sample, you do a survey, and then the information gets attributed after the fact. It's really part of care.

Now, the issue there is, how do you get sufficient sample size to get to being able to have enough data to know whether performance, what performance should be and whether people are meeting benchmarks? So, there is kind of a push-pull there on how you understand it, how you collect the data, and the quality of the data, I think.

DR. PHILLIPS: I think it depends on the PRO-PM, on the patient-reported outcome performance measure. If it's about value, that is about the patient, and attribution is less of a concern. If it's like the person-centered primary care measure where it's about the relationship and different aspects of the relationship, then it matters a lot.

So, if you're in a health system like I visited last week in Texas where a driving metric for primary care is number of new patients seen per month, which shreds continuity and relationship, then PCPCM[45] is probably not a great measure for a clinician through attribution.

It might become a more powerful measure for the system. You know, across your patient population, your patients are not rating their relationships, or feeling like their needs are being met, or that they've been through a lot with their PCP.

So, for me, in a system that does not have attribution baked into the model, then it really becomes a measure of how are the patients rating the systems meeting their needs.

DR. WILER: Angelo?

CO-CHAIR SINOPOLI: Thank you, Jen.

So, my question is for Barbara, but anybody else can chip in also. So, Barbara, I very much appreciated your presentation, great comments and very direct and clear as usual, and what I wanted to get your thoughts about was -- the things that you mentioned obviously made a lot of sense.

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[45] Person-Centered Primary Care Measure

As we talk to other specialists, particularly the non-procedural specialists, the more cognitive specialists, you know, their request is, how can I be more integrated into the ACOs as opposed to being separated? Because we haven’t really figured out a way to separate those non-procedural specialists out into a separate model.

Have you given any thought to their roles, and how they should think about participating in an ACO, and any ways that we can advance engaging those types of specialists?

DR. McANENY: I think that -- thank you for that question, it’s a great question. I think it harkens back a bit to attribution. When I am seeing a cancer patient, I basically am doing their primary care. I may yell for help when I mess up their diabetes to their primary care doctor, but mostly they’re in my office constantly. So, attribution really needs to follow who is managing the intended disease that is really foremost in the patient’s mind at that point.

To be able to put other specialties

into an ACO, I think, requires a model redesign, and I’m actually working on one here locally in Albuquerque, a clinically-integrated network which we are designing to put the attribution for the quality measures and the PMPM[46] management of various things with the appropriate specialist who is doing it, with the primary care doctor as sort of the umpire to make sure that things are all going properly, but our goal is to create a clinically-integrated network where we are paid well for managing the very expensive chronic diseases that we manage.

And I think the model we used in COME HOME, where we take chronic disease, which I include cancer in now, and you figure out when that person is going to have an acute exacerbation, which is where the expense comes in. Then you have an opportunity to intervene early and prevent the hospitalization, et cetera.

So, for example, COPD, about $55 billion a year is spent on COPD, and most of it happens when the patient decompensates and ends

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[46] Per-member-per-month

up in the emergency department and the hospital. So, if we used the COME HOME process of early intervention and office visits, which are a low-cost thing, then we ought to be able to impact that.

I see the same thing happening with diabetes, with renal failure, with congestive heart failure. I think we have to redirect our quality measures and our interventions toward the exacerbations of chronic disease.

There will always, however, be acute illnesses that just need to be managed at the time when they're managed. So, I wouldn't throw the fee-for-service baby out with the bathwater because when we had lots and lots of doctors, they had the time to maybe churn and see people more often. These days, we have a shortage. We don't have time to see people who don't need to be seen.

So, if somebody has an acute stroke, or they've discovered they have a relapse in cancer and they need to be seen today, the main way we're going to encourage physicians to do that extra work is to pay them perhaps a differential for putting that patient in on an acute visit, or building a system that allows us to manage that. Did that answer your question?

CO-CHAIR SINOPOLI: Yes, thank you.

DR. WILER: Lee?

DR. MILLS: This is directed at Bob, primarily, but I think others will have thoughts, opinions about it. And I wanted to dive a little bit more into ADI[47] topic. I know, you know, I've talked about and shared, and I'm fascinated by its potential role moving forward.

And can you just expand a little bit more about how you think about ADI, and what are all the various places that could have an input which, conversely to what are the best places that should be used as an input, for instance, I mean, as a risk of, sort of as a marker of social needs or resource. I mean, it would have both inputs to make fee-for-service work better under the basic principles of RBRVS[48] and in value-based care as well.

So I mean, it could be a risk

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[47] Area Deprivation Index

[48] Resource-based relative value scale

adjustment, could be input to risk adjustment system. It could be tied to payment directly, right, it could be a modifier, it could set baseline goals, it could be used to adjust quality measures. Where would you start in-depth focus?

DR. PHILLIPS: Well, I think the first place is where CMMI has started, and this is with payment adjustment. They've done it as a global payment usually. And Maryland did it as a heart payment, so its heart payments are a combination of clinical risk and social risk.

And based on that, using the Area Deprivation Index, they get paid up to $110 per member per month for someone who meets that threshold risk score with that combination.

I think that that puts money in the hands of the practice. You know, they get a quarterly check, $500,000 with some loose but important guidance about how they use that.

Are you hiring community health workers, are you hiring social workers, are you doing food vouchers, I mean, very direct kind of service provision that you can't typically fund out of fee-for-service when it's tied to visits.

Because now you’re focused on a population of patients that you have, and particularly addressing those who aren’t coming in. How do we get the community health worker out to them?

So I think payment is a really important thing. I think it is really important for population health assessment. So in our registry, we’ve actually built a capacity to use patient addresses to tell you the service area that you’re taking care of. And in my practice, we found that physicians over-estimate that geography by 100 percent for 160 square miles.

So it helps you focus and get very specific about whom am I caring for. And then what are the risks, the social risks of those populations that I’m caring for? Is this neighborhood comparable to this neighborhood?

We had residents who used that tool to map their patients with food insecurity so that they could really locate the four neighborhoods where they should put that mobile food delivery, or they should put in a SNAPsubsidized farmer’s market.

So I think the deprivation indices help you get focused on where are the populations that I need to take care of and how do I take care of them where they are?

But then I think risk adjustment is another place where it’s important. In my practice, in the third wealthiest county in the country, we found significant differences in quality for our patients based on the deprivation index.

So, you know, geography matters, neighborhood matters. And it’s not that we were systematically biased against them, it’s that they couldn’t fill their medications, or they couldn’t travel to clinic as often as we wanted them to.

So again, I don’t want to hide poor care for poor people, but I want to understand are there differences related to social risks? And then am I doing as well for that population as I would be expected if I adjust?

It doesn’t absolve me from fixing the inequities I find, but it tells me how -- is what I’m doing actually making a difference for that population, even if that inequity is still there? So those are the three most important ways I would use it.

DR. WILER: Barbara, you have your hand up?

DR. MCANENY: I do, and I come at this from my practice which has a clinic in Albuquerque and a clinic in Gallop, which is the medical heart of the Navajo Nation, average income $20,000 a year. Often no running water, no electricity, telemedicine is sort of a wasted effort there.

And I have a couple of points I want to add with this. One is it does cost me more to get clinicians, or even patient care coordinators, or other people to work in an underserved area than it does to get them to work in Albuquerque, and I pay more.

For the last 22 years, we've had a foundation, and I do not think philanthropy is the appropriate underpinning for a health care system, but we created it to actually pay patients' bills. Because if you're going to be thrown out of your house and get your chemotherapy living in your car, you're probably not going to show up to get your next treatment. And then outcomes are much, much worse.

And what I see is people have now discovered the social determinants is that we’re busily measuring them. I find it a little heartless to measure something and ask the patients, so, do you have food insecurity, without having something to offer them in exchange for that. It seems just heartless to me, and it will destroy trust.

So one of the things that we make sure we do is we get the appropriate patients to, whomever they choose disclose to that they have a problem, and any patient who discloses to any member of my staff, that staff person can make a referral to the foundation, and we will help them manage these issues.

So it kind of goes back to ask the patients what they need. Sometimes it’s firewood, sometimes it’s food for the sheep, you know, so we don’t limit it on that.

And the second point I want to make is to set up the infrastructure to do that, I love the idea of a bulk payment so that I can just do these things without depending on philanthropy, but to set up the infrastructure to be able to manage the social determinants and other things, is hugely expensive. Because it’s people who want salaries and need a place to work. And so we really have to look at that cost and make sure we’re paying for it.

And then as you direct CMMI, one of the things that offended my Navajo patients, and therefore irritated me, was that when they came up with the Enhancing Oncology Model, or even the Oncology Care Model, they did not partner with the Indian Health Service, and they did not partner with Medicaid. Where do they think these people are?

And a lot of people are buying the Medicare Disadvantage plans, because they have a zero co-pay. That’s where poor people are going, and then discover they can’t get the services. I pay people to find free drug so that the Medicare Advantage program who’s denied that drug, that patient doesn’t die for lack of that.

So the place where we are putting

our money is often in the wrong area. They need to partner with Medicaid. For the Oncology Care Model, we had to draw up a chemotherapy bill to get any of the payments for support.

Well, if it’s a Medicare/Medicaid dual eligible or Indian Health Service, the oral chemotherapy is paid for by those entities. So I never dropped a CMM bill to Medicare, and therefore I had to pay back all of those MEOS[49] payments that paid for the support I was giving those people, the people who need it the most.

So that was, to me, sort of a perverse way to look at this. And so I hope you’ll pass that -- I did tell CMMI that directly, but I’m hoping that PTAC can reinforce that.

DR. WILER: Lisa?

MS. SCHILLING: Yes, I want to carry forward a little bit of what Barbara just said. So earlier we heard from one of the speakers about holding the academics accountable for

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[49] Monthly Enhanced Oncology Services

creating clinical pathways. Because that’s their expertise.

And I’d like to put that on the other end, which is the safety net systems, and the FQHCs, and the other -- I’m in a county system that has all those wraparounds and supports, right. And there are community-based organizations that they’re required to participate with. And I understand. I’m in California, and there’s an extreme unevenness about how the communal systems work, how do county systems and state systems work.

But that being said, I would love to understand how CMMI might work with HRSA[50] and others to create some networks. Because if Barbara was in my area, my system would be working with her to make sure those social supports and wraparounds actually exist for those patients, because were accountable for them.

But we will want to partner with her in order to provide the services that she provides. So how do we without creating too much infrastructure? Because I also agree too

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[50] Health Resources and Services Administration

big a system is not really great for the patients or the providers. How do we create some networking or cooperation and collaboration between the organizations that have the social assets, the social supports with those who have the clinical supports?

DR. WILER: Great point.

Larry, your hand’s up next, and then we’ll go to Jim.

DR. KOSINSKI: Well, I think I'm getting redundant in all my comments as I open up a question. I’m just continually impressed with what I’m receiving as a member of this Committee from the subject matter experts. And I guess we should give some credit to the PCDT[51] and staff for bringing such a great team of speakers.

There has been a theme through a couple of the sessions yesterday which was brought up again today. And that is that the drivers for business success for a medical practice should coincide with the population health value drivers as well.

And those two have not necessarily

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[51] Preliminary Comments Development Tam

been in sync. And we talk about something called the physician’s fee schedule. Well, maybe we need to start thinking about this as a practice business reimbursement schedule.

And it begs a question though, and I know I’m going to fire up Barbara here. But it begs a question. Because what medical entity does CMS really want to favor? Do they want to favor the small practices? If they do, then they need to change the way they’re reimbursing. Because they’re reimbursing large entities, and we’re seeing this tremendous consolidation that’s occurred since the Affordable Care Act was passed.

The other thing that I think came out very strongly here is that a visit is not a visit, is not a visit. We heard yesterday that new patient visits require 10 times more work than a return visit, and yet the compensation does not reflect it.

What I just heard now was that maybe a TSA PreCheck, a clear status to get a patient through the maze of the visits when they really need to be seen, need to be compensated better. Because maybe, just maybe, if we compensated the practice more to get that patient in quicker, we’d have less emergency department visits that are resulting.

I guess I made statements and not a question, but I have to say that you really impacted my thinking process.

DR. WILER: Any thoughts or reflections from our --

DR. KOSINSKI: Barbara, you have to say something.

DR. MCANENY: Yes, I would be happy to say something. And I agree with you. And one of the things that really I wanted to stress was carrots work, sticks don’t, risk is a stick, and a stick that could potentially put me out business. And then who’s going to Gallup to deliver cancer care, right?

And so carrots are the way that I think we should move forward. And physicians respond to those well. They respond to sticks with burnout and leaving the practice. And this is not something we can afford, because CMMI and PTAC need to take the physician shortage into account.

My concern is that, as we keep

adding on another nurse to manage the electronic patient-reported outcomes, if we don’t develop a system where those things go into our dashboards, and we can manage those patients, that we will just have an over-burden of expense and of missed messages which destroy trust.

And so what we do, in the practice that I consider my laboratory for value-based care processes, is we pull all of that data into a dashboard. We’re doing telepsych via a screening and then hooking people up. One thing, that if they want to make a difference on some of that, get rid of the co-pays for some of these coordination of care codes.

You heard earlier from our primary care colleague that coordination of care saves lives. It does. But a co-pay of 10 bucks to one of my Native American patients is unaffordable. And it costs me more than 10 bucks to collect it.

So let’s get rid of those kind of things in our CMMI programs, let’s encourage patients to do what we think is the right thing for them to do, encourage the doctors to do what we think is the right thing for them to do, and leave the sticks at home.

DR. KOSINSKI: So CCM[52], and PCM[53], and TCM[54] should be first dollar claims.

DR. MCANENY: They should be. Because I have patients who don’t want to do that. And even when I have the depression screening, which we’re doing on every patient, when I suggest that they take advantage of our telepsych process, they say there’s a co-pay. Thank you very much, I’ll just talk to my sister. And then I have no way to know whether or not talking to your sister is a very effective way to manage your depression.

DR. WILER: Great point. And if you don’t have a sister, that could be even more challenging.

DR. MCANENY: That’s right, everyone needs a sister.

DR. WILER: That’s right.

Jim?

DR. WALTON: Thank you very much. It’s a great listening session.

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[52] Chronic care management
[53] Principal care management
[54] Transitional care management

This is for everybody. I was struck by a thread that was almost in everybody's comments, which was trust. And I'm going to flip it, for the sake of our conversation, to trustworthiness.

And I think that it's implicit in what you were saying. I think Lisa even kind of probably got it right when she spoke, which was this trustworthiness of us is really vital, in particular in the county work that she's doing. And I think all of you said the same thing.

And projecting onto the patient that they've got the problem of trust troubles me just a little bit as opposed to the system has the problem of being trustworthy. So I just kind of, like, that's an editorial.

But I really wanted to go deeper here because we have a few more minutes. And this health-related social needs used to be called social determinants of health. And trust was a thing, you know, or trustworthiness was a thing. You know it's kind of like, well, different sides of the same coin.

But imbedded in that trust, it gets

sanitized just a little bit, doesn’t it, our trustworthiness? Because embedded in there is this notion that some populations experience bias in their interaction. And the bias can be in a lot of different spaces, and different moments. And it can also be characterized by a lot of different adjectives.

And that puts people on edge. And we really don’t want to talk that, because it’s really still part of the currency that we need to think through as far as how do we talk about trust, trustworthiness as a health-related social need?

Is it an outcome of doing great work in health-related social needs? You know, is it catalyzed by addressing that? And are there any models or experiences the experts have in taking a look at that trust, trustworthiness scale and connecting it, drawn a through-line to improvement, improvement in adherence, improvement, in particular, in value-based models, chronic disease management, prevention therapy, acute management, particularly like this issue around pregnancy-related morbidity and mortality for certain races. It’s an acute event, often. And there seems to be a pretty significant disparity that keeps persisting.

And I wonder if bias, and perception of bias, and trust, and trustworthiness all fit with all of that. So I'll leave that there as you all talk through this.

DR. MCANENY: Well, at the risk of jumping in too much, I'll jump in too much. You absolutely have to earn trust. And the first part of trust is showing up, and showing up consistently, and not just going away, not being one intervention.

I think our health care system has switched to episodic type of care. You go to the ER, you go to the urgent care clinic, you go to your primary, and you see their nurse practitioner. You don't see your physician because we don't have enough of them. And it's really hard to build up trust without building that relationship first.

And I point out that's why I declined to participate in the Enhancing Oncology Model, because I wasn't going to sacrifice the work I've done for the last 17 years to have someone who looks like me build up trust on the reservation, to be able to have those patients disclose to me what they need to for me to be able to have a meaningful partnership.

The other thing you have to do is recognize that about 80 percent of the issues are poverty, but 20 percent are cultural. When we built our Gallup Cancer Center, we put a classically built hogan in the front yard, that is a ceremonial building, as a signal to the community that we were respectful.

We worked very hard to support the local entities open our Cancer Center up. We now have Women’s Wednesdays where we have a bunch of elderly Navajo ladies doing crafts and line dancing in the Cancer Center which I think is just a phenomenal thing. And it shows that we’re succeeding at building trust. But you can build it over many years, and you can destroy it in a moment.

And so that consistency part that you heard before, that has to be there. And it has to be a value of the practice or the system. And it has to be constantly reinforced by leadership and deviations from that can’t be tolerated.

The other thing is that you ask the community what they need, you know, nothing about us without us. And so you reach to the community you're trying to serve and find out what it is they want to have done.

And one of the best ways we found to do that is you hire people from the community, and you offer them that entry level job, and then you continue to grow them. And some of our entry level people have just completed a job being a radiation therapist and are working in our Gallop clinic to help treat patients. And so we have offered career paths. And you have to embed yourself into the community and be there for the long haul.

DR. KOSINSKI: Lisa.

MS. SCHILLING: Yes, in my experience trust is about belonging. And I think Barbara touched on this. But what we found, both when I was at Kaiser Permanente and in Contra Costa, is that you can assign a person to a clinic or a provider, and that person may or may not go there, right.

Where they'll go is where they feel

welcomed, they feel they belong, and they feel treated culturally and socially in the way that they expect. So in KP we would assign people to clinics. And we found people would drive more than an hour to go to a clinic where the providers affiliated the way they did with their care.

And likewise, in the safety nets in Contra Costa, the Latinx and Hispanic population tends to be drawn to Contra Costa. And you can establish programs, right, that help with that affiliation. I think Barbara just spoke about it.

But for example, centering pregnancy, we talk about Black and African American women who are pregnant having a centering pregnancy program, where women of that community are leading the centering pregnancy program, makes those women feel like they belong and can get pre-natal care the way they want to.

So I do think there's an opportunity to incentivize that and then to measure. Are people going where you think they should be going, or are they going where they want to go?

And how do we support those places in providing care to diverse populations?

DR. MCANENY: You can come to New Mexico any time you want. I’d love to have you here.

DR. PHILLIPS: So longitudinal healing relationships, I hope I displayed, they have a therapeutic effect. And at the heart of that is trust. Because trust is necessary for patients to believe the treatment you’re recommending is something they should do or that the person you’re sending them to is worthy of their trust also, that they can reveal to you about past experiences with sexual abuse, or physical abuse, for the things that are leading to poor health outcomes or at least poor health choices later. Until they tell you about those, you don’t know how to address them. So trust is really at the heart of those.

And I said earlier in my slides, you know, our effort is to try and align the measures that we’re using in care to align the intrinsic, what I feel is right for this patient, with the extrinsic, what I’m paid to do or what my system tells me I should be doing.

And when those are in conflict, burnout is a product of that. Because now you’re leveraging my professionalism. I’m going to do what’s right for this person even though it’s going to be counted against me over here.

So there’s real importance, not only in doing the things that build trust for the patient but that support the capacity to be trustworthy for the clinician.

DR. SCHOLLE: I just want to call out the point of starting from a conversation with individuals, and families, or communities about what’s important, what matters, and then designing around that rather than designing around an outcome that doesn’t matter, right.

And so I think what my colleagues have said, have given examples of, is really starting from that listening mode, that honoring that perspective. And in our quality programs, I think we don’t do enough of that, design the program so that it attends to the needs of the individuals who are being served but also offers the care team a way to serve them in a way where it feels like a mutually rewarding relationship.

DR. WILER: I want to thank each of our experts so much for a really rich discussion. We covered so much ground and learned so much from your expertise. So thank you so much for your time.

At this time, we’re going to take break until 1:10 p.m. Eastern Time. Then please join us. We will have a great lineup of guests for our final listening session on addressing challenges regarding data, benchmarking, and risk adjustment. We’ll see you then.

(Whereupon, the above-entitled matter went off the record at 12:21 p.m. and resumed at 1:11 p.m.)

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

CO-CHAIR SINOPOLI: Welcome back. I’m Angelo Sinopoli, one of the Co-Chairs of PTAC. We’ve invited four guest experts with unique perspectives to share on addressing challenges regarding data, benchmarking, and risk adjustment.

You can find their full biographies and slides posted on the ASPE PTAC website along with other materials for today’s meetings. I will now turn it over to Committee member Chinni Pulluru to introduce our presenters and to facilitate this listening session.

DR. PULLURU: Thank you, Angelo. I’m excited to facilitate this listening session. At this time, I ask our presenters to go ahead and turn on video if you haven’t already.

After all four have presented, our Committee members will have plenty of time to ask questions. Presenting first we’re happy to welcome Dr. Robert Saunders who is the Senior Research Director of Health Care Transformation and Adjunct Associate Professor and Core Faculty Member at the Duke-Margolis for Health Policy at Duke University.

Welcome, Rob, please go ahead.

DR. SAUNDERS: Thanks, everyone, and

I appreciate the opportunity to speak with you all today. I’m happy to be informal with these remarks, so if folks have questions, PTAC members have questions as we go, happy to pivot.

But my role here today is to set the stage and talk a bit about where we’re seeing actions in setting benchmarks, what we know about benchmarks setting based off of our research and, you know, what are some of the implications of that? And as mentioned, I’m with the Margolis Institute for Health Policy here at Duke University.

So if we jump to the next slide, and there’s probably about four key points that I want to point out here. One of the issues is that early on in the value-based payment journey, we saw the benchmark was tied very heavily to whether an organization succeeded or not.

There’s a little bit of de-linking happening on that now. So it’s not as true as it used to be. But it’s still a strong motivator and a strong determiner of whether the organizations join by base payment models.

I think the second piece here is related to that, is that that benchmark also has a lot to do with how long folks stay in different value-based payment models. And our research has shown that survival of, say, an organization to stay in value-based payment model is pretty heavily determined by that benchmark.

But there's a lot of diversity in the field right now in terms of how those benchmarks are set, what's the -- and moreover what's the the impact for different types of organizations. So a benchmark is going to look a little bit different for a hospital versus physician-led ACO in terms of how they respond. You know, safety net organizations are going to feel the impact of that benchmark a little differently.

And while we've got a fair number of data and technical changes that we can make to improve benchmarks, there's actually a number of policy tradeoffs that we'll have to do regardless of what way we want to go forward. So those are the top sort of takeaways that I want to push on today.

But jump to the next slide. We'll show a couple of graphs. So on the first point of what's the impact of benchmarks, so this is some research we've done every year after the Medicare Shared Savings Program releases its result. And it's comparing the results from 2016 to the 2016 program year to 2022.

And it looks at the shared savings rate, so how many organizations achieved shared saving compared to their benchmark. And what you see earlier on in the Medicare Shared Savings Program was that as the benchmark went up, the probability of achieving shared savings also went up. And it was a pretty strong effect.

If you look at the 2022 effect, 2022 performance year, you don't see as much of an effect. Shared savings across the board has increased, so more organizations are achieving shared savings in those programs. And it is not as closely tied to the benchmark. There's a couple of reasons we think that that's probably the case.

Some of this is probably a selection of effect. Those organizations that weren't doing as well probably pulled out of the program. But also there’s also been a lot of lessons learned from organizations over time on how to achieve shared savings at different levels. So I think we’ve seen a little bit of a flatter amount. But the benchmarking can still be really important for how long organizations stay in programs and whether they come in the first place.

So if we jump to the next slide, this is some research we did a few years back looking at the likelihood of organizations that stay in, like, the Medicare Shared Savings Program. And the dark blue line is those organizations with the highest benchmarks, and the lighter blue, sort of sky-blue dash line is those organizations with the lowest benchmarks. And you’ll see a bit of a gap that those organizations with higher benchmarks are more likely to stay in programs.

It’s probably not a surprise to many of the folks in the audience. But it’s always nice when research backs up what your intuition tells you probably should be the case.

So let’s talk a little bit about the

next slide. What are some of the details, we'll go to the next slide, what are some of the specific issues that we're hearing out there?

And so from qualitative research and interviews with folks in the field, we've definitely heard some feedback from organizations that they're not likely to join if the benchmark is unfavorable.

You know, it's in some ways hard to fault an organization for running the numbers before they join the -- you know, a board would probably expect nothing less from a fiduciary responsibility. You know, a chief financial officer would also probably be under fire if they didn't think about the financial implications.

But this is a bit of an unintended consequence in that organizations then might take some steps that aren't necessarily adding to the value-based payment model's impact. So for instance, we're seeing a rise in organizations doing some pretty micro-sculpting of their networks if they can to look at the local benchmark, to look at that organization's benchmark, and bring in organizations that are more likely to succeed.

This is a lot easier for the physician group practice ACOs versus, say, like the hospital-based ACOs, which tend to be about more, you know, geographically concentrated. Although there is exceptions to that, and there’s changes over time.

But knowing that, we’re starting to see a pretty lively trade in the consultancies for, you know, thinking about what the benchmark might look like. And it doesn’t necessarily relate to improving care or care improvement, which is the ultimate goal of our value-based payment models.

I think the other one that we hear, and we see this backed up in the data, is that many of our safety net organizations don’t have the same culture of coding. And so that’s going to impact their ultimate risk adjustment scores. But it’s going to also have some impact on benchmarks to the extent that those are, you know, risk adjusted.

And we’re starting to see some impact on including social factors into the benchmarks now. Data is early, and we've got some early lessons learned. I think it is fair to say that we're not totally where we want to be on incorporating social factors.

A lot of what we're doing right now has been based off of geographic factors that can be very broad. And so organizations, let's say, like the safety-net organization in an urban area may not get as much of a benefit from some of the social adjustments to benchmarks than, say, other would, or you might expect.

And of course there's still a challenge here that we're hearing from many organizations on the differences in incentives between programs. So some of our value-based payment participants have noted that they have felt a disadvantage compared to, say, organizations participating in, like, the Medicare Advantage Program.

Because there are very different benchmark/risk adjustments algorithms in use here which can make it more financially sustainable to participate, let's say, in like the Medicare Advantage Program compared to many of the traditional Medicare value-based payment programs. So we’ve got some challenges here.

If we jump to the next slide, there are some places where we might be able to see some improvements over time, especially on the technical side. So on the social factors in improving social risk adjustment, a lot of this comes down to data.

One of the reasons that many programs have started more with geographic risk adjustment is that that’s where the data currently are. And that’s where we’ve got high-quality data. We might be able to start to use individual-level data over time. However, we’ve got a pretty unstandardized approach right now.

And from our research we’re hearing a lot of health care delivery organizations express concern that there’s a lot of different types of social risk instruments out there. And so we might be recreating some of the challenges we had with quality measure, a lack of alignment in the social needs data space.

I want to flag risk adjustment. I know some colleagues after me will dive deep, but just noting one of the challenges we’ve seen with risk adjustment right now is that it’s very coding-based off diagnoses and a lot less on what actually is done to that risk.

And there are opportunities with new data that, you know, Aneesh and other have worked to free, that can help us really understand and use new types of data to help understand what risk adjustment should be.

So I think another piece here is that we’re still learning about new approaches to capture, you know, full population health risk, such as through the health equity benchmark adjustments. We’re still early, we’re still -- have some data challenges. There’s still some places where we probably want to improve. But it is a start.

I think in addition to health equity benchmarks, some specific populations that we hear concerns about from a benchmark or risk adjustment approach are, say, like the seriously ill who oftentimes are underrepresented or under, you know, maybe coded and in various risk-adjustment benchmark algorithms, especially those that don’t have say frailty adjustments and may be excluded for other means.

And then also, just to flag that benchmarks are part of the financial equation for many health systems, but there’s oftentimes a need for up-front capital to really make the types of investments they need.

So if we jump to the next slide. So just to repeat, the key conclusions here, benchmarks are really important. It’s not as important as it used to be, but it’s still really important if we want to increase participation in non-risk payment models, especially to areas that may be traditionally under-participating, like rural areas.

We’ve definitely seen a benchmark has been tied to participation, whether that’s staying in a model or entering a model in the first place. We see that there’s a lot of issues right now in benchmarking, and those could have some differential effects depending on the type of organizations.

And we’ve got some technical approaches that can be used to help improve benchmarking, but we’ve still got some policy decisions that need to be made.

And with that, I’ll stop and turn to the next presenter.

DR. PULLURU: Thank you, Rob. Next, we’re excited to have Dr. Randy Ellis, a Professor in the Department of Economics at Boston University.

Welcome, Randy, it’s over to you.

DR. ELLIS: Great, thank you, I'm delighted to talk to this distinguished audience, and it’s been fun visiting and listening to the sessions over the last two days.

I’m going to talk about risk adjustment, and you’ve seen this slide that we’re focusing on the meeting content today.

And next slide. My background is that I’m one of the co-developers of the HCC[55] risk adjustment which gets much maligned, and I agree that it has lots of weaknesses. But it is underlying the payment formula used for risk adjustment in Part C, Part D, and also in the ACA[56] Marketplace. And it also underlies the

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[55] Hierarchical condition category
[56] Affordable Care Act

German system that I helped develop back in the early 2000s.

Importantly for today is I just finished an AHRQ[57] funded project that comes up with a new disease classification system which we call Diagnostic Items, or DXI. We have three publications based on that now. And I'm excited that I think it addresses some of the topics that are of central interest to this conference.

Included in that is the development -- I'm a co-developer, with Arlene Ash, of a new machine learning algorithm that automates the creation of HCC-like risk adjustment formulas. And also relevant is that Arlene and I have been working on revising the primary care payment model used in Massachusetts for the Medicaid program. And they are just adjusting that in a new sophisticated way using additional information about social determinants of health.

Next slide, please. So we were given -- I was given three topics or questions to try and address in my talk. And since 10

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[57] Agency for Healthcare Research and Quality

minutes is extremely short, I decided to just go right to the questions and then, in passing, mention how it relates to my work.

The first one is about how -- one of the most important, I'm going to be covering these on the next slide, so let's go to the next slide. So what is the most appropriate models just based on my lifetime of experience of almost 40 years of doing risk adjustment?

I happen to have become a convert to preferring the concurrent models as are used in the Marketplace over the prospective models used in the Medicare program, partly because there's a lot of turnover of people between plans and between in and out even of Medicare or out of Marketplace. And so it gives a better framework. And also, we hear lots of complaints about, oh, we have all these acute problems that aren't necessarily recognized and paid for in a prospective framework.

So that's-- the other key thing is that the ACA has a risk equalization process rather than an add-on formula, and a budgeted formula as is done in Medicare Advantage. And that has some advantages of making the budgeting more predictable for the funder and not rewarding as much the over coding and up coding that has been going on.

I also think that it’s really best to not think of it as one formula but a whole family of risk adjustment formulas where you can perhaps refine the incentives across different dimensions. For instance, you may want to carve out primary care, as I’m a fan of doing, and have separate incentives on them, in addition to using it for the overall budget of the -- of practices or an ACO.

The work I do is estimate on really large samples, and that gives you a lot of precision and lets you look at very refined models. The models we’ve been developing are using 60 million commercially insured eligibles. And that gives us a lot of precision to look at even very rare diseases.

So we developed a system that had about 2,000 disease groups, and we used it to predict primarily total spending, not just the plan paid spending. And we’ve been working on adding these social drivers of health. And I think that that’s the exciting new area that everybody should be trying to figure out how to best do.

And I’m also in favor of for risk adjustment models being updated regularly, not just every 20 years. And I think that in Europe, there are -- both the Netherlands and Germany update their formula every year and even make fundamental changes pretty regularly.

Next slide, please. So another question is, well, how do you encourage providers to want to participate in a bundled type of payment system? The simple economist answer, I am an economist of course and would be don’t make it optional.

And I believe the Medicare program also has this issue when they talk about participating and not participating, and all the incentives they have in traditional Medicare. I can imagine that’s not going to work as well in this, given the structure of ACOs where people can move in and out of them.

But I can imagine that the carrot that can be offered to participating may make it attractive for almost every practice to want to join. And that would be the direction. And

I think another way you can make it attractive is not just the carrot but by trying to make it relatively administratively easy on providers. And some of the ways you can do that is partly you can try to tilt the system to reward the ACO and their providers to take on the most complex patients. I think the existing HCC formula does a very poor job of that.

And so we should try to avoid over-paying for healthy and reward providers and plans for focusing resources on the chronically ill, and people with complex patients, and also those with social drivers of health which are really important.

Another factor that hasn't come up as much in the discussion so far is prevention. And that's something important to build in correct assessments for that. And I also am a fan, as an economist, of trying to make the bonus, the carrot parts of this about 10 percent or more of the total.

And I disagree from some of the people earlier today that I think sticks can be important, especially when providers make mistakes or do unacceptable behavior. I think having it such that you’re punished but not necessarily going out of business might be the way to go.

Next slide, please. So then we get to how to deal with the different organizational structures. Well, the ACA and the Marketplace have dealt with this by having different versions, different formulas that take into account generosity.

In the Medicaid and MassHealth program that I work with, they have separate formulas for ACOs that choose to only provide medical-- medical services, and then a separate formula used when you add in taking responsibility for outpatient behavioral health, a third formula for adding in inpatient behavioral health. So that’s one way to go. It adds a lot of complexity, but it has been used in five -- for five years in Massachusetts. And then Medicare Advantage, of course, has a large number of separate formulas.

I’ve already mentioned social determinants of health, and I won’t have a chance to talk about that much today. And I also think you should think of risk adjusting the fairness formulas and performance measures and focus on how well you do on subsets of interest.

Next slide, please. But I think it’s really important for CMMI and others to move beyond the HCC system which has remained largely unchanged since we created it and started using it in 2004.

There’s a growing number of problems of fraud and up-coding, and I think that can partly be dealt with possibly by not just rewarding the complexity of the patients but punishing providers or plans when they have a lot of coded diseases that aren’t actually being treated. So that’s a new direction, a kind of performance weakness.

I think that the new formulas can do a better job at documenting what they’re doing and being transparent. They can be speedily re-estimated. And computers have gotten very fast, and data should be made available to make that feasible.

The next slide, please. I wanted to show my favorite slide from the project that we just ended. And this is a very rich slide. This is showing how well do five different payment formulas do across different groups of enrollees clustered according to how rare is their rarest disease.

So at the bottom are people who don’t have any diagnoses. And across the different plans, the one that I put in for a standard because a lot of people are still using the Charlson Comorbidity Index which has only 18 metrics used, and it grossly overpays for people that’s what it means with a negative residual for people who don’t have any illness. And it’s consistent across even up to things that are as rare as, say, 1,000 per million which is one in 1,000.

And the HCC is the second bar down in each of these clusters. And you can see that it also greatly overpays for common diseases but massively underpays for rare diseases. And surprisingly, even though diseases can be rare, about 40 percent of the total commercially insured population have at least one diagnosis during the year that is relatively rare. And so it’s not really fair to say, oh, we do really well on all the common diseases when we're actually doing very poorly on a lot of the rare diseases.

And what I will end by saying is the DXI[58] model, and the DCG[59] framework we've implemented that builds in appropriate concerns about incentives, basically corrects for this underpayment for people with rare conditions and is the main reason why I favor relatively rich models that are both more predictive and more usable.

Next slide. And I think I've run out of my time. So thank you.

DR. PULLURU: Thank you, Randy.

Next, we have Mr. John Supra, who is the Chief Data Health and Analytics Officer at Cone Health. Welcome, John. Please go ahead.

MR. SUPRA: Okay. Thank you. I think Aneesh was going to go before me.

DR. PULLURU: Oh, sorry about that. So let me --

MR. SUPRA: No worries.

DR. PULLURU: Let me welcome him.

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[58] Diagnostic Items
[59] Diagnostic Cost Groups

We're happy to welcome Mr. Aneesh Chopra, who is the President of CareJourney. Welcome, Aneesh.

MR. CHOPRA: Well, thank you all very much. And John and I can basically swap time, so consider this, like a tag team, if you will, for the presentation.

But I want to address the challenges on data benchmarking and risk adjustment, similarly to our two colleagues, but maybe driving a little bit deeper on data access and use. So if you'll indulge for my 10 minutes, if you don't mind going to the next slide, I'm going to make a few general observations.

Data sharing in health care has been governed since the original HIPAA[60] around administrative transactions. And CMS oversees a team that effectively guides the regulations, advised by the National Center for Vital Health Statistics. And it's largely seen as the sort of EDI[61] transactions governance program.

This is a method of data sharing and, you know, for the last decade we've tried

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[60] Health Insurance Portability and Accountability Act
[61] Electronic Data Interchange

very hard to add content through the EDI-based system, and we’ve struggled.

Two very high-profile examples, CMS wanted to address some kind of prior authorization for advanced imaging. That was expected to save hundreds of millions of dollars, I think close to $750 million a year, originally, I think, proposed in 2018, ‘17, somewhere in there, under the PAMA[62] laws.

Well, a critical part of that prior authorization process was the need for physicians to be able to document in the chart or in their EDI process, that they did, in fact, review the literature and therefore are making judgements informed by the literature as called for by the regulation.

Unfortunately, that system could not accommodate this technical need. And so last year CMS had to withdraw, sadly, a program that would have saved hundreds of millions of dollars but technically could not work.

Similarly, the FDA[63] for years has asked for medical device identifiers to be made

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[62] Protecting Access to Medicare Act

[63] Food and Drug Administration

available in the data so that we could do a much better job if there's recalls for safety. And once again, last summer, I believe the answer was too difficult, can't do it, and won't make it.

On the other hand, we're entering an era of, with the HITECH[64] Act, we've invested quite a bit in electronic health records. These are not run by the traditional, you know, transaction systems of yesteryear, the EDI systems. These collect electronic information that's shareable in a more modern way.

The standard today is basically a restful API, or application programming interface. And so what we're hearing at the moment is a lot of opportunity to take previous policy objectives and re-imagine doing them in a modern technical stack.

You want to know the medical device? It's right there in the FHIR[65] API. You want to be able to document, the -- sort of, the prior authorization for advanced medical imaging, it's right there in CDS Hooks.

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[64] Health Information Technology for Economic and Clinical Health

[65] Fast Healthcare Interoperability Resources

So I wanted to highlight in my opening remarks the notion that we need to start converging all of our policy objectives, including the work we're doing in this session on value-based care, think about what a FHIR-based alternative would look like, so it's more of an enabler and not a hindrance or a headwind.

There are five specific areas I think we need to work together. One, we need to know what benefits the insurance companies are making available to our patients. More and more of those benefits address supplemental social needs, and they're not typically available in the swiping of the credit card to say, geez, you're insured, great, but did you know you're also qualified for six Uber or Lyft vouchers?

Second, more and more of our payment systems, including the new CMS Enhancing Oncology Model, need clinical data in order to administer those programs. Well, we do a great job sourcing administrative data in claims, but we don't have a mechanism yet for payers to more easily access clinical data, especially that data that sits within that USCDI[66] framework.

Third, perhaps most importantly, we want to be very respectful of the bedrock of data sharing, minimum data necessary. And to do that, we have to be able to talk to each other’s IT systems and filter only those patients for whom our partner, the ACO, the health plan, providers in the network, a few out of network partners that have immediate need, to be able to filter access to information only to the populations that they’re legally entitled to, and for the amount of information within that population they’re allowed to share, honoring the spirit of minimum data necessary.

The last two provisions are the emerging need. CMS has asked all of us to work on basically embedding specialty bundles, or shadow bundles, within total cost of care models. And there’s a similar effort in the fee-for-service world about price transparency.

So whether I request a price for a

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[66] United States Core Data for Interoperability

bundle, or I request a price for a fee-for-service treatment where I have to assemble, effectively, a bundle for a same day procedure, I still want to be able to know price and, ideally, the quality associated with my request.

And last but not least, in the era of AI[67], how do we make sure all this information is made available to the consumer and, as President Obama told us in 2015, to the applications and services that can help them make sense of it?

Now, this is 10 minutes, I'm giving you the highlights. Maybe I'll just hit a few notes before I reach the end of my time. Can you just help me go through the slides very quickly so I can go deeper on everything I've just said?

One, I'm very thrilled that to the through the Sync for Social Needs collaborative, our friends at Epic have made available the ability to take screening assessments that are collected through My Chart or other applications where the patients answer

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[67] Artificial intelligence

questions. In this example, you see a demo shared. And the survey asks about financial challenges. That was collected in My Chart.

And thanks to SMART[68] on FHIR applications, you can see a fine health application's able to, with the health system's permission, access that information, so we don't need the patient to re-enter the same surveys over, and over, and over, and over again.

Here it's collected once, distributed to places where it's needed, and then the last step of getting that individual connected to the resources that could help them is handled seamlessly. This is all through framework of FHIR-based data sharing.

And as we think about the plan going forward, we could ask ourselves, as I said earlier, on what format will a doctor be able to know that the patient in front of me qualifies for Lyft vouchers? And that information today doesn't show up in the traditional systems. We've got to bring it in

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[68] Substitutable Medical Applications and Reusable Technologies

this era of FHIR convergence.

Next slide. Oh, by the way, if you go to the last slide, just to remind people, sometimes when you look at the CMS programs, like SSBCI[69], I just wanted to give you an example, it may be listed as eligible for this patient, but only if they've been diagnosed with CHF[70], COPD, dementia, diabetes, et cetera.

So even at that level of granularity, we need computer systems that can read these words in order to understand who actually is eligible. And that too needs a little bit more real-world testing.

Okay, like me just quickly -- and then we can go ahead. Number two, I mentioned the CMS cancer program, the Enhancing Oncology Model. This requires about maybe a dozen, maybe 18 clinical data elements, cancer staged, you know, TNM[71], a whole range of other data elements.

We are embracing a program called MCode-Lite as the data model, an open data model. And that's being made available for

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[69] Special Supplemental Benefits for the Chronically Ill
[70] Congestive heart failure
[71] Tumor, Node, Metastasis

folks in the CMS program. And today, at Datapalooza, where I’m calling in from, both McKesson’s Ontada product and Epic are making that EOM capability ready for any one of customers free of charge who wish to be a part of that program. It’s a small program, hopefully more will sign up, but this is an example of how open data FHIR standards can help facilitate.

Third, I mentioned briefly this idea of bulk FHIR. This is an example. Today the Under Secretary of Health at the VA[72], Shereef Elnahal, announced that, through the Veteran Interoperability Pledge, half a dozen health systems are already able to query to see whether this person’s a veteran.

So if I show up in the emergency room, I hit this database, I can confirm that they’re a veteran. And here you can see an example from Tufts Medicine. They’ve been screening thousands of people, and when they find out that they are a veteran, they can implement more care coordination programs.

This program today was announced

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[72] Veterans Administration

also at scale, both Epic and Oracle have announced that they're going to make this functionality available to any health system that wants to do that.

And that, by the way, is the ultimate value-based care. So we know you're a veteran, we know you get care, you have services and benefits. Let's put those together. Whether there's a weird benchmark, or some convoluted formula, let's leave that to the side. Let's just do the right thing. We can now do that technically.

Last couple, and then I'll wrap. Price estimates, again, same principle, what's the command for me to ask for my good faith estimate? Congress gave me the authority to do that. What is a good faith estimate?

And so I've worked on this program called Project Clarity to try to get episode bundles open sourced. That's to be very narrow, in the same day or within three days, you know, to get, kind of, the bundle of services you need. And we need to get a FHIR API to facilitate my request for the good faith estimate.

And last, certainly not least, and I’ll wrap with this, it’s time for us to align patient engagement with all the new AI tools coming to market that are available to interpret my data. ONC[73] just announced last week 93 percent of newly diagnosed cancer patients go on to their patient portal and access that information mostly before their oncologist calls them.

Imagine having an AI second opinion that can help you interpret your results to make you have peace and some understanding of the options as you go into that next call. This is possible, and I’m grateful for the time.

Thank you so much. And we’ll get to John Supra.

DR. PULLURU: Thank you, Aneesh.

And finally we’re happy to welcome Mr. John Supra who is the Chief Data Health and Analytics Office at Cone Health. Welcome, John. Please go ahead.

MR. SUPRA: Great, thank you, and you can go to the next slide as well.

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[73] Office of the National Coordinator for Health IT

Great. So what I want to build on, both what Aneesh talked about and both -- as I appreciate the opportunity to share my perspectives with the Committee and their work on value-based care, it’s through the lens of doing this work on the ground.

And as Aneesh said, there are a number of standards in place in order to move us forward. And I’ll talk about those, but when you’re an ACO considering participation, or a provider group, you have a number of challenges. And I want to talk about those challenges on the ground.

From my lens, I’m trying to build the data and analytics requirements needed to succeed in value-based care. To drive success, you’re often faced with looking at all of these various data types, the clinical data, that EHR[74] data, payer data, program data that you may be involved in, and a whole bunch of third-party data that you may find valuable for the risk adjustment or other work.

This may require pooling that data together. And if you can figure out how to get

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[74] Electronic health record

this data in a regular, timely manner, then more importantly you need to be able to figure out how to both use it, you may need to do quality reporting, financial reporting, operational reporting.

And this requires, often, a patchwork of internal services, selecting vendors, learning about the data types and/or systems. And these are the realities on the ground when we look at how to build data and analytics infrastructure for success in value-based care arrangement.

And on the next slide, however, even if you’re able to overcome those data access in -- oh, going back, sorry, one. There was just the overlay. Oh, yeah.

Bringing together and building on what Aneesh said and what President Obama said, our goal is to build a data application. And these data applications are what is needed to transform care. It isn’t just enough to be able to get access to the data or do the reporting. But what we really need for population health management are applications that allow us to be able to understand the risk of a patient, to be able to do patient attribution to various primary care or specialist care providers.

To do risk stratification and segmentation for eligibility into a program, or to support and drive the workflow of our care management teams, or engage and communicate with patients, or referrals, either clinically or with community benefit organizations in support of social needs, it’s all of this tracking, and reporting, and bringing together of the data that is required for support in value-based care.

And on the next slide, as we think about what are some of these barriers to participation, the work that we have right now is more akin to artisan craftsmanship than standardization and automation that the modern technology era enables us.

And this real cost is high. In my experience, to get the foundations in place, we are still talking about hundreds of thousands, if not a million dollars, both initially and annually, for a successful ACO to build the data and analytics infrastructure to accomplish the things that we’re talking about here.

And this cost is often weighed against the potential up and downside financial arrangement that the value-based care model drives.

And on the next slide, along with these data and analytics investments, the complexity for providers and the teams supporting them in clinical transformation remains high. A recent review of quality measures in value-based care arrangement suggested that many providers are trying to balance success across over 50 unique measures.

And as the groups throughout this two-day session have talked about, that’s a high burden. And the data and analytics infrastructure needs to be able to report both to the clinicians in practices, as well as back to the programs, success on these measures in near real time so changes and adjustments can be made.

On the next slide, although it may seem that these challenges are difficult, we are making progress. As Anesh just talked about, many of those core foundations, foundational elements have been put in place to drive standards and standardization.

HHS, including CMS and the CMMI, as well as ONC and related standards' efforts, have delivered on giving us some standard data models, have given us exchange specification, primarily the FHIR interoperability resources that Aneesh talked about, and some common frameworks to manage data exchange.

These are all important efforts to reduce the burden in data and analytics infrastructure. But I would also say they're only akin. On starting with agreeing to what language we're going to speak the data conversation in.

Next slide. As we work to establish these standards, we also need to make sure there's timely data access. Again, CMS has made meaningful progress in our efforts to bring API driven access to the CMS data -- model data. It's an important step forward.

However, the timely use of this data still requires those expert skills and efforts in order to integrate the data into systems that ultimately are able to drive clinical transformation and improve the clinical and financial outcomes.

Next slide. To overcome these challenges, we need to be thinking differently about how we share and exchange both data and insights. I like to think about the need to develop a health data and analytics ecosystem where access to the data, and the ability to use the data, no longer requires the craftsmanship and significant up-front work that we talked about over the last two days.

Modern technologies allow and enable this type of ecosystem development. However, they're not widely used, or we're just at the beginning of their use in health care.

Next slide. As Liz Fowler represented yesterday -- referenced yesterday, I also wanted to quickly highlight some of the key takeaways from CMMI's recent data sharing overview and its alignment with the challenges that I've pointed out today, as well as those that have been described by many others over these last two days.

I believe this last takeaway sums it up, that the use of health care data remains a burden. And that burden must be addressed for us to accelerate participation and success in value-based care arrangements.

So what can we do on the next slide to address those challenges? One of the important -- some of the important work we can move towards is alignment that can encourage greater participation in risk-based contracts. We can do this to accelerate the speed at which data is made available.

As Aneesh discussed, many of the interoperability frameworks that have been put in place allow us now to make real time and near real time considerations of data available from other systems. But that requires us to shift towards data system-ready or machine-readable format.

If you consider the number of reports available to ACO members and MSSP or REACH programs, many of these files were designed and are helpful for humans to review. However, to make use of them, ACOs often take the time and effort to de-construct them and load them into their data systems to make use in other data applications and reporting. We need to make this information available in files that other data systems can read easily and drive data application.

Similarly, CMS can consider using modern data sharing applications. We’ve talked about APIs and the FHIR standard. Many modern ecosystems also use data shares that allow users to pick up and access that data directly without the need to pick up a file, ingest it, and then make use of it, and then manage the changes to it.

These types of modern data shares can also support the movement to data system-ready reporting and access to data to fuel and power application.

Similarly, CMS can consider requiring module logic to be open source. I liked Randy’s comment on speedingly being able to re-estimate values in either risk adjustment or make calculations of various options available for the next best care opportunities to provide to a care team, a clinician, a care manager.

By open sourcing that model logic, and combining it with data shares, near real time modern systems can be used to leverage and power data applications. This will move us forward in the use of data and analytics away from having to get the data, driving the craftsmanship or expertise to pull it together, and then driving insights from that work.

This really drives towards a next generation of data and analytics infrastructure that we believe CMS can lead the way by encouraging public and private investment to drive innovation and success in the value-based care models at much lower entry and operational costs when we think about data and analytics.

In my experience, building the infrastructure needed to support value-based care programs, this work has become more complicated, not less complicated. And the cost, efforts, and expertise required continue to increase.

We need to reverse that trend. And I think doing so involves not only the data and analytics infrastructure and its modernization, but we also need to be thinking about the value-based care models themselves and reducing the complexity, as many of the speakers over these two days have talked about.

These, I believe, can help drive participation in our value-based care arrangement and ultimately the goal of improving care for the populations that we are serving.

Thank you for the time to share these thoughts with the Committee.

DR. PULLURU: Thank you, John.

At this time, I will turn to our Committee members for questions. As usual, if you have a question, please flip your name tent up and raise your hand in Zoom.

Larry, and Josh, who would like to start?

Angelo?

CO-CHAIR SINOPOLI: So this may be more of question for Aneesh, but anybody can chime in. So as I heard all the new models for obtaining data and data integration, how does that fit into non-epic patient or physician workflows with different EMRs? And obviously, getting the data is one thing, having it fit into a workflow is different.

MR. CHOPRA: ONC has regular, I

should say, the Assistant Secretary for Technology Planning, ASTP, has regulated all EHRs in the Cures Act to not only export data in the FHIR format, that is to enable application access, but also to allow any clinician to download the equivalent of an iPhone app store, a smart on FHIR app, that can be sponsored by anybody, the ACO, a health plan, Apple, anyone.

And that app has the ability to be able to read which chart you're on. So if I'm in eCW[75] clinic, practice, and I'm looking at patient Susie's chart, the app, tied to the ACO, can read that, ask the mother ship do you have anything to say to me about that, and then bring that information back.

So that is something all certified EHRs, through the Cures Act, are technically capable of doing. Now that means, Angelo, you'd have to have an app that you want to put on top of someone's EHR, but it's a heck of lot easier than having to rip and replace everybody's EHR.

CO-CHAIR SINOPOLO: Thank you.

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[75] eClinicalWorks

DR. PULLURU: It looks like Randy and John have their hands up as well. So, Randy, we'll go to you first and then John.

DR. ELLIS: Very briefly, the software, the modeling that we did for creating the diagnostic items and the risk-adjusted version, we have posted the classification system online as a supplement to our JAMA[76] paper, and the coding of the final preferred model.

And we're committed to software that can be used by anybody to apply these models, unlike many of the other risk adjusters. And our framework has already been used in Belgium and Korea because they were the quickest to jump on it.

MR. CHOPRA: Let's put that link in the chat

MR. SUPRA: ha, ha, ha.

DR. PULLURU: John?

MR. SUPRA: Yes, that's great, Randy, really. That is the sort of open sourcing that I was talking about and, I think, as Aneesh touched on, that idea of how do we

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[76] Journal of the American Medical Association

get these models available.

I think, agreeing with Aneesh on the standards, the movement, that the regulatory bodies have pushed towards all the EHRs, I think it still enables us to start to build on the workflow. So, I think, as we move through the data and analytics piece, we've got to be able to work on what are the right workflows that are going to change and transform care.

And I think Aneesh, a lot of the point, you're making is also it's not only just in the EHR vendors. It's other both public opportunities like Randy and his team are working on, private opportunities that can say here is a workflow that can help and be integrated in.

And I think that is the type of future, I think, in response to Angelo, your question, around how do we make these usable, not just in a certain EHR, but to many groups of clinicians and care teams.

DR. PULLURU: Aneesh, did you want to jump back in?

MR. CHOPRA: A friendly reminder, nothing works just because the government mandated or regulated it to do so. It requires real world adoption. And so part of the reason I'm excited to talk to the PTAC is you represent the demand for these capabilities.

And if you start exercising that demand muscle, then when you actually go to turn these features on, if they don't quite work the way you wish, or they're too burdensome, or there's a problem, that feedback has to go back to the regulators so that we can iterate and improve.

Today we've got a lot of supply side regulation, EHR's must, but not a lot of demand clarification. So when they release a feature and there's been no actual implementation or testing because no one knew to turn that on, it's a little bit unfair to assume it's going to work well on day one.

So the dream, as you contemplate recommendations in the PTAC, enabling a kind of real-world implementation to test and then validate some of these technologies before they get released to the public, might be the key to answering your question, Angelo. How do I make this work in a multi-EHR network?

DR. PULLURU: Everyone's still doing the happy dance from Randy’s comments, but we’ll go to Jen, then Jim, and Larry. Jen?

CO-CHAIR SINOPOLI: We're having some microphone issues.

DR. PULLURU: Yes. Do you want to take this one, Jen?

DR. WILER: Well, it's ironic because I was going to make a comment about technical expertise.

DR. PULLURU: Ha, ha, ha.

DR. WILER: Thank you to you all. What I was going to say is this get so technical so quickly. And we really, we appreciate your expertise.

My question is going to be predicated on some of the previous conversations we’ve heard. One, you all know how important this access to meaningful data at the point of care is in order to execute on the visions of value-based care and the outcomes.

So we heard a little bit the other day about really being able to leverage what we believe will be the promise of AI technologies and LLMs[77], which is predicated on the fact that all of this data can be somewhere that can be mined, i.e., the data mart or whatever that format looks like.

And that allows us to do the risk adjustment that we've talked about, create insights, decrease administrative burden, both at the point of care and also from a revenue cycle perspective.

So here comes my question about the three wishes. If each of you could have three wishes, what would those be in this space to make the vision that we all aspire to possible around executing on what high-value care looks like?

DR. PULLURU: Go ahead, Aneesh, then we'll go to --

MR. CHOPRA: Thank you for the question. And I think you're kind of teeing up the deliberations that your body has the power to bring forward. And I think, in that vein, I would say number one, we absolutely need to do a better job organizing the demand signal.

So if a payer wants to do a social

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[77] Large language model

determinants of health risk adjustment, we sure as hell would benefit from a common demand signal. What constitutes a patient with food insecurity?

Is it someone who answered one question that they struggled for food? Is it a clinical judgment based on whatever their perception is? Is it a health system that asks do you want my help addressing that condition so the denominator falls?

When we have these requirements, but there’s no consistency in the demand signal, if you’re the IT people, you don’t know what you’re supposed to put into the system. So you put your best efforts, and it may not work, and then you get frustrated. And you’ve got to all the workarounds.

So step one, please recommend that we organize the demand signal for outcomes measures and then work towards ways in which that can be automated, number one.

Number two, I believe we absolutely have to measure the administrative burden in value-based care. So we track all this RVU stuff in fee-for-service. If it turns out that we’re spending another 30 percent more administrative costs just to administer the building blocks, asserting attribution, tracking benchmark trend, identifying gaps, addressing, you know, rising risk, whatever the attributes are that you’re going to deliberate, then being able to have a foundational benchmark gives the industry a signal as to how burdensome is it so we can make iterations and improvements.

And if I had my third wish, this might be my first wish, we -- in the pandemic, we needed Israel to tell us what treatments worked. Because they had a learning health system. They had clinical data and administrative data combined. They could understand what was happening to the COVID population in very real time fashion. And they were able to make decisions. They could learn from the experience of the network.

That’s not us, people. As of right now, there are no public-private partnership databases where clinical data and administrative data are pooled to be able to understand what treatment protocols work and which ones don't work.

And that infrastructure is the most important gap in identifying not just who wins in value-based care but what on earth did they do, what was the clinical protocol? How can others adopt and scale?

That learning requires access to that information. And at the moment, it ain't there. Worse, as much as we've made open data a priority, we have Medicare fee-for-service data that gets updated monthly in the public domain, so that's pretty good, but Medicare Advantage data is 2022. That's half the population. And Congress today prohibits the release of that information until all the last Is and Ts have crossed around payment. That's no bueno.

So we've got to have a way to do all three of these things, organize the demand signal, do our best to benchmark performance so we lower the costs, and then hopefully truly build a learning health system that would deliver the kind of evidence-based we need to scale.

DR. PULLURU: Thank you, Aneesh.

Let’s go to Robert, and then Randy, and John in this question. And then we’ll go to Jim for the next question. Thank you.

DR. SAUNDERS: Great, so I have sort of my three -- the first one plays off of the ask about the AI piece in those three wishes. And in that case, I think it’s very important to watch for those unintended consequences, especially among the AI, and think about the better data that you have.

I mean, AI is very exciting. It can do a lot, but it also can pick up things that we don’t mean it to. And that can oftentimes bake in disparities or inequities.

So I remember when I was a young graduate student, I was putting together an AI system looking at new ways of detecting breast cancer in mammography and found a great method that was getting this great sensitivity.

And the way it was working was it was looking at -- this is back when you had film mammograms, it was finding specific markers, position markers in the mammogram that were indicative of call backs, which meant that the woman was at higher risk of breast cancer.

It had nothing to do with the actual anatomy.

And just like then, it's very similar in a lot of AI tools being able to pick up signals that are, in fact, evidence of existing inequities, like say in risk adjustment, that may be that somebody has lower utilization because there are access issues or the like, as opposed to really understanding where risk is.

So just want to, sort of, put a plug in there that we'll need some better data for those AI tools so we don't bake in any type of disparities and inequities.

Then second, one thing we're hearing from our provider friends is just, again, the need for standardization, especially in social drivers of health. There's a lot of excitement right now among better social drivers of health data. But that also means that we have created this just diversity of tools that are out there.

And, you know, if we talk to different health systems, they'll say I have, I don't know, three to five different instruments, each of which have slightly different question variants, each of which will have different answer variants, each of which are storing the data differently on our EHR.

And it’s just creating this morass that’s going to possibly cause people to be a little bit hesitant to participate in some of these social drivers of health programs. Because they’re feeling overwhelmed by just the administrative burden that’s happening in screening.

And I think tying to that, one of the things that we are finding in our work in North Carolina, especially the North Carolina’s Healthy Opportunities Pilot, which were one of the first in the nation, or the first in the nation, to use Medicaid funding for addressing social drivers of health needs, is just how challenging it is to actually do a lot of social drivers of health screening and get those data in the first place.

So, you know, our clinician friends in the audience will probably be -- resonate with the fact that clinicians hate asking questions if they can’t do something with the data. And we definitely hear that in our research, that when we're asking clinicians to screen for social drivers of health, they want to make sure that something's actually being done with that data more than just an administrative, you know, administrative sort of matter.

And so where there's programs like, you know, North Carolina we've got Healthy Opportunities that are actually addressing social drivers of health, you can win more clinician buy in, because there's something being done with that data, there's a reason that we're asking our clinicians to spend that time and recognize that many of our clinicians haven't been trained in asking these types of questions.

And so there's a long start-up and process in order to get those data to be accurate, in order to be able to get the data we want. So I think my three are get better data for AI, think about standardization, especially as we start to roll out a lot more of these social drivers of health tools, and then making sure we're able to tie these data to actual uses in order to make sure that we continue to buy in, especially my clinician colleagues.

DR. PULLURU: Randy?

DR. ELLIS: I think I'm next. I agree with Aneesh and John. I would like -- I'm sorry. Anyway, the thing I want to highlight is that there should be Medicaid data across states. That would be very helpful because those are so siloed and not yet available from CMS in a standardized way.

The Medicare Advantage program is woefully slow in getting data. Actually, CMS has been making some efforts to make it harder for people to take data out of their own computers which is really impacting researchers. They've delayed it, but that -- implementing that restriction, but that's going to be a huge impact on all of us.

And the last thing is on social determinants of health and work we've been doing in Massachusetts is using the state's own Medicaid data that includes the Census block-level information about each enrollee. And we found that does quite well, in some ways is better than the individual's own self-reported measures because it's capturing the environment that they live in. And a lot of it is related to those factors.

And also, if you think about what providers do when they select who they want to treat, they have an enormous geographic component about that. We know that certain parts of cities don't have any doctors. And rural areas have much weaker prevalence.

So geography is really important. It captures environment and pollution and water quality and food availability. So that's going to be a challenge for data provision because neighborhood information is extremely touchy.

In my own concurrent risk adjustment models, once I know your diseases, I can do so well that I don't need to know your age. I do prefer your gender. But age is unimportant once I know all the diseases you have.

And I think a lot of doctors would agree for many things. Once I know your constellation of diseases, your age isn't really the central feature. So if we drop age, then maybe we could sometimes get bundles of geographic information instead of age.

And I would love to have that for my social determinants of work -- of health variations.

DR. PULLURU: Thank you. And John, and then we'll go to Jim's question.

MR. SUPRA: Thank you. Very much agree with the other speakers, and I like the way Aneesh framed that. And I want to drill it down a little bit to the work on the ground of managing both an ACO and the operations.

And I think one of the first things and it's been touched on is the alignment of value-based care models across lines of business because many of the ACOs are managing Medicare in the CMS or CMMI models in Medicare Advantage, as well as Medicaid models. And how do we look to bring alignment across those? And that may be incentivizing what the value – the quality metrics are, aligning across what the payments are.

So how do we find that because that becomes a burden that I think is important to be thinking about broadly. I think as I talked about the standardization of data sharing and using modern data management platforms. Right now, we continue to do much of the work in a lot of point-to-point data transfers.

And that is a challenge when you think about the burden of each one of those. So that's a very practical wish list item. And these are available for potential use.

And then finally, I think this notion of open sourcing the various methodology. So if we are going to align around social determinant of health screening, if we're going to align around how we look at the different resources available in a community, if we're going to align around referral processes, we need to really drive backwards from that alignment to what data is necessary for the next group to act. So how do we make sure that the work is data interoperable in order to connect the various parts of the health delivery system? So three wishes there.

DR. PULLURU: Next we'll go to Jim.

DR. WALTON: Thank you. I'm reminded that our opportunity here is to recommend to the Secretary some ideas from the Committee based on expert testimony about how could we lower the barriers that have been identified around data, data sharing, data insights, predictability, and such. And I was curious if any of the subject matter experts on the call would offer some near-term solutions that could help us in the next six years.

Help CMS and CMMI achieve the goal of 100 percent participation in a population-based total cost of care model that addresses a few of the key things we've heard from providers that are kind of sticking points with either participation or with performance recognition. And some things that we heard I'll just reiterate. We've heard something from a physician just a few hours ago around just timely communication of the care of their patient when they're not in front of them by another provider.

And we've talked about clinical data sharing. And someone just mentioned just the disease burden, actually being able to share the number of diseases that a patient has. But it goes into a common large language -- an AI machine that basically satisfies what is that risk for that patient that we share commonly, much like HCC scores.

And then the data analysis and reporting insights relative to predictability, are we being effective in our goals of achieving quality and reducing cost? And then last but not least is data sharing around our health-related social needs. So I'm curious -- I'll just restate it is that I'm curious if our experts might recommend something that we can actually put in a report that could actually be executed to help kind of achieve that goal.

DR. PULLURU: How about -- I think I saw Aneesh and Randy at the same time. So why don't you go ahead, Randy, and then we'll get to Aneesh.

DR. ELLIS: Aneesh is first.

DR. PULLURU: Okay. Aneesh?

MR. CHOPRA: I'll go fast. You said six years. How about we say 90 days? So what I would like to do is to remind us, at the very practical, what could you ask the Secretary right now?

Number one, to hit the 100 percent goal, we must decouple the data sharing options from the participation in payment models that take risk because right now the only way for me to get CMS claims data as a doctor to do all my risk stratification and all the things that we talked about today is I have to be enrolled in Alternative Payment Model. If I'm a surgeon -- orthopedic surgeon and I want to do a better job, like, addressing low back pain, I can't get the data. CMS has not made that available.

And so now with the brand-new rule, the ACPM[78] proposed a billing code which is essentially a bundled primary care payment, this should be an opportunity for any doctor who wishes to do better care to get the claims history. Once CMS sets that default, then that will usher other plans to do the same, number one. So decouple the release of data from those who participated in the account.

Number two, enforce the laws on the books. I don't know how many of you know this, but CMS put the highest regulatory authority, a condition of participation for every hospital in the Medicare program, is that they give doctors the admissions, discharge, and transfer notice when their patients show up in the ER

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78 American College of Preventive Medicine

admitted or transferred. The number of doctors who are aware that this is even a requirement is below 10 percent.

It might even be one percent. And I've seen zero enforcement action from HHS to highlight that this happens or that it's a possibility. Or here's a form. Ask your hospital about how to get your rights. Not a peep, nada. So number two, enforce the laws on timely communication ADT[79] feeds the doctors.

Finally, all the infrastructure we talked about, I hug John Supra through this virtual -- I'd give him a hug in the meeting if I could. Open source the CMS logic for every attribution model, benchmark model, forecasting of trend model, et cetera. We pay through the nose to have a CMS contractor develop it and then to reverse engineer it, to guess. What a complete and total waste of money. Thank you.

DR. PULLURU: I believe Randy is next.

DR. ELLIS: I'll try and be brief. But I have to comment on that last one because CMS posts the software needed each year for

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[79] Admission, discharge, transfer

risk adjustment of the Medicare Advantage and HCCs. And it's written in the most inefficient, archaic SAS code imaginable.

And it takes up me -- my research assistants a couple of weeks to reprogram it. They intentionally split it into many pieces. They have horrible coding.

It's written as if they don't want anyone to use it. That's how bad this software for risk adjustment is. The second comment is just that when I join a health plan, they always ask me, do you want to allow the doctors to coordinate with other health plans and other hospitals and doctors and everything?

And every patient says yes. I believe that there's an allowing of your HIPAA privacy to be violated, if you will, by doctors and hospitals. Of course they need to.

But the interconnections between those emergency rooms and the hospitals is atrociously bad. So CMS should want to have a communication where they can prompt some source that would let each doctor and hospital emergency room actually access the patient's data, which is partly what Aneesh was complaining about. And I'll end there. I could go on, but --

DR. PULLURU: John, and then we'll get to Robert.

MR. SUPRA: Great, thank you. And Randy, very much agree with you. The reverse engineering is a huge burden. I want to take, and I'm probably going to look for a time frame between Aneesh's 90 days and the question six years, to a sort of one- to two-year framework that I want to split into two pieces.

How is it easier for those ACOs that are participating and can remain participating? I think we've talked a lot about the open sourcing, the access to the data, the logic around it, so we're not trying to recreate as a whole collection of ACOs the same logic in slightly different ways. And I think that can be done by CMS.

I think moving the data sharing approaches from what is done today in making certain files available and then wrapping the logic of how attribution is done. The risk adjustment is one piece of it. And then, I think on another side when we think about new

ACOs, new provider groups, can CMS also make a tool set or encourage a private investment in a tool set that just says, if I'm an ACO, I come in and here is a set of dashboards, best practices that are very open and transparent based on that data that align to the open source models that some of the ACOs may want to run themselves?

And I don't know if that's something that is possible. I know it's possible. Is that an encouragement that we can make to allow people not to have this huge investment to just get into the value-based care arrangement?

DR. SAUNDERS: Building on my colleagues' points, I think one piece I'll end with is a major challenge we hear from our health systems and provider groups that we talk with is just also the data for engaging with their specialty colleagues. And so that depends, of course, on the type of organization, whether it's a primary care physician group practice versus, say, like, a large health system that has a number of specialists in house. But you know, having that data on different types of specialty characteristics, understanding the quality of care that is being delivered by different specialists and their local geographic region for different types of procedures they want to make referrals for.

It has been limited to date. CMS has done some good work in their defense on releasing shadow bundles, although that's really about just a base level pricing for the BPCI bundles. I think the next layer would be being able to get more granular data around, like, use or cost or quality or potentially something like, appropriateness, to really help health systems understand how best to engage, especially for a specialty care. And that would help make a lot of these payment models much more effective over the long term.

DR. PULLURU: Thank you. Randy, did you have something to add?

DR. ELLIS: Just 20 seconds. Throughout this conference, one of the key themes has been that the reason people aren't in ACOs and ACOs don't want to participate in these types of payment is because the money in the U.S. is made by selection. That the avoidance of really sick people and keeping them out of these ACO-like more tightly managed systems is important to them. And so, these six years to try and get rid of selection is a very ambitious goal. It's much more than 90 days because that is how the American health care insurance system is configured.

DR. PULLURU: Thank you. Now we'll go to Larry, one of our Committee members who is on video.

DR. KOSINSKI: Thank you. Well, as a certified data geek, I've loved this session. I've had to hang on for dear life at times, but I've enjoyed it.

It's very rewarding to hear open-source data exchange that this can be done in 90 days, two years, whatever. That it can actually be done is heartening for me. The problem I have is the data requires data fields.

And we spent the last decade, ever since the Recovery Act and meaningful use, pushing fields into EMRs and expecting physicians to check boxes because we knew we had no way of extracting it out of the doctor note. And so we could digitalize review of systems, past medical search history, all of those things and we've got nice fields. But that doctor, history of present illness, and more importantly their impression and plan where what's in their head is supposed to be placed into this document has been a major challenge.

We've heard from CMS that, expect at least five years for the creation of any quality measure. Well, that's crazy. We can't live in that kind of a world. And so what I'm going to ask all of you is not to get your wish list. I want you to rub your crystal ball and tell me if I'm crazy in what I'm going to suggest.

Have LLMs and AI systems got us to a point where that doctor can speak in an examining room and software can take what that doctor said, populate fields that may not even exist in that EHR so that we can capture the meaningful pieces of information of data so that we can create intelligence from it? How far are we from it? Can we stop forcing EMR vendors to create new fields and maybe allow AI to give us a runaround?

DR. PULLURU: This is like Jeopardy.

DR. KOSINSKI: Am I crazy?

DR. PULLURU: So I believe I saw John first and then Aneesh and then Randy and Robert. Thank you.

MR. SUPRA: Great. Thank you. No, not crazy at all. We have been working in -- work that I've been doing with our care management teams. It's been focused, and I think it is equally applicable to physicians, all types of care teamwork where we've been using ambient listening to essentially collect the interaction between the care manager and the patient.

Be able to then summarize that into a summary note. Being able to pick up on different instructions being made to the patient or their care team. Being able to also take, say, a social determinants of health screening and be able to fill in parts of that along the way and then take that care summary.

And some of the work we're working on right now is to turn that into what you might think of as a standard care plan, problems, goals, interventions, and move that into discrete data so we can track it. So that is work that I've been engaged with, with some of our clinical teams and our technology partners. And it is real work, and it's real work that we're deploying.

And I personally have done a little less on the physician side. But I am pretty sure that that same work is going on in physician exam rooms with the same notion of how do you take that, get the transcript, get a summary, get actionable data, and then put that into the places that we can then report, monitor, drive those data applications. And I think it is real. It's here.

We also keep track of the transcript so that the clinical team can go back. And if they're not sure, and all of those are editable by the clinician so if they either disagree, would like to modify it. So I think it very much is current state. It is what we need to do more of to reduce the burden on our physicians, our providers, our clinical teams.

MR. CHOPRA: In the spirit of time, three things. One, we're at Datapalooza in an hour. One of the EHR vendors, McKesson Ontada division, is demoing how they introduced the FHIR Cancer Moonshot, Enhance Oncology Model data mapping.

These 18 data elements are not currently captured. And today, they're manually collected in Excel spreadsheets by doctors that participate. Today, they are demoing how they are able to take the LLM capability, summarize, map, and then test and accurately measure whether they can submit what's needed. That's being demoed right now.

Two, the VA put a half a million-dollar prize competition last fall and focused on ambient dictation, use cases exactly as outlined by John, but for clinicians. And then two, related to that, kind of a document summarization tool. So you can pull all the historical information besides listening to the actual clinic visit, you can prepopulate.

So both of those things are happening. And over 200 companies were competing in this competition. Several won, and so that's another example.

And then three, just to be super

pragmatic, we are early days. So HealthcareAICommitments.com, we've organized a voluntary self-regulatory body for payers and providers who want to step into better uses of LLMs so that we collectively are governing how to minimize risks, minimize hallucinations, minimize inaccuracies because we're not solving world hunger through an app. We're having to work together to put these technologies in the best interest of the people we serve.

And so I would strongly recommend maybe the body can discuss, should there be more encouragement of self-attestation and regulatory efforts. Because currently, these are not regulated activities for hospitals and health systems. There's nothing specific that they have to do under AI work. It's still the same, don't discriminate and so forth that’s existing.

DR. ELLIS: I agree with the previous two comments. My son is a doctor, and he is also using recordings of his clinical meetings with patients. And it greatly simplifies part of his duties, and it's a great tool.

His complaint is that the goal of the software that he's using is to maximize the apparent complexity of the patients because for many purposes whether it's DRGs[80] or health plan ACO compensation, they will get more money if he codes up more detail. So he's annoyed. You know all those buttons that you used to have to click, and doctors would give up and not do all of them?

The AI equipment can keep prodding him over and over, are you sure they didn't have this? Did you mean -- what did you mean when you said that? And that's the bane of these systems, the same profit motive.

DR. SAUNDERS: And I'll bat cleanup here. I mean, and I think just building on John's point and Aneesh's, I think we, in our research, have been hearing about ambient listening being implemented in health systems around the world, not only in the U.S., it's Canada, you know, England. There's a variety of folks.

So I think to your point, Larry, the future is here. It's just unevenly distributed

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[80] Diagnostic-related groups

right now. And to quote -- to paraphrase a famous quote, and I think this brings up three points.

One is probably the biggest advantage of AI right now is in streamlining administrative burdens. We can potentially get in some trouble where we put AI into things that have more care delivery decisions because there's a variety of issues that can happen there. But I think to the extent that this streamlining, there's still a clinician on the other end of that AI tool that's maybe spending a half hour at night to clean up their notes but not necessarily spending four hours over midnight trying to write their notes at night.

I think there's a lot of advantages to deploying AI that way. I think the other two points here are that AI aren't perfect. They can drift over time. They can vary depending on where they're implemented and different organizations.

There's a lot of potential gremlins that can pop out there. So to note that there's a lot of power but also a lot of places we don't know. And finally, I'll just note as a bunch of health care, it all comes out of people. And so to the extent that the AI can support people's needs and reduce burdens, that's great.

But there's also a lot of sort of unintended consequences that can happen in terms of do our clinicians -- are clinicians trained in knowing what the various implications of some of the tools do? We also open up some cybersecurity concerns to know what new devices are involved and listening. So there's some places here that we may have to think about as we do implementation.

DR. PULLURU: Thank you to all four of you. So we have four minutes. And since we have this brilliant panel, I thought I would end with a question. So now we're all in 2030. It's six years down the road.

CMMI, CMS, and the Secretary have all listened to your panel, and they have implemented one insight to follow. What would that be? So each one of you, 30, 40 seconds, and we'll end it there. Let's start with Randy, go to Robert, and then John and end it with Aneesh.

DR. ELLIS: I think I'd like to see that they implement a simple payment system to all the primary care practices that free them up from all of the paperwork of worrying about all those buttons and yet is still able to eventually evaluate that they did a good job and their patients are doing well because that would mimic what is happening in Europe with much, much simpler payment systems.

DR. SAUNDERS: And I would probably build on Randy's point here and that if our goal of value-based payment models is to improve care, which I think all the folks on this meeting will agree with. A big challenge here is predictability. So we have a lot of different types of benchmark and risk adjustment and other incident methods out there. They're changing over time. It depends on the line of business, payer. And so to the extent that we can have a simpler, more predictable set, I think that will serve us all well.

MR. SUPRA: Thank you. Continuing to build on that, I think that system needs to be underlying with data tools that enable not just our health care providers but our community benefit organizations. All of those people are going to drive outcomes in our value-based care models to be able to participate in an equal way regardless of their existing data capabilities and not needing to be experts in crafts.

MR. CHOPRA: Yeah, I would just like this to be care. So the way that care is delivered is doctors know a lot more about you before you walk in and help contribute to your overall longitudinal improvement by helping along the way, help a colleague close a care gap or share that there may be an issue that this particular doctor missed in this encounter, but hopefully the next member of the team would. And to do that in 2030, I think the Secretary’s going to look back and say, as I look market to market

Medicare and Medicaid have done what they can do to move people. But as we look to the commercial market, it sure looks like we've done a lot more that's decoupling value-based care by raising hands, saying, I want to deliver care on a team separate from I want to take risk on a population. And I think that decoupling will be presented in the 2030 lookback as a key driver of the growth.

DR. PULLURU: Thank you. I'd like to thank all four of you for this incredible conversation and joining us this afternoon. You're welcome to stay and listen to as much of meeting. We're near the end. I will now turn it over to Angelo.

CO-CHAIR SINOPOLI: Thank you, Chinni. That was a great session. I appreciate everybody's participation. And I'll see some of you later.

*** Public Comment Period**

CO-CHAIR SINOPOLI: So I don't think there's any public commenters. No? Okay.

*** Committee Discussion**

CO-CHAIR SINOPOLI: So we're going to move into some time for the Committee to discuss what they've heard today. We spent a lot of time yesterday talking about what we heard through the course of the day yesterday. So I'm going to ask that today we spend time just adding new thoughts from yesterday and things that we've heard today.

And we can have those conversations between now and 3:00 o'clock. And who wants to start? I'll pick on Lauran since she's beside me.

CO-CHAIR HARDIN: All right. So today, I was listening and could actually take everything in. So it was a really rich day. A couple of themes that really stood out for me are the importance of, really, adjustments for socially underserved populations, the factors in benchmarking, looking at ADI as a determiner potentially of looking at increased dollars to account for risk, and the importance in where those dollars shift, whether it's also investment and community-based organizations to build out network adequacy for meeting needs. Or, Schilling brought up the concept of the need for an integrator in the community to really pull these services together into a really efficient network. So I'll stop there and pass it on to my colleague, Chinni.

DR. PULLURU: I thought the day was, it was pretty incredible and diverse perspectives. And a couple things stood out. I wasn't quite prepared to speak to them.

But I think speaking to the last part, which is data, one of the most powerful things that really stood out was the decoupling. I do think that everybody should have access to CMS data presented in a way that is consumable by physicians. And they don't need to deconstruct and reconstruct it.

I think that's, that’s, really important in our goal to get to 100 percent participation. The other thing that really stood out today was the concept of measures. The fact that we really need to look at patient-reported measures, as well as things like longitudinal and access measures that don't currently exist as a part of the overall measurement of how clinicians and provider groups are compensated through the model. So I'll pass it on.

DR. LIN: So another rich day, another rich public meeting. So thank you very much for the PCDT, ASPE, NORC's hard work in organizing just a phenomenal panel of speakers. I think I'll try to link the -- some of the things I heard these two days.

Our public meeting back in June, we

talked about how skewed Medicare spending is. And that's because of the seriously ill and those with chronic complex conditions. One of the things that we've heard kind of over and over and again these past few days is the risk adjustment system doesn't work and doesn't take into account things like frailty.

But I just thought, like, today's session just now where the experts commented about the importance of delinking data distribution, data sharing with participation in value-based care initiatives was also very timely and informative. Just kind of as a practicing PCP, trying to figure out which cardiologist, which nephrologist to send my patient to right now based upon data, that's really hard to get. And so hopefully a suggestion like that will go a long way.

One of the things that also struck me today was the fact that I think CMS has been making it more uncomfortable for providers to stay in fee-for-service. So Alice Chen this morning talked about how there's been a cumulative fee reduction of some significance in the physician fee schedule. And the thing is, though, I haven't been comforted in the solution to that which is to move people into value-based care it sounds like.

It's not been the smoothest of transitions for many participants. And in fact, some of the participants that we most want to participate in value-based care, those ACOs taking care of highest risk-adjusted spending because of their ability to be more efficient with these high-cost patients, have not really materialized as much perhaps because of some of the benchmark issues and risk adjustment issues that we've heard about.

The last thing I'll mention is one of the things I greatly appreciated about these two days is the emphasis on patient or beneficiary participation in their own care and how important it is to have involvement and some ownership from the patient's perspective and creative ways to think about incentivizing that such as through waivers of co-pays and such.

DR. WILER: I agree with all of the comments from my colleagues and would echo what a wonderful couple of days that we've had. And thank you to all who put it together. What I'm reflecting on is the comment that I think Larry actually summarized quite well.

And that's at the highest level, the drivers of business success have to be aligned with the health of populations. And we heard yesterday, payers, providers, and purchasers need to have alignment. And it seems both of those things can be true in the comments that I just made.

So working backwards from that, it seems like it shouldn't be aspirational. It should be doable. The other thing I took away from today's session was this conversation also around engagement and trust which was described as an outcome measure.

But I actually think it's more of a process measure. And the idea that I think we all know that it's true, but that that sort of therapeutic effect it was described to us, of longitudinal relationships. Maybe it's not with a provider.

Maybe it's with an entity now that we heard that 75 percent of providers are employed but that there's value in that relationship, both for the patient and the provider related to burnout in workforce. And I hope this Committee in the future will consider that what the impact is of churn, or on these kind of relationships actually being a positive impact on workforce sustainability. Then the other thing that I heard that continues to be the elephant in the room is carve-outs.

We heard just now, money is made by selection. We keep hearing about models where there's carve-outs of high-cost activities or therapeutics that make a big difference in actually total cost of care. And so I hope in the future there's an opportunity to really look into drug spend. And we heard described in our panels today around to one entity can be a cost and to another entity it might be margin and how there's a perverse incentive to use that margin for currently low-revenue generating activities that actually might be of high value.

And then the last comment I'll make is, I'd love maybe as a follow-up to our last panel to get a little bit more clarity for our letter to the Secretary around what are the current regulations or rules that have been put forward that can help put, help to execute on this challenge around data and insights and sharing where there might be an enforcement opportunity. So there's already been agreement on where we should focus. But really, it's now on maybe highlighting the opportunity around enforcement.

DR. BOTSFORD: Thanks, Jen. So I heard some themes around maybe questioning the status quo in current value-based programs and where we need to maybe push more. So a couple of our presenters discussed about the unintended consequences of rationing effects and decreasing incentives for participation based on what ratchetting mechanism is used.

I also heard a couple speakers question if downside risk is really needed, which I think has been built into many of the models in the past. And I think it's worth probing a bit more there. Maybe a little bit questioning the status quo, but maybe less of alternative models in the current state.

But what other levers do we need to

pull to make the current state less attractive to make the Alternative Payment Models and value-based care a reasonable alternative? So we heard examples such as the current drug margins that are keeping practices a fold. I know we've talked about Part B and D as areas to talk about.

But yeah, what levers do we have to think about in the current state to help us move towards a future state? Some other ones we heard yesterday but I think also today were what financial incentives could exist for beneficiaries? How can we involve patients more?

I think the new theme I heard also is about how we might consider access to care and continuity measures as quality measures as we think about future models. And this is not new, but I just have to say it came out again. We have to find ways to pay primary care more.

DR. MILLS: Yes, agree with all of that. I took notes of the high points that really struck me as bringing out something somewhat new or unique compared to what we've heard before. Some of those include focusing in and changing how the ACO benchmark systems work, that there's a disincentive for worser performing groups to join an ACO program because their benchmarks are set artificially lower.

They have to do even better to have any shared savings. So it's just not worth it for them. And then the ratchetting effect we've heard about for high performing, it just doesn't make any sense of just, you have to compete versus yourself. We want everybody to be successful and the best performing should continue to reap some of those benefits.

I was struck that we've talked a lot about the need to make value-based care increasingly attractive and fee-for-service decreasingly attractive and move into that more aggressively. And yet a speaker spoke to the effective fee-for-service rates are decreasing through the fee schedule. But the -- with the expiration of the APM bonus on the fee schedule, the APM rates are also decreasing under zero percent update.

And that doesn't seem to track with our strategic initiatives. I heard an appeal that we need to build a pathway for smaller PCP groups or PCP only groups to participate in ACOs. And that will have a variety of considerations to make that possible.

We heard a lot about focusing in on beneficiaries and what incentives beneficiaries could be put into place. And I was particularly struck by the flexibility to compete with MA plans, are able to offer essentially no copayments or discounts to copayments and deductibles that we want to figure out a way that maybe ACOs can issue some of that as well. Heard some powerful words about -- though I know it's in progress, but to accelerate into collapsing site of service payment differential that moves everything to outpatient hospital departments and hospitals instead of ambulatory.

Someone said, you know, not sure that ACOs make sense for primary care because there's really no -- not much savings in primary care. And that just struck me that we shouldn't be looking to capture health expenditure savings out of primary care. We should be using those mechanisms and payment mechanisms to push more money into primary care, right?

The only specialty that increasing assets and access improves health outcomes for the country. I was struck with using just rulemaking process to change high-value services to no copayment for beneficiaries including mental health care, TCM/CCM, complex care management and the new APCM codes. I thought that was seemingly within our grasp.

Heard this last panel really appealing to us to standardize social determinants of health screening and then define the demand signal. And I think having worked in that area as well, I would just say there are many good screeners. Just pick one and declare this is your standard.

And I agree. It's probably not a single yes answer to a need that is a demand signal, but just define it. And then the normal process will make that update as research comes out. So that's my take-homes.

DR. WALTON: If I can add just a little bit to what the colleagues have said. I felt like I was -- it was a little bit like a

Tale of Two Cities for me. In the first example on the left hand or right hand, whichever, is that macroeconomic pressures really matter.

And so the world is changing around the APMs. And our goal to participation 100 percent is under the influence of some of that. And what we heard was consolidation for market power.

As we all know, it pushes up prices where possible in health care. And that increases the gap between the actual costs of health care and the quality that's delivered. That gap has to be filled.

And APMs provide an opportunity for there to make some shared savings to fill that gap in the fee-for-service space. Those participants, as we know in population-based total cost of care voluntarily choose to participate. And oftentimes, they're motivated by this point that was made by Larry and Jen, relative to the business enterprise of providers must be successful in order to be sustainable because of the capacity issues confronting a population that's more complex and more disease complexity because they're aging into that and living longer.

But the truth is, is that motivation by financial opportunities may not necessarily translate to what providers want and improved communication and integration, what patients want and patient-related outcome reports, what society wants in equity and quality and cost control on their income tax. But the other side, the other story was the hope from our colleagues. We had three really great examples, Barbara McAneny, Bob Phillips, and Steve Furr.

I thought their, our colleagues, right, had ideas that resonated with me because of how well they individually and collectively articulated the strengths and the weaknesses. And we may have actually heard from them and others yesterday that the key ingredients to how APMs could actually stabilize the capacity of the future that will provide the access to patients and families. And so I think that's our opportunity and, of course, it's our challenge in how to organize those core elements that we heard. So it was a great meeting. Thank you for letting me participate.

CO-CHAIR SINOPOLI: Thank you, Jim. Let's go to Larry.

DR. KOSINSKI: Well, it's great when you pick on me later so I have a chance to summarize my notes. Anyway, the first thing I have to remark on is that the ECHO[81] was built to improve collaboration and promote accountable care. And it succeeded in some of these but has had unintended consequences.

We heard multiple speakers remark on this. It created administrative complexity which ultimately led to a lot of provider consolidation because they couldn't deal with the complexity. They threw up their hands and they got employed.

This consolidation has resulted in rising costs, loss of physician autonomy, physician burnout. We heard that it also caused provider mail distributions. It's in payment nuances where improvement in care by providers doesn't provide savings to them but results in Part A savings.

On the second point, now our value-

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[81] Extension for Community Healthcare Outcomes

based care solutions need to be crafted around large entities because of this consolidation. The entities receive the value-based payment, but is it really being passed down to the provider? I don't think it is. I think it's being used for other activities.

We heard very clearly, medicine is a business. Whether it's at a medical practice, a solo practice, a hospital system, an academic medical center, it's a business. And the drivers of medical business success need to be considered when we are crafting reimbursement models, especially for population health.

The other point on the business side that came out multiple times is risk assessment is basically better coding. And so we need to look beyond that or figure out better solutions to it. We also heard a visit is not a visit. They are not the same.

We heard the example of the much higher investment necessary for a first visit than a return visit, and yet the payments are not ranked accordingly. We also heard there's a need for urgent visits. And maybe we need to think about TSA PreCheck kind of thing where we can get patients through into practices and actually figure out ways of compensating practices for handling those urgent visits who are certainly cheaper than ED visits.

We heard loud and clear that the specialists in value-based care remain a problem. They're still on fee-for-service. We heard about hybrid models, blending PMPMs with fee-for-service.

We did not hear any real good solutions for how to create payment models for positive internal medicine specialists in value-based care. We heard about nesting solutions which was music to my ears. That could be a major -- nesting solutions for specialists could be a subject for one of our meetings.

We heard about data, of course, and that they need to be decoupled. That came out loud and clear, and I think that's something that we can push forward. And they cannot continue to be proprietary.

They need to be open source. But they also need to include PRAMS[82] in SDOH. And

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[82] Pregnancy Risk Assessment Monitoring System

I heard very optimistically that LLM may benefit the acquisition of data. That was really something very encouraging.

I like to close with quotes. I love the quote, Medicare Disadvantage plans. I love that. That was great. Barbara said that. I heard, if we fund it, they will come.

I heard the best drug can't be the worst one for the practice. It takes more practice resources to take care of patients who lack personal resources. And finally, don't put physicians in the position of choosing patients over practice. That's it.

CO-CHAIR SINOPOLI: Thank you, Larry. Jay?

DR. FELDSTEIN: Well, I don't know if there's anything left to add after what everybody said. It really was another great day. Like Lindsay, I mean, how many times do we have to hear that we have to pay primary care more before we actually do it?

And the last two days really have given me the feeling, and Jim's comments trigger this. I kind of feel like we're building the airplane while we're flying it at the same time because we're trying to come up with you know, value-based care and payment models. And Tim hammered -- first hammered this home for me yesterday.

We've got capacity issues and an antiquated delivery system. So we really -- and we're almost looking for the payment model to ease the access issues when, in fact, it's a catch-22 because with all the consolidation going on, we're actually creating less access which is increasing cost. So that's a conundrum we just got to figure out how we're going to work. So again, you know, great panels, great work by ASPE and NORC and the PCDT team. Just another great two days, and thank you.

CO-CHAIR SINOPOLI: Thank you for that. Josh?

DR. LIAO: Great. Well, I share Jay's point that much of I think what I was going to say has been said. But I kind of put together what I was able to hear today in part and then yesterday. I think it's been kind of baking in my mind.

And so maybe I'll just -- my

comments will be to kind of organize what a lot of other Committee members have said but in a framework. And in my mind, it's baked into a bit of, like, a layer cake. In my mind, there's a three-layer cake that's emerged.

And I think the bottom layer is really about the things that we can do. Certain speakers think on 90-day timelines. Some people think longer.

The thing you can do in the nearest term and that shouldn't be maybe in the confines of payment models, so things like data and giving people data in a more unrestricted way, democratizing source code. And that kind of leads to that second layer of that actually may help drive this point of participation and engagement in payment models. But I think on that second layer about clinicians and groups in payment models, one of the things that kind of floats to the top for me is this idea of simplicity, predictability, generous incentives, and care flexibilities.

And I highlight those three because the predictability of knowing what's in being generous as I mentioned yesterday in how people are incentivized in the models. And then to not over index on the cost, what are the care flexibilities to make care better efficiently? Not efficient and it may be better I think is really critical.

So that's -- all that's driving into why -- if you have a base layer of data and democratize utility and tools, why would you get into the models that we're describing now? I'll just comment again that MA[83] and others work in context there. And then the top layer, so to speak, is, like, really double-clicked in on the design features, right.

So ratchetting, benchmark, risk adjustment, those are technical things that have to be done. Can be improved, is what I heard, in models. They don't really matter if there's not simplicity, generosity of incentives, and flexibilities to make care actually better. Kind of on the bedrock of data and other things that all clinicians should just have based on existing or merging regulations. So those are my comments from the two days.

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[83] Medicare Advantage

CO-CHAIR SINOPOLI: Well, thank you for that. All great comments. The only thing that I -- everything has been said. The only thing I would add and emphasize is that last session I thought all around data was excellent. And they actually proposed a number of very specific recommendations and statements that I think we should not lose the opportunity to make sure that those are incorporated in our letter as strong recommendations because I think that's the bedrock of what's going to be able to make things move forward the way we want them to.

*** Closing Remarks**

CO-CHAIR SINOPOLI: So I want to thank everybody for their participation today, our expert presenters and panelists and PTAC colleagues and those listening in. We explored many different topics today regarding identifying a pathway toward maximizing participation and population-based total cost of care models. Again, a special thanks to my colleagues on PTAC. There was a lot of information packed into these two days. I appreciate your active participation and thoughtful comments this afternoon and all through the two days.

We'll continue to gather information on our theme through a Request for Input on our topic. We're posting it on ASPE/PTAC website and sending it out through the PTAC listserv. You can offer your input on our questions by October the 18th.

The Committee will work to issue a report to the Secretary with our recommendations from this public meeting. As we conclude, today I would like to comment that this is my last public meeting. And after being on PTAC for six years, I'll be rotating off after serving two terms.

I want to express my deep gratitude to my fellow PTAC members, the ASPE and NORC staff who've done just such an amazing job and are clearly so dedicated. Together, I think we have had some meaningful impact in achieving our patient-centered care and innovation of visions. It's been a true privilege to contribute to this work.

I look forward to seeing the continued work and expect this very capable team with a new chair to continue to move things forward. In addition to myself, Jen is rotating off too. So I'm going to hand it to Jen for any comments.

DR. WILER: Well, I couldn't agree more than six years goes so fast. I too would like to thank ASPE staff and my colleagues who give many, many tireless volunteer hours and are each experts in their own right in why they were selected. But, really, to create a payment system that values high-quality equitable care and thinking about how to be a good steward of limited resources.

In this forum, it's so important to shine the light on national best practices and give a voice to those who are in the field to describe the challenges. And I hope this group continues to have the opportunity to use this format to try to achieve these important goals around improving the health of all Americans. So thank you for the opportunity and privilege to serve with all of you.

CO-CHAIR SINOPOLI: Thank you, Jen. I'll turn it over to Lauran.

(Applause.)

DR. KOSINSKI: I'm going to miss the two of you.

CO-CHAIR HARDIN: So we'd like to officially thank both of you for the deep contributions and impact that you've had in the Committee over the last few years. It's been an absolute pleasure to co-lead the PTAC with you, Angelo. I will be staying on PTAC, and I'm really excited to hand over the Co-Chair leadership role to Chinni and Lee who will be taking over for our next meetings going forward.

So you're in very good hands, and we look forward to the next phase of the organization. We didn't get a chance to ask Audrey or any of the staff if they had additional comments or questions. Is there anything else that you wanted to add? No?

And then with that, I just want to say one final thank you to the Committee and the expert presenters for joining us to make this a memorable and informative PTAC public meeting. And I think you should adjourn.

*** Adjourn**

CO-CHAIR SINOPOLI: Meeting

adjourned.

(Applause.)

(Whereupon, the above-entitled matter went off the record at 3:11 p.m.)

CERTIFICATE

This is to certify that the foregoing transcript

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Before: PTAC

Date: 09-17-24

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Neal R Gross

Court Reporter