Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

March 26, 2024
9:00 a.m. – 2:58 p.m. EDT
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attendance

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

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

PTAC Members Not in Attendance

Jay S. Feldstein, DO (President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine)
Joshua M. Liao, MD, MSc (Professor and Chief, Division of General Internal Medicine, Department of Medicine, The University of Texas Southwestern Medical Center)
Soujanya Pulluru, MD (Independent Consultant)

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

Lisa Shats, PTAC Designated Federal Officer *
Audrey McDowell
Steven Sheingold, PhD
Via Zoom

List of Speakers and Handouts

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

   Danielle A. Whitacre, MD, CMD, Chief Medical Officer, Bloom Healthcare*
   Brian Smith, MD, MPH, Family Physician, Versailles Family Medicine*
   Adrian F. Hernandez, MD, MHS, Executive Director, Duke Clinical Research Institute, and Vice Dean, Duke University School of Medicine*
   Moon Leung, PhD, Senior Vice President, Chief Informatics Officer, SCAN Health Plan*

   Handouts

- Roundtable Panel Discussion Day 2 Panelists’ Biographies
- Roundtable Panel Discussion Day 2 Introduction Slides
- Roundtable Panel Discussion Day 2 Discussion Guide

2. **CMS Panel Discussion**

Dora Hughes, MD, MPH, Acting Chief Medical Officer and Acting Director of the Center for Clinical Standards and Quality (CCSQ), Centers for Medicare & Medicaid Services (CMS)
Michelle Schreiber, MD, Deputy Director, CCSQ, and Director of the Quality Measurement and Value-based Incentives Group (QMVIG), CMS
Doug Jacobs, MD, MPH, Chief Transformation Officer, Center for Medicare (CM), CMS*
Susannah Bernheim, MD, MHS, Chief Quality Officer and Acting Chief Medical Officer, CMS Center for Medicare and Medicaid Innovation (CMMI)

Handouts

- CMS Panel Discussion Day 2 Panelists’ Biographies
- CMS Panel Discussion Day 2 Introduction Slides

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

Karen E. Joynt Maddox, MD, MPH, Practicing Cardiologist, Barnes-Jewish Hospital; Associate Professor, Washington University School of Medicine and School of Social Work; and Co-Director, Center for Advancing Health Services, Policy & Economics Research*
Mark Friedberg, MD, MPP, Senior Vice President, Performance Measurement & Improvement, Blue Cross Blue Shield of Massachusetts*
Nick Frenzer, Population Health and Implementation Executive, Epic*

Handouts

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

4. **Public Commenters**

Jennifer Gasperini (National Association of Accountable Care Organizations [NAACOS])*

Via Zoom

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

The ASPE PTAC website also includes copies of the presentation slides and other handouts and a video recording of the March 26 PTAC public meeting.

Welcome and Co-Chair Overview

Lauran Hardin, PTAC Co-Chair, welcomed the Committee and members of the public to the second day of the March 25-26, 2024 public meeting. She explained that the first day of the public meeting included remarks by Elizabeth (Liz) Fowler, Center for Medicare and Medicaid Innovation (CMMI), about the role of PTAC and several guest speaker presentations on opportunities to improve the development and implementation of performance measures for population-based total cost of care (PB-TCOC) models. Co-Chair Hardin then reviewed the agenda for the day, noting that guest speakers represent a variety of perspectives, including previous PTAC proposal submitters who addressed relevant issues in their proposed models.

Co-Chair Hardin indicated that a public comment period would be held in the afternoon. Participants must register to provide an oral public comment, and public comments are limited to 3 minutes. She stated that the meeting would conclude with Committee discussion of comments for inclusion in the Report to the Secretary (RTS). Co-Chair Hardin then invited Committee members to introduce themselves and their experience with developing and implementing performance measures for PB-TCOC models. Following Committee member introductions, Co-Chair Hardin acknowledged 3 Committee members who were not in attendance but contributed significantly to preparation for the meeting: Jay Feldstein, Soujanya (Chinni) Pulluru, and Joshua (Josh) Liao.

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

- Danielle A. Whitacre, MD, CMD, Chief Medical Officer, Bloom Healthcare
- Brian Smith, MD, MPH, Family Physician, Versailles Family Medicine
- Adrian F. Hernandez, MD, MHS, Executive Director, Duke Clinical Research Institute, and Vice Dean, Duke University School of Medicine
- Moon Leung, PhD, Senior Vice President, Chief Informatics Officer, SCAN Health Plan

Co-Chair Hardin moderated the panel discussion with 4 subject matter experts (SMEs) offering their perspectives on best practices for measuring spending and quality outcomes in PB-TCOC models. For additional details, please see the transcript and meeting recording (07:12-1:38:54).

Panelists introduced themselves and provided background on their respective organizations. Full biographies and panelist introduction slides are available.

  - Danielle Whitacre introduced herself as the Chief Medical Officer of Bloom Healthcare. Bloom Healthcare delivers in-home primary care and operates a high-needs Accountable Care Organization (ACO). Its patient population includes a large proportion of older adults who experience challenges with leaving their homes and require varying levels of assistance with activities of daily living. Dr. Whitacre described key takeaways from operating the high-needs ACO. Successful activities include: claims-based quality metrics (unplanned hospitalizations, all cause 30-day readmissions, days at home) are low-burden, efficient, and aligned with patient preferences.
  - Concurrent risk scores within the measurement year.
  - Claims alignment with quarterly voluntary alignment.
  - A reasonable patient minimum for participation allows small practices to participate in value-based arrangements.
  - Primary care capitation and payment allow small businesses to have the funds to operate.
  - Multiple risk options allow more practices to embrace value-based care.
- Dr. Whitacre also described areas for improvement in the high-needs ACO, including the following:
  - Expanded inclusion criteria for patients who do not qualify for the high-needs ACO.

    - Benchmark predictability and stability, as regional benchmarks are more accurate and stable than historical benchmarks due to the changing nature of a high-needs patient population.
    - A patient experience survey that is designed for high-needs patients.
    - Faster access to data.
    - Alternative attribution methods that allow providers to voluntarily align patients in the home setting.
- For additional details on Dr. Whitacre's background and organization, see the panelist introduction slides (slides 2-4).
- Brian Smith introduced himself as the owner of Versailles Family Medicine and a member of Evolent Healthcare ACO. Dr. Smith noted that he is currently working in a Versailles critical access hospital. He described several challenges his practice faces with quality reporting. First, he described how more time is spent on searching for patient records from outside the system than educating patients on their health conditions or scheduling appointments. Second, Dr. Smith indicated that it would be helpful if the Centers for Medicare & Medicaid Services (CMS) reported to providers when tests, vaccines, and consults are completed rather than requiring providers to report the activities to CMS. Relatedly, Dr. Smith also described the burden associated with inconsistent reporting requirements across Medicare, Medicaid, and Medicare replacement products. For example, some programs require the use of CPT II codes, whereas other programs require the use of electronic clinical quality measures (eCQMs). Fourth, Dr. Smith recommended that providers be reimbursed based on measures that are objective and under the providers' control in the office, such as determining whether a test was completed or not. For additional details on Dr. Smith's background and organization, see the panelist introduction slides (slides 5-7).
- Adrian Hernandez introduced himself as a practicing cardiologist. Dr. Hernandez described key lessons learned about performance measures from the perspectives of research, the health system, and regulatory programs and payers. Regarding lessons learned from a research perspective, Dr. Hernandez noted that patient-reported outcomes are designed to understand the benefits and risks of a therapy, a medical product, or strategy of care. Patient-reported outcomes are also designed to be valid, responsive to a clinically meaningful action, and used for evidence generation. Data can be used to identify patients' unmet needs and gaps in patients' health status, allowing providers to address the gaps for individual patients and for the population. Regarding the health system perspective, patient-reported outcomes may accelerate prevention, diagnosis, and treatment. He noted that there are many available patient-reported outcome measures (PROMs), with some measures more operationally feasible than others depending on the setting. Dr. Hernandez also noted that providers' efforts to report measures are rarely reimbursed and rewarded. Regarding lessons learned from a regulatory and payer perspective, Dr. Hernandez noted that we must address the needs for precision-payment models. He recommended the development of new treatment paradigms that incentivize and consider the long-term benefits of healthy days at home. For additional details on Dr. Hernandez's background and organization, see the panelist introduction slides (slides 8-10).
- Moon Leung introduced himself as the Chief Informatics Officer of SCAN Health Plan. SCAN's mission is to keep seniors healthy and independent. This year, SCAN launched the Program of All-Inclusive Care for the Elderly (PACE) and a program that provides mobile care for homeless seniors. Dr. Leung described several takeaways from participating in value-based models and incentive programs. First, value-based care models with sufficient incentives to improve quality provide risk-bearing entities the flexibility needed to manage total cost of care (TCOC) while ensuring quality of care. Second, incentive programs must be transparent, and the measure sets

should be balanced to include all aspects of care. Third, Dr. Leung described a program that incentivizes 3 aspects of care: performance (i.e., meeting or exceeding a target level), improvement (i.e., year-over-year improvement), and excellence (i.e., rewarding the best performers). Fourth, Dr. Leung recommended that performance measures be case-mix-adjusted to account for differences across patients. Dr. Leung also described considerations for performance measures. He encouraged the use of a true measure of access to primary and specialty care using claims data or patient experience data. Dr. Leung also encouraged the assessment of access-related never events to ensure that services are provided to patients in a timely manner. Finally, he advocated for the advancement of health equity and described research results showing better outcomes for patients who speak the same language as their providers. Given the connection between mental health and utilization, Dr. Leung also emphasized the importance of using mental health measures. For additional details on Dr. Leung's background and organization, see the panelist introduction slides (slides 11-17).

Panelists described gaps between what is currently measured and the types of measures that would be most meaningful for providers, patients, and caregivers.

- Time spent at home matters to patients. Although measuring time at home is not the usual focus, time spent at home is measurable and actionable, and can provide information on supportive services needed to transition patients from the hospital to home.
- There is a lot of data on health status measures. These measures are feasible in research settings but can be difficult to implement in health care settings. However, providers engage patients to understand their needs before they come into the clinic; these engagement strategies can vary across the country.
- Practices need the flexibility to decide how they will address patients' needs. Patients can identify gaps, such as improving care transitions and collaboration among health care professionals. However, this is not to suggest that creating more measures to address gaps in care is the answer because the large number of measures is a burden to providers.
- There is a reliance on sending patients health status surveys instead of having patients complete the surveys in person at the office. Asking patients to complete surveys after their visit can introduce biases when linking the surveys to performance measures.
- There are few gaps in the available clinical measures.
- Patients and providers typically have different agendas during appointments. Assessing whether a patient's goals of care were met may be more meaningful than using a doctor/patient communication measure.
- Efforts should be made to shorten the amount of time between the patient's appointment and when the survey is administered.

Panelists discussed best practices to collect patient-reported data in real time.

- Patient-reported measures need to be made easy for patients and caregivers to complete.
- It is important to use the data collected from patients and their caregivers. It is critical for patients to understand that their health status measures are meaningful and that there will be action taken based on the information they provide.
- Measures must be tailored to obtain patient feedback from high-needs populations (e.g., patients with cognitive impairment). One size does not fit all. Proxies and caregivers should be engaged when working with high-needs populations. Ask patients to complete surveys in person or by telephone if they cannot complete the measures digitally. Shorter surveys can be used for these populations.

- Consider using a net promoter score (NPS) and asking patients, “would you recommend your provider to someone else?”
- Shorter surveys should be used for high-needs populations.
- Texting is not Health Insurance Portability and Accountability Act (HIPAA)-compliant. However, some providers use HIPAA-compliant applications on smartphone to administer surveys via smartphones.
- There are many patients in rural and/or underserved areas with poor internet connection and/or with flip phones. Virtual visits are not possible for some rural patients, and this technological challenge can impact equity.
- Some practices cannot use telehealth because of the patient-level barriers. Even in locations with strong internet access, cognitive impairment can limit a patient’s ability to use telehealth.

Panelists discussed the percentage of their total practice costs dedicated to data collection.

- Dr. Smith reported that data collection requires substantial costs. When providers experience gaps in data, they typically have to duplicate efforts, and this increases costs. He estimated that 10% of his organization’s employees’ time is spent on data collection.

Dr. Whitacre stated that use of claims-based measures has not burdened her practice. However, the data shared with the practice from the ACO Realizing Equity, Access, and Community Health (REACH) program require support from a data analyst. Small practices typically do not have the staffing and resources required to understand data. Hiring vendors is expensive and unfeasible for some practices. Data analyzed for value-based programs must be easy to understand.

Panelists described opportunities to improve care through financial incentives.

- One potential strategy could be to pay specialists when a consult note is shared with the primary care physician. Patients tend to assume that health records are integrated across settings, but this is not always the case. Financial incentives should be directed toward specialists and hospitals.
- There are opportunities within the ACO REACH program to incentivize good transitions of care, better outcomes with home health, and shorter hospital stays. However, the performance data are aggregated, making it difficult to identify high-performing teams and outside entities.

Dr. Whitacre provided additional information on the type of care provided to patients in her practice who are not in the high-needs ACO. She noted that all patients benefit from the interdisciplinary care team, and that the practice does not discriminate based on the payer. The practice has a team of social workers, nurse case managers, and pharmacists who support providers in the field and help with transitions of care. This collaboration would not be possible without ACO REACH. Other payers benefit from the ACO REACH model.

Panelists discussed potential ways to measure effective interdisciplinary team care.

- Effectiveness of an interdisciplinary team care is a difficult concept to measure directly. The level of difficulty to measure team-based care may depend on how the teams are formed and on the health condition. Successful health care models are tailored to different communities.
- A proxy measure could include Chronic Care Management (CCM) billing if the interdisciplinary team is funded through billing CCM. This type of measure is imprecise, but it might be the only method currently used in practice.
- Dr. Whitacre noted that her practice impanels patients to interdisciplinary care teams. Her practice could identify the top-performing providers and teams to learn successful strategies and

areas of improvement. However, the ACO currently cannot identify top performers due to a lack of data; the data are aggregated with a one-year lag.
- Data can be obtained from the health information exchange and used to understand how many times patients go to the emergency department or hospital. Dashboards can help providers identify where to deploy resources.
- Access to the health information exchange should be easier for providers.

Panelists discussed different methods to monitor patients while they are at home.

- Dr. Whitacre indicated that in-home patient monitoring and wearables were not clinically valuable for her practice's patient population. However, building relationships with patients and understanding what matters most to them can be valuable. High-touch, proactive care can improve function, symptom management, and quality of life.
- The existence of a smartphone application does not mean the application is useful. Data overload is not useful or actionable. However, integrating alerts into remote patient monitoring can be actionable. Use of simple approaches can allow practices to improve patients' time at home.
- One challenge with remote patient monitoring is that the patients who need to be monitored the most also tend to have the most difficulty with using the technology. Remote patient monitoring is also not a permanent solution because the costs are not covered in the long term.

Dr. Hernandez discussed potential ways to pay for patient-reported measures in TCOC models. Translating measures into health care delivery requires financial alignment. Valuable and actionable measures have data showing the measures will improve health and well-being. In these cases, the measures can be integrated into a value-based care model. However, one challenge is deciding whether to address health and well-being across large populations or focus on improving health and well-being in high-priority populations with a high burden of disease and costs. Many patients do not have one disease; the patient's comorbidities must be considered.

Panelists discussed meaningful health equity and social needs measures. Panelists also provided their recommendations on using health equity and social needs measures in TCOC models.

- Patients are stratified by language, race, area of residence, and social vulnerability index to identify disparities in measure outcomes. If a disparity is identified, the practice incentivizes providers to reduce the disparity.
- From a health care system perspective, it is helpful to have directions on where to focus.
- Dr. Whitacre stated that her high-needs ACO program does not have specific metrics focused on ensuring equity. However, the ACO REACH program allows her practice to design its own method of assessing equity (e.g., completion of annual wellness visits). The ACO REACH program does not tell the practice how to meet the needs of its population. She recommended future models provide this type of flexibility.
- Some payers do not allow telehealth for annual wellness visits. This requirement can create barriers for patients who cannot leave their homes or do not have the technology required to conduct virtual face-to-face conversations with their providers.

Panelists described the risks and benefits of population-based quality metrics based on all providers involved in the patient's care journey. In addition, panelists provided their recommendations on who should be responsible for aggregating and reporting the data.

- Data reporting has become more siloed and less integrated over time. As a first step toward improving data integration, Medicare, Medicaid, and commercial payers could require vaccines to be reported.
- Performance measurement considers what, on average, is occurring within a specific population. Data integration issues have not yet been fully realized.
- Dr. Whitacre noted that until the data are integrated, providers need the flexibility to decide with the patient what should be addressed in their care. Claims-based performance metrics required in the ACO REACH program have been useful for her practice's high-needs patients, and the metrics consider the patient's preferences.
- Providing timely performance feedback to providers is critical.
- With primary care providers who should be coordinating all the care, the quality measure is attributed to that physician. But in the fee-for-service (FFS) situation, patient attribution depends on the number of times a patient has visited a provider such that the more times the patient has seen the provider, the more weight there is on the measure performance to that provider.
- Attribution models that apply weights to providers are feasible. These methods can help to identify where patients receive their care and the type of care provided.
- Challenges with attribution can arise when a patient sees a mid-level staff member multiple times and sees a physician once. In these cases, the patient will be attributed to the physician. Use of mid-level staff members to deliver outpatient services will increase over time.
- Dr. Whitacre indicated that her high-needs ACO does not encounter challenges with patient attribution for mid-level staff (e.g., nurse practitioners, physician assistants), but the ACO needs patients to be attributed to the ACO quickly because patients' life expectancy is relatively short after they join the ACO.

CMS Panel Discussion

- Dora Hughes, MD, MPH, Acting Chief Medical Officer and Acting Director of the Center for Clinical Standards and Quality (CCSQ), Centers for Medicare & Medicaid Services (CMS)
- Michelle Schreiber, MD, Deputy Director, CCSQ, and Director of the Quality Measurement and Value-based Incentives Group (QMVIG), CMS
- Doug Jacobs, MD, MPH, Chief Transformation Officer, Center for Medicare (CM), CMS
- Susannah Bernheim, MD, MHS, Chief Quality Officer and Acting Chief Medical Officer, CMS CMMI

Angelo Sinopoli, PTAC Co-Chair, moderated the panel discussion with 4 subject matter experts (SMEs) offering their perspectives on CMS quality programs. For additional details, please see the transcript and meeting recording (00:02-1:02:32).

Panelists introduced themselves and provided background on current CMS quality measurement activities. Full biographies and panelist introduction slides are available.

- Dora Hughes introduced herself as the Acting Chief Medical Officer and Acting Director of the Center for Clinical Standards and Quality (CCSQ) at CMS.
    - Dr. Hughes shared a few words about CMS' National Quality Strategy and noted that the CMS Quality Conference is scheduled for April 8-10, 2024, which many of the panelists will be attending.
    - Dr. Hughes shared that the CMS Principal Deputy Administrator and Chief Operating Officer, Jonathan (Jon) Blum, noted that CMS has a less direct relationship with the

    providers of Medicaid and Medicare beneficiaries and therefore less opportunity to influence health care delivery through payment because many of those decisions are being addressed through the Medicaid and Medicare plans. This increases the importance of CMS' quality measures and CMS' quality reporting and payment programs.
  - Dr. Hughes described that CCSQ is the lead Center for quality at CMS. 20 of CMS' 27 quality reporting programs sit within CCSQ. CCSQ also houses the Quality Improvement Organizations (QIO) program which allows the Center to address quality issues across a range of facilities. CCSQ also surveys and provides oversight of measures accrediting organizations. CCSQ has been doing work during the last 2 years to align and seamlessly integrate quality measures across all CMS programs and policies, including Medicaid, Medicare, and the Marketplace.
  - Dr. Hughes stated that the CMS National Quality Strategy that was released in 2022 was the first truly cross-center effort to think holistically about the quality enterprise at CMS. CMS' quality mission is to achieve optimal health and well-being for all individuals across all care settings (e.g., hospitals, long-term care facilities, hospice programs, home health, inpatient psychiatric, inpatient rehabilitation, skilled nursing facilities). The vision statement of the CMS National Quality Strategy is: "CMS, a trusted partner, in shaping a resilient high-value American health care system that delivers high-quality, safe, and equitable care for all."
  - Dr. Hughes explained that the CMS National Quality Strategy has 4 priority areas, each with 2 goals. Each goal has associated objectives and targets to support successful implementation.
    - The first priority area focuses on promoting alignment and improved health outcomes within high-impact areas such as maternal and behavioral health, equity, and safety.
    - The second priority area focuses on advancing equity and engagement with the goal of embedding the social determinants of health (SDOH) screening requirements across all programs and health care settings.
    - The third priority area focuses on ensuring safety and resiliency across health care systems. CMS is expanding its focus on resiliency to address issues of cybersecurity, drug shortages, and climate change, as well as workforce-related concerns (e.g., burnout and staff shortages).
    - The fourth priority area focuses on accelerating interoperability and scientific innovation. CMS is committed to transitioning to all digital quality measures and data collection by 2030. It is also focused on supporting learning health systems and incorporating evidence-based approaches both within CMS and across other agency partners, notably the National Institutes of Health (NIH), the Food and Drug Administration (FDA), and the Office of the National Coordinator for Health Information Technology (ONC) to increase data sharing and advance learning throughout CMS agencies, programs, and policies.
- For additional details on Dr. Hughes' background and role at CMS, see the panelist introduction slides (slides 2-7).
- Michelle Schreiber introduced herself as the Deputy Director for CCSQ where most of her work centers on quality measurement in all 27 general Medicare value-based programs.
  - Dr. Schreiber shared that CCSQ is focused on aligning and standardizing measures across all CMS Centers due to the challenges in having similar but not identical measures. CCSQ works closely within CMS and across the federal government meeting routinely with the

Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), and Veterans Affairs (VA) to try to standardize and collaboratively develop measures across programs. For example, CCSQ is working with the CDC to move safety measures to the National Healthcare Safety Network (NHSN) and to report through Fast Healthcare Interoperability Resources (FHIR). CCSQ also participates in the Corporate Quality Measure Collaborative (CQMC) which is led by AHIP and the CMS Consensus-Based Entity (CBE) to try to standardize measures across all payers.

- Dr. Schreiber noted that CCSQ has 27 reporting programs (excluding CMMI/the Innovation Center programs) in addition to public reporting programs (e.g., Marketplace) and the Stars program. CMS develops, stewards, and owns 38% of its measures. Another 20% of CMS' measure portfolio is from the National Committee for Quality Assurance (NCQA), and the remaining measures are developed by many other organizations, including CDC, AHRQ, and specialty societies. The Merit-based Incentive Payment System (MIPS) program has the largest number of measures because the statutory requirements are such that CMS must have measures for every specialty, as well as cost measures to cover 50% of Medicare Part A and B spending.
- Dr. Schreiber explained that CMS' strategy going forward to reduce the number of MIPS program measures is the MIPS Value Pathways (MVP), which are measure sets that include all 4 MIPS program performance categories—quality measures, improvement activities, cost measures, and promoting interoperability—but centered around a specialty or medical condition. Within the MIPS program, there are measures that CMS stewards, as well as registry measures that can be submitted by anyone, any source, or any entity. MVPs are meant to be smaller, less confusing, and more meaningful to providers. They are an important strategy going forward at CMS because they are going to be used intentionally in specialty reporting, ACO programs, and specialty models. The first MVP reporting was in 2023.
- Dr. Schreiber shared that in the last several years, CMS also has focused on burden reduction by decreasing CMS' overall measure portfolio and the MIPS portfolio. A few gaps still exist, however, including equity, care coordination, and PROMs. Most measures follow the standard measure lifecycle: conceptualization, specification, testing, implementation, use, continuing evaluation, and maintenance. CMS reviews submitted measures and drafts a "Measures Under Consideration" (MUC) list that is made publicly available before it is submitted to the CMS CBE who holds meetings with the Pre-Rulemaking Measure Review (PRMR). The PRMR is a large group guided by 3 committees that provide input into measure review to help CMS determine whether a measure will be proposed in a program. If a measure is proposed in a program, CMS writes the proposed rules and publishes them in the Federal Register with a 60-day public comment period. CMS considers the received comments and publishes the final rules in the Federal Register. The development of measures from conceptualization to implementation in a CMS program is about a 5-year process, although it often takes longer. All measures are carefully thought out and receive input from technical expert panels (e.g., clinicians and diverse stakeholder groups) throughout the entire process.
- Dr. Schreiber reported that CMS is committed to the transformation of measures in a digital way. Most patients do not receive services at only a single hospital or hospital system; therefore, CMS is making efforts to move toward FHIR-based reporting and eCQMs. eCQMs are cheaper, more efficient, and less burdensome compared with chart-

    abstracted and claims-based measures, and they are the only measures that can capture the rich information in electronic medical records (EMRs). It takes standardized data elements to develop eCQMs. CMS works closely with ONC, the United States Core Data for Interoperability (USCDI), and the USCDI+ to identify standardized data elements that can be used in digital measures. Digital measures have several advantages, such as the ability to capture large amounts of data; reduce burden; leverage measures for advanced machine learning, artificial intelligence (AI), and advanced analytics; and provide real-time results. Providers need more cost information, and payers and providers need closer linkages so cost information can be provided.

- For additional details on Dr. Schreiber's background and role at CMS, see the panelist introduction slides (slides 8-13).
- Doug Jacobs introduced himself as Chief Transformation Officer at the Center for Medicare at CMS. He shared that over time, there has been a proliferation of quality measures allowing for aspects of the U.S. health care system to be measured that previously could not be. On the other hand, this proliferation of measures adds administrative burden due to a lack of alignment. The Universal Foundation was developed a little over a year ago out of CMS' efforts to align quality measures. Dr. Jacobs explained that the idea of the Universal Foundation is to provide a universal set of quality measures that can be used across as many quality and value programs as feasible. CMS chose to include measures that: 1) make a meaningful impact on patient outcomes; 2) are digital now or would become digital in the future; 3) are able to be stratified now with known gaps that point to disparities or that could be used to develop stratification methodologies in the future; and 4) have no unintended adverse effects. Last year CMS published the Universal Foundation in both pediatric and adult settings, which includes cancer measures, behavioral health measures, preventative care measures, chronic disease management measures, coordination of care measures, and patient experience measures (i.e., Consumer Assessment of Healthcare Providers & Systems [CAHPS]). Dr. Jacobs noted that the MVP for primary care includes all Universal Foundation measures. For additional details on Dr. Jacobs' background and role at CMS, see the panelist introduction slides (slides 14-21).
- Susannah Bernheim introduced herself as the Chief Quality Officer and Acting Chief Medical Officer of CMMI.
    - Dr. Bernheim discussed how CMMI thinks about the National Quality Strategy and mentioned some recent work on the new Quality Pathway Initiative, which is an internal initiative to elevate CMMI's focus on quality, outcomes, and experience.
    - Dr. Bernheim shared that all the work performed by CMMI sits in the context of: 1) the statute that created CMMI and directs focus to creating Alternative Payment Models (APMs) that reduce costs and improve quality; and 2) the recent 2021 strategy refresh which focuses on accountability, equity, innovation, affordability, and partnerships.
    - She noted that CMMI models have the opportunity to influence and improve quality in several ways. CMMI wants to increasingly use the models to understand specifically how care can be re-designed and improved.
    - Dr. Bernheim described how CMMI decides what quality measures to use in specific models.
        - The first step is to determine the primary improvement goals with a focus on outcomes and experience. Every model has distinctive participants. Therefore, CMMI wants to ensure that each model has a primary goal and an aligned set of strategies toward those goals focused on the benefits to the participants of that model. She noted that the quality measures are just a piece of what CMMI can do to drive this.

        - During the second step, CMMI looks for familiar low-burden, aligned measures. This may include looking to the Universal Foundation for where the measure fits in the models' goals. CMMI has the flexibility to tailor its measurement strategy to distinctive participants with distinctive goals and additional tools to drive improvements. The CMS National Quality Strategy is just one component of CMS' improvement work.
    - Dr. Bernheim noted that CMMI commonly produces voluntary models, and it is accountable for having a measure design that providers understand, feel is meaningful, and motivates them to participate. CMMI also has flexibility in how it uses measures. For example, CMMI can build benchmarks, introduce accountability, and test measures without processes required by CCSQ. CMMI is thinking about how to use this flexibility to create a portfolio of measures and build models more broadly because, although alignment is crucial, CMMI is doing so a bit retrospectively. CMMI is also considering how to build approaches that might be useful in the future in broader contexts across the agency as a whole.
    - Dr. Bernheim explained that CMMI is launching an initiative called the Quality Pathway, which further articulates and strengthens CMMI's focus on quality, outcomes, and experience, from the earliest part of model design through evaluation. CMMI is considering and welcomes recommendations on how to design evaluation to assess impact on quality goals that not only support quality improvement but also evaluate and disseminate successful strategies.
- For additional details on Dr. Bernheim's background and role at CMS, see the panelist introduction slides (slide 22).

Panelists discussed data sharing for interoperability and scientific advancement.

- Historically CMS' data were locked and used only for evaluation. Recently, CMS and CCSQ have been thinking more creatively about how data can be used internally and with external stakeholders. Colleagues who can do additional analysis are helpful given CMS' limited bandwidth and financial limitations. It also helps to have an external pair of eyes validating what CMS is doing internally. CMS is also committed to participating in efforts toward a whole government approach to data sharing (internally coined the Evidence Generation [EvGen] working group).
- A few years ago, CMS decided to make it possible for external parties to view all data on CMMI models and specifically which providers were participating in specific models. This allows researchers to examine what evidence is generated by the models. Currently, data on 20 models are available.

Panelists discussed care coordination measures and the factors that impact both good and cost-efficient care delivery.

- Effectiveness of current efforts depends on CMSs authority. In the context of broader models that cross multiple settings, CMS can hold many different entities and settings accountable through specific measures; however, no single measure can encompass effective care coordination. Capturing patient experience will be important because it provides a lot of information about care coordination. An effective process for making diagnoses often requires better coordination, and there is a lot of work going on at CMS in that area.
- ONC, CMS, and other organizations have been trying to ensure the exchange of information by promoting interoperability. Virtually every program has an exchange of information requirement -- for example, the release of information to the next provider, the release of information to the

patient, and information blocking rules. That infrastructure to allow for the exchange of data is being built. In a model or shared approach to taking care of a specific population, it is easier to hold people rather than individual facilities accountable. CMS has proxies for care coordination, such as readmission, and it is starting to be explicit in some measures about the exchange of information such as the time for consultation. However, some of this information may need to be collected through PROMs and patients' perceptions of the coordination of care.

- Beyond specific quality measures, what is paid for, both inside and outside of value-based models and programs, can be important in driving care coordination. Over the last 10 years, Medicare has started paying for transitional care management, which essentially pays more to an institution after the follow-up of an inpatient admission. Additionally, the Center for Medicare has chronic care management codes, and in the last year finalized new codes for community health integration and principal illness navigation, which are primarily for patients with unmet social needs that affect the diagnosis and treatment of medical problems or high-risk conditions. These were the first codes designed to describe services performed by community health workers, peer support specialists, and other care navigators. Over time, patients who receive these services have fewer readmissions. Therefore, readmission measures can be an important indicator, but should not be the only indicator used.

Panelists discussed recommendations for the medical field that could in turn produce better quality outcomes for patients.

- Codes are being created and other team members are being hired (e.g., community health workers, peer support specialists, and other care navigators) who could, in theory, lighten the load for physicians and reduce burnout. Tying payment to what physicians are asking can be helpful. Reducing the number of quality measures is important, specifically by identifying which measures are not driving quality and therefore need to be removed.
- One recommendation would be to accelerate the use of digital measures as they are the most efficient and least burdensome measures. Another recommendation is to make EMRs more user-friendly. The ultimate goal of data interoperability is to have data that can be shared, inform better patient care, be used on a real-time basis at the level of clinical decision support, and be tied to clinical guidelines. Health care has been slow to digital transformation compared with other industries.
- Identifying and moving toward a Universal Foundation will make a meaningful impact on physician burden. Prior authorization leads to a tremendous amount of burden. The rule that was recently released from the Office of Burden Reduction and Health Informatics (OBRHI) provides not only prior authorization reform but also improvements in the way providers access data. Medicare Advantage made new requirements that went into effect this year to make managed care prior authorization no more restrictive than in traditional fee-for-service (FFS) Medicare, which will hopefully make a big difference. There is an element of clinical practice related to the intrinsic satisfaction of seeing and treating patients that cannot always be captured in traditional measures. It is about providers finding satisfaction in their work.
- CMS has models that are purposefully expanding investment in primary care. Investing in primary care and creating flexibility for physicians to practice differently will be key to addressing some of these issues.

Panelists discussed attribution and the efforts being made to address it.

- CMS thinks about attribution often as it applies to cost and quality measures. It is unclear what providers can be held accountable for. This issue is discussed endlessly in the technical expert panels. It's a tough conversation but, in the end, there needs to be some shared understanding from providers that we are all in this together. For example, the dermatologist does not want to be attributed to tobacco cessation because "it's not what they do." However, it is unclear if, as a collective, there is a greater calling for all physicians to be held accountable for multiple aspects of patient care, such as tobacco cessation.

Panelists discussed the variation in data sets required for race, language, and ethnicity reporting among CMS portfolio programs.

- CMS is mindful of this and aligned in focus on reducing and harmonizing race, language, and ethnicity reporting.
- Within the next year or so, there will likely be a recommendation for standardized data on race, language, and ethnicity across the U.S. Department of Health and Human Services (HHS).

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

- Karen E. Joynt Maddox, MD, MPH, Practicing Cardiologist, Barnes-Jewish Hospital; Associate Professor, Washington University School of Medicine and School of Social Work; and Co-Director, Center for Advancing Health Services, Policy & Economics Research
- Mark Friedberg, MD, MPP, Senior Vice President, Performance Measurement & Improvement, Blue Cross Blue Shield of Massachusetts
- Nick Frenzer, Population Health and Implementation Executive, Epic

Co-Chair Hardin moderated the listening session with 3 SMEs on linking performance measures with payment and financial incentives. Full biographies and presentations are available.

Karen E. Joynt Maddox presented on the impact of different kinds of performance-based payment incentives on desired outcomes.

- Dr. Joynt Maddox reviewed the prevalence of programs with upside, downside, or both types of risk. Most programs have both types of performance risk. However, some tracks of the Medicare Shared Savings Program (MSSP) have upside risk only, and the Hospital Readmission Reduction Program (HRRP) and the Hospital Acquired Conditions Reduction Program (HACRP) have downside risk only.
- Dr. Joynt Maddox noted that global models refer to models that are moving toward TCOC and are the focus of the presentation; however, there are still lessons to be learned from limited models, such as the Bundled Payments for Care Improvement (BPCI) and Hospital Value-Based Purchasing (VBP) Program.
- Dr. Joynt Maddox reported that focusing on the most prevalent APMs, the Bundled Payments for Care Improvement-Advanced (BPCI-A) program has seen small savings of $52 per person per quarter, but no measurable improvement in 90-day readmission rates over the same time period.
- The MSSP program had annual savings per beneficiary in early entry cohort of physician group ACOs, but less significant savings among the early entry cohort of hospital-integrated ACOs. Prior to introduction of regionalized benchmarks in 2016-2017, spending per beneficiary per year relative to the region was decreasing. However, low-cost ACOs began joining at approximately the time of benchmark introduction, which affected the relative performance of the pre-existing ACOs. This was a missed opportunity as high-cost groups relative to the region should be the targets for the MSSP program.

- Dr. Joynt Maddox shared that a 2021 article in the *New England Journal of Medicine* showed the degree to which success of models in reducing costs cannot be predicted solely by risk type (up, down, both) and included costs (global versus limited).
- The overall goal of TCOC models is to improve health outcomes, including wellness and productivity, alongside achieving cost savings.
- Dr. Joynt Maddox stated that evidence over the last 2 decades shows that the move toward quality measurement has improved processes of care and documentation. An example is the increased use of statin medications, a cost-effective approach to reducing cardiovascular morbidity and mortality.
- Health outcomes, such as obesity, do not show similar progress. We are missing the mark for improving population health.
    - Similarly, looking at 30-day readmission rates, there has been very little improvement over the last decade across payer types, which suggests that current approaches are not working. Unmet social needs are likely playing a large role. We need to think more broadly about how to move the needle in the right direction.
- Dr. Joynt Maddox summarized 2 main challenges facing TCOC models and the goal of improving population health: pervasive and persistent inequities in health outcomes, especially in mortality rates by race; and administrative costs, which require huge amounts of time and have created consolidation and corporatization of documentation and coding among health systems and insurance companies.
- Dr. Joynt Maddox provided recommendations to improve upon the current state of quality and cost measurement: harmonize performance measures and prioritize measurement; use risk adjustment to combat risk aversion and gaming of the system; adjust benchmarking to reflect inequities in the system and patient populations, and coordinate tackling the causes of unmet social needs societally; and allow practices to make their own decisions on best measures and methods.
- Dr. Joynt Maddox concluded that there should be a refocus on the why, and that national priorities should be chosen that are grounded in public health to guide measurement and payment reform.

For additional details on Dr. Joynt Maddox's presentation, see the presentation slides (pages 2-20), transcript, and meeting recording (0:42-15:23).

Mark Friedberg presented on best practices for designing performance-based payment incentives for PB-TCOC models from a payer perspective.

- Blue Cross Blue Shield of Massachusetts (BCBSMA) has had an Alternative Quality Contract (AQC) program in place for close to a decade. Currently, 7 groups participate. This program has a global budget that adjusts for health status of the patient population, includes upside and downside risk, uses quality incentives that focus on equity and uses valid and reliable measures, and has long-term contracts with medical groups and health systems.
    - BCBSMA's ACQ program has been extensively evaluated and found evidence of cost savings and improved quality with no exacerbation of inequities in cost and quality between low- and high-income patient populations.
- Dr. Friedberg summarized the history of features of the AQC contracts, highlighting the addition of equity to other quality measure categories, such as process, outcomes, and patient experience.

- The AQC model prioritizes data (annual equity reports), support (Equity Action Community, equity grants through the Institute for Healthcare Improvement [IHI]), and payment (pay-for-equity incentives), with a recent focus on equity across all 3 components.
    - Confidential equity reports stratify all ambulatory quality measures by race and ethnicity and reveal previously hidden inequity in performance among AQC groups relative to each other.
    - IHI assisted with aligning quality care improvement with improving racial equity of care and distributed equity grants from BCBSMA to groups participating in the Equity Action Community.
    - Pay-for-equity incentives increase payment for provider groups that improve quality of care in a way that reduces racial inequities in care.
    - AQC groups are offered a menu of valid and reliable measures that can assess reduction in inequities and fit the needs of their patient population. Equity measures are tailored to each group according to the largest inequity and largest minoritized group in the patient population. A commonly chosen measure was hypertension control.
    - The Equity Action Community focuses on improving collection and accuracy of health equity data and specific health targets for reducing inequity.
- Recommendations for payers include establishing a clear purpose for the performance-based payment program, evaluating the payment model regularly, increasing achievability and magnitude of financial incentives, and providing support for provider groups to improve data quality.

For additional details on Dr. Friedberg's presentation, see the presentation slides (pages 21-29), transcript, and meeting recording (15:33-28:44).

Nick Frenzer presented on improving data collection and timeliness of data sharing of performance information with providers.

- Mr. Frenzer reported that Epic is invested in supporting the goals of transitioning Medicare FFS beneficiaries with Parts A and B coverage into TCOC by 2030, and secondarily increasing the proportion of beneficiaries from underserved, rural communities in value-based payment models.
    - To achieve these goals, Epic is focused on improving the speed of data collection and sharing. Giving providers real-time clinical data on their patient population will help achieve desired outcomes, which is the ultimate goal of the shift to value-based care.
    - Increased participation in upside and downside risk value-based programs is a positive trend that requires accurate and timely data collection and dissemination to support these programs.
    - Lack of standardized measures across models is a challenge to accurate and timely data collection and sharing. For example, slight differences in eCQMs used by ACOs and clinical quality measures (CQMs) used by MIPS can create additional work for providers and data systems. Lack of standardization creates confusion through too many choices or pathways and unintentionally excludes rural and specialty providers.
- Mr. Frenzer discussed Epic's policy strategy to improve nationwide exchange of electronic health information (EHI) through participation in the Trusted Exchange Framework and Common Agreement (TEFCA).
    - Epic is encouraging TEFCA adoption through various policy initiatives, including connecting TEFCA and information blocking policies (Health Data, Technology, and Interoperability: Certification Program Updates, Algorithm Transparency, and

    Information Sharing [HTI-1]) and providing funding for rural and safety net providers to join TEFCA, which would allow greater clinical data sharing and real-time data for providers about their patient populations.
    - An FHIR roadmap is needed. The manner in which FHIR is used is critical; there are multiple paths to implementation that would still require additional investments and defeat the purpose of one data sharing methodology.
    - A clear strategy for reporting electronic quality measures is needed. There are different paths to follow using either the Quality Reporting Document Architecture (QRDA) or FHIR, 2 different technology standards for health care data measurement and reporting, which can lead to investment in multiple paths and defeat the purpose of reducing cost of care in the United States.
    - Epic developed its own qualified health information network (QHIN) to encourage customers to join TEFCA. Its QHIN uses standardized file formats and patient-matching algorithms, which allows deployment of quality metric dashboards to providers so they know what they are being measured on, and the measures are synonymous with the clinical care they provide. This builds on "Care Everywhere"—direct clinical sharing with Epic and non-Epic EMRs to create a network that its QHIN infrastructure builds upon. Epic's Payer Platform also focuses on sharing the data directly with providers and reducing administrative burden.
- Mr. Frenzer outlined challenges to improving the speed of data collection and sharing.
    - Many quality measures rely on claims data. A benefit is that measures are standardized, but the data are inherently inefficient due to a 30- to 90-day lag at a minimum. Claims data cannot substitute for direct clinical data sharing.
    - Variability in electronic health record (EHR) capabilities means that the technology of some health care systems or medical groups is lagging behind and cannot meet basic certification requirements for data collection and sharing, such as producing a QRDA.
    - Limited investment in rural infrastructure for data collection and sharing is a challenge. Rural providers need basic infrastructure such as Wi-Fi but also unique accountability and attribution structures within standardized programs.
    - Creating consistent and achievable metrics for specialists is important.
- Mr. Frenzer shared key takeaways to achieve more timely data collection and dissemination: standardize and enforce adherence to quality measure reporting requirements across APMs, and provide additional support to rural providers to facilitate participation in APMs.

For additional details on Nick Frenzer's presentation, see the presentation slides (pages 30-38), transcript, and meeting recording (28:45-37:41).

Following the presentations, Committee members asked questions of the presenters. For more details on this discussion, see the transcript and meeting recording (37:42-1:17:06).

Mr. Frenzer discussed recommendations on how to use electronic data to support patient-centered delivery of evidence-based care. It is critical that there is adherence to the same standards for collection and exchange of clinical data that move us toward a shared goal. Provider groups differ on how they measure performance, even though specific quality measures are built into clinical practice guidelines. Epic and other vendors have the tools to generate real-time clinical practice recommendations but are hindered by lack of adherence to the same standards for measurement. For example, there is over-investment in creating multiple ways to document breast cancer screening across a health system. The data sharing mechanisms exist but require standardization of the measurement to be useful in informing clinical practice.

Presenters discussed recommendations on how to identify metrics that capture the underlying behaviors that drive health.

- The way that our payment system is structured does not support reimbursement of the type of team-based care that would lead to the best outcomes for patients. Investment in care transformation toward team-based care is needed, as well as alignment toward the same overarching goal(s). We also need to be selecting measures more upstream that capture quality and performance before patients become too sick. Traditional measures of hospital readmissions and emergency department visits are a good check on the system but do not capture health.
- A good measure of health depends on life stage. Diabetes and hypertension are good measures for young and healthy adults. Functional status and frailty are appropriate measures for older adults.
- It is a balancing act of choosing a valid and reliable upstream measure of overall health versus measures that are less global but that are relevant and achievable for clinicians.
- From a technology standpoint, we need consistent risk-adjustment methods and measures to enable the support of clinical decision-making.

Mr. Frenzer discussed the status of PROMs at Epic. Epic already collects PROMs through MyChart, used by over 200 million patients in the United States. The larger question is where in the workflow can that information be obtained from patients, especially from underserved patient populations that may not have access to the needed technology. Epic can obtain information from patients proactively. One example is campaigns, where information is solicited from a particular patient population directly. Another example is queries, where information is pulled from other sites where a particular patient population has been seen.

Presenters discussed the impact on quality improvement trends of one-sided versus two-sided risk models.

- Comparison of one- versus two-sided risk models is difficult due to variation across so many other program characteristics, such as mandatory versus voluntary programs. Mandatory programs have been less effective in improving quality than voluntary programs. Voluntary programs need to protect practices from risk in order to attract them to join. The use of penalties, while more effective than rewards, is a double-edged sword because it motivates action but cannot ensure that action is positive for patients and the health care system. But until we have real risk, which means real investment, we will not see true transformation.
- The available evidence is not convincing on whether upside or downside risk models are more effective. There is more heterogeneity within specific risk models than between them. Focusing on the overlap between different risk models is more important than focusing on their differences.

Dr. Friedberg discussed whether groups within Massachusetts successfully leveraged their incentive program to close identified disparity gaps. He shared that there are no quantitative data yet to comment on, but, qualitatively, the 5groups that participated in the program for a full year have been committed in a way that would suggest that there will be measurable improvement. However, trying to close equity gaps, such as with hypertension, is very difficult and needs high up-front investment. Socializing leadership, such as the Chief Financial Officer (CFO), is a new area of focus, and the payoff may be well worth it.

Presenters discussed recommendations on where to collect race, ethnicity, and language data and how to standardize the collection.

- BCBSMA has collected race, ethnicity, and language data directly from about 25% of its in-state members through a voluntary survey on its app. These data, while not representative of all its members, have been validated as highly accurate relative to data collected via CAHPS surveys, for example. The accuracy of race, ethnicity, and language data in EHRs varies widely by provider group. Most often there is a substantial undercounting of members self-identifying as Hispanic.
- It has been very difficult to standardize race and ethnicity questions across states, health care systems, or payers. However, if we can standardize the method of mapping these data, such as the Health Level Seven International (HL7) gravity standards, then we can coordinate efforts to use these data to change and impact health equity outcomes.
- Use of Medicare data for race and ethnicity information has been inadequate because the data are old. There is not consistent and timely collection of these data at the federal level. Practices and insurers are collecting these data more routinely, despite collecting it differently in some cases.

Presenters discussed reasons for differences in effectiveness of programs highlighted by Dr. Joynt Maddox and Dr. Friedberg.

- From a philosophical perspective, health care is a small part of health, so our targets may be unrealistic if we are focusing on individual patients as opposed to public health. We need to harmonize and think more broadly to improve population health. However, outcomes for individual patients are still important, and that requires real-time systems to inform changes to clinical practice versus receiving penalties after the fact. We need both a broader approach to impact public health, which requires coordination, as well as to move on the individual patient level. This requires a cultural change, and that is very different in different parts of the country.
- Dr. Friedberg noted that BCBSMA is the largest commercial insurer in a small market and thus has more influence over how and where investments are made. It has a large support staff to provide technical assistance and build relationships with participating groups. BCBSMA is currently measuring quality through intermediate outcomes, such as hypertension. It has not yet considered broader measures of health largely because it does not have the data structure in place to be able to follow members or a comparison group longitudinally.
- The federal government has a role to direct private insurers in the same direction and guide them in what should be measured. It should have the bird's eye view of which measures predict quality and length of life overall as our population is designed to end up with government health care.

Dr. Joynt Maddox discussed the importance of using system-level versus provider-level measures for transforming health care beyond just the health care experience, and opportunities to leverage existing data. There is difficulty in defining a health care system in our country as it is decentralized. A way forward for measuring system-level health is to collaborate with the community, such as through accountable health communities. Dr. Joynt Maddox described that in her market, they are using EHR data to work with community partners at the intersection of certain health conditions and unmet social needs.

Presenters discussed needed incentives or investments to collaborate with under-resourced organizations and communities.

- Safety net hospitals see community and equity work as the priority. We can shift the business model for other practices to focus more on downside risk and to incentivize the work on unmet social needs. Technology supports the ability to incentivize providers and community organizations to work together to improve outcomes for underserved patient populations.
- Incentives are to find the highest-paying patients and to follow the money. Real change requires significant investment in vulnerable communities.
- Dr. Friedberg described that safety net providers in his program are no longer compared to other systems that may not have the same high-risk patient population. They are now compared to themselves in the pay-for-equity program and are rewarded for improvement over time.

Presenters shared final insights on performance measurement and PB-TCOC models.

- Pursuing a quality strategy, as CMS is pushing, is a smart way forward because it can align priorities nationally to improve population health and bring equity to the forefront. PB-TCOC models are a tool to bring us there.
- Dr. Friedberg noted that measure alignment across payers is very important. His program has had a measure alignment task force in place for 5 years and, while alignment is voluntary, it has had good alignment across local payers, except for Medicare FFS, which has a national uniform dataset. Coordination of alignment of quality measures in FFS Medicare often happens at the state level, so the Medicare program may need to adopt local data and be more flexible with standards across states.
- CMS needs to lead the way forward. This will help private industry be more successful in supporting the shift to value-based care by following a more limited set of measures.

Public Comment Period

Co-Chair Sinopoli opened the floor for public comments. Jennifer Gasperini, Director of Regulatory and Quality Affairs for the National Association of ACOs (NAACOS), made a comment.

Committee Discussion

Co-Chair Sinopoli opened the floor to Committee members to reflect on the day's presentations and discussions. The Committee members discussed the topics noted below. For additional details, please see the transcript and meeting recording (07:54-30:02).

- It is difficult for federal agencies to create a data infrastructure that simplifies the process of data sharing and aggregation. However, a digital platform that treats data as a utility and technology as a commodity is critical to the success of quality measurement and improvement.
- The business case for transitioning to TCOC models differs when participation is voluntary versus mandatory. Voluntary programs require high incentives and moderated risk. All-payer participation and simplification of measures can help moderate risk.
- A balanced scorecard approach must occur at the system level. Measures should be simplified and prioritized, focusing on measures related to quality, safety, patient experience, and equity, rather than cost and efficiency.

- Data and information can be used to change performance and outcomes. Data must be actionable, specific, and at the individual level; thus, it is important to encourage data sharing. Whoever has the data should be required to share it; the accountable entity should not be solely responsible for pulling it. Having insights into the data is also important. Incentives, such as paying for consultation notes or hospital discharge summaries, should be explored as a way to encourage data sharing.
- Timeliness and access to care are metrics for both quality and safety. A list of timeliness metrics may be made available, including metrics such as specialist visits after a cancer diagnosis. Even if timeliness metrics cannot be used within CMMI or CMS models yet, other payer programs could utilize them.
- It is well-documented that health care has a relatively small impact on health. Beyond CMS, other federal agencies could help address social determinants of health (SDOH). For example, the U.S. Department of Housing and Urban Development (HUD) could help address housing issues, and the U.S. Department of Agriculture (USDA) could help address food-related issues that impact health.
- Solidarity among physicians regarding the importance of SDOH could help encourage more action and investment in SDOH in the future.
- Existing measures do not capture all of the important metrics for TCOC models. Emergency room and inpatient admission rates should be included but are not comprehensive. Other measures that should be considered relate to access to care, population health, mental health, and language.
- Existing patient-reported measures and surveys may not meet the needs of high-needs populations.
- Upfront investment in team-based care is key to the success of population health-focused initiatives.
- As new measures are developed, the “quality industrial complex” should be guarded against. It is important to consider potential adverse financial incentives among companies that develop measures and how to ensure that data do not become proprietary.
- Physicians should be encouraged to improve their equity metrics relative to their past performance and their peers’ performance, rather than just meeting minimum thresholds. Investment is needed to encourage improvements in equity.
- Although there have been improvements, the data infrastructure in the United States remains archaic and siloed. The data burden falls primarily on physicians and practices. A health data utility approach and routine data aggregation for quality measures could reduce the burden of data collection on physicians.
- Risk adjustment needs further attention. To improve care and outcomes, providers need concurrent risk adjustment, which differs from prospective risk adjustment.
- The use of process measures that are not directly tied to outcomes should be reduced. The collection of patient-oriented measures can be challenging because they must be collected at the individual level rather than the practice level.
- Private health plans benefit from CMS’ leadership and efforts related to performance measurement without contributing investments. Many health systems and practices cannot afford to operate differently for different payers. To improve population health, more investment across all payers is needed.
- There is a clear call for a multi-year glide path toward patient-reported outcome measures (PROMs) and health equity. CMS could offer a transitional plan, beginning with 25% prospective

population-based per member per month (PMPM) payments and 75% payments based on the current system, and then fully transitioning over 4 to 6 years.
- A public health approach is needed because health care plays a relatively small role in health outcomes.
- Presenters called for "winnable" measures and the ability to have input into these measures.
- One framework that encouraged providers to invest, learn, and change included a payer-provided dashboard with actionable data for providers, a learning community, and implementation of incentive-based outcome measures.

Closing Remarks

Co-Chair Sinopoli adjourned the meeting.

The public meeting adjourned at 2:58 p.m. EDT.

Approved and certified by:

//Lisa Shats//	3/26/2024
Lisa Shats, Designated Federal Officer Physician-Focused Payment Model Technical Advisory Committee	Date
//Lauran Hardin//	3/26/2024
Lauran Hardin, MSN, FAAN, Co-Chair Physician-Focused Payment Model Technical Advisory Committee	Date
//Angelo Sinopoli//	3/26/2024
Angelo Sinopoli, MD, Co-Chair Physician-Focused Payment Model Technical Advisory Committee	Date