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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Monday, March 25, 2024

PTAC MEMBERS PRESENT

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

PTAC MEMBERS IN PARTIAL ATTENDANCE

JOSHUA M. LIAO, MD, MSc*

PTAC MEMBERS NOT PRESENT

JAY S. FELDSTEIN, DO
SOUJANYA R. PULLURU, MD

STAFF PRESENT

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

* Present via Zoom

A-G-E-N-D-A

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

9:30 a.m.

* CO-CHAIR SINOPOLI: Good morning, and welcome to the March 2024 meeting of the Physician-Focused Payment Model Technical Advisory Committee known as PTAC. My name is Angelo Sinopoli, and I'm one of the Co-Chairs of PTAC along with Lauran Hardin, who is sitting next to me here.

Since 2020, PTAC has been exploring themes that have emerged from publicly submitted proposals over the years. After each theme-based meeting series, the Committee releases a public report to the Secretary of Health and Human Services with its findings and recommendations.

We recently posted the June 2023 report to the Secretary on Improving Management Of Care Transitions In Population-Based Total Cost of Care Models to the PTAC website. Soon we will be sharing our September 2023 report to the Secretary on Encouraging Rural Participation in Population-Based Total Cost of Care Models.

As we learned throughout the previous PTAC theme-based discussions and several submitted proposals, providers face challenges with implementing performance measures,

particularly for total cost of care models. We know that this topic is also of interest to the Innovation Center at CMS.

So before our first presentation of the day, we're honored to have our opening remarks from Dr. Liz Fowler, the Deputy Administrator of CMS and the Director of the Center for Medicare and Medicaid Innovation.

Dr. Fowler previously served as Executive Vice President of Programs at the Commonwealth Fund and Vice President for Global Health Policy at Johnson & Johnson. She was Special Assistant to President Obama on Health Care and Economic Policy at the National Economics Council.

From 2008 to 2010, she also served as Chief Health Counsel to the Senate Finance Committee Chair, where she played a critical role in developing the Senate version of the Affordable Care Act. Liz, welcome.

*** Elizabeth (Liz) Fowler, JD, PhD, Deputy Administrator, Centers for Medicare & Medicaid Services (CMS) and Director, Center for Medicare and Medicaid Innovation (CMMI) Remarks**

DR. FOWLER: Thank you, Dr. Sinopoli

and Ms. Hardin. It's great to be here today and nice to begin this year's series of theme-based discussions on performance measurements. Let me also say, we were just talking a little earlier, we're really glad that the House and Senate were able to pass legislation to keep the doors of the government open.

It was a little touch and go whether CMMI would be able to join you this morning, so I'm glad it worked out for us to be here.

I wanted to also thank, before I begin, the ASPE staff who coordinate this meeting for bringing together again yet another fantastic set of panelists and topics. We're excited to learn from all of you over the next two days.

As we start the 2024 theme-based discussions, I wanted to just spend a moment talking about the importance of PTAC and the impact this Committee has had on CMS innovation models.

As many in ASPE know, and perhaps some of the PTAC members also know, prior PTAC submissions have influenced the design of several of our prior models on Primary Care First, which was influenced by AAFP[1] and the University of

1 American Academy of Family Physicians

Chicago submissions; the Oncology Care Model and its successor, the Enhancing Oncology Model, both influenced by submissions from Hackensack Meridian Health and COA[2] and ASCO[3]; and then our Kidney Care Choices Model, which was heavily influenced by the Renal Physician Associates.

The last couple of years, PTAC has shifted to theme-based meetings, and I wanted to highlight that this shift has been particularly helpful for the Innovation Center. The health care landscape is very different from when CMMI and when PTAC were first established.

The challenges we face in moving to value-based care are more complex; our models and initiatives overlap in ways that they didn't when CMMI first started launching models. And our models take this into account and have tried to evolve as a result, and so has the work of PTAC.

Maybe one example to note in particular, as the Innovation Center has tackled integration of specialty care and primary care, PTAC's theme-based discussions have been instrumental to our work. For example, in the development of the Specialty Integration Strategy

2 Community Oncology Alliance
3 American Society of Clinical Oncology

and the policies in Making Care Primary.

Over the next two days, the Innovation Center is really excited to hear from PTAC members and the expert panel discussions to learn more about performance measurement, where it is today, where PTAC thinks performance measurement can go by 2030, and particularly as it relates to population-based total cost of care models.

I'm also excited for the panel discussion with CMS' quality leadership, which will happen tomorrow, so you can hear from other leaders at CMS, not just the Innovation Center, but other leaders in the Agency about where performance or quality measurement is today and where CMS and the Innovation Center is hoping to go tomorrow.

But I wanted to introduce, in the time I have here, transition to Dr. Susannah Bernheim who is our acting Chief Medical Officer and our Chief Quality Officer at the Innovation Center. She's going to provide the rest of the opening remarks and then is our lead on the panel tomorrow. So, Susannah.

* **Susannah Bernheim, MD, Chief Quality Officer and Acting Chief Medical Officer, CMS CMMI Remarks**

DR. BERNHEIM: Thanks. I'm really happy to be here with all of you today. As you can imagine, I'm thrilled by the topic of the panel today and tomorrow, and you've assembled just an amazing group of folks to hear from. So thank you for this work.

Performance measurement is a critical tool, provides insight and incentives, but it really needs to matter to patients, and it needs to make sense to our clinicians for it to work, and we need to continue to evolve our system.

We've been working a lot in the Agency on alignment of measures, thinking about the burden and the task, but we also need to continue to look forward and think about how measurement can be used as a tool to make care better.

So I want to just say a couple of words now about the focus of Innovation Center on quality, and then we'll talk more tomorrow in the panel. We're really trying to center our new strategy on the transformation of health care for person-centered outcomes and experience.

And as you know, when the Innovation Center was started, the Affordable Care Act gave us two paths to expanding models. If they were successful, one was if we reduce spending and

maintain quality. But the other was that if we could show that we improved quality while maintaining spending, that also creates a path for expansion of models.

And so we're really early on focused on spending reduction. But we're trying to rebalance the emphasis, spending reduction will continue to be important, but really committed to broadening our definition of success and seeking a path to improving quality in all of our models.

Again, I will talk about this a little bit more, but the sneak preview, we're going to talk in more detail at the CMS Quality Conference which is in Baltimore from April 8th to 10th about the new quality pathway, and we have a publication coming out about that.

I will just say two words about what that focus is: it's really around aligning all of the pieces of our model around quality improvement efforts. It's around making sure that we're looking at outcomes and experience, including those measures that come from the voice of patients.

Doing that as our systems and clinicians are capable or aware of the burden that's associated with the evolution of measure

and trying to do that in a strategic way, but knowing this is the direction that we need to go.

And finally thinking about how we evaluate our models to be able to show when we've made changes that are really important to patients and clinicians. So more on that tomorrow, but this is an incredibly timely discussion for us, and I'm grateful to be here and for your work.

CO-CHAIR SINOPOLI: Good. So thank you for sharing those remarks, and we appreciate your continued -- do you have something else to say? No, okay. Continued your support. We really enjoy it, and we've felt as PTAC, the increased engagement from CMMI with your leadership and just really enjoy the constant conversations that we've had and the input that you have given us, so appreciate that. Thank you.

DR. BERNHEIM: The feeling is mutual.

* **Welcome and Co-Chair Update - Developing and Implementing Performance Measures for Population-Based Total Cost of Care (PB-TCOC) Models Day 1**

CO-CHAIR SINOPOLI: Thank you. All

right. So for today's agenda, we'll continue to explore a range of topics, including the Defining Performance Measurement Objectives for Total Cost of Care, Selecting and Balancing between the Number and Types of Performance Measures of Total Cost of Care Models, Best Practices for Linking Performance Measures with Payment and Financial Incentives in Total Cost of Care, Addressing Challenges Related to Implementing Performance Measures, and Incorporating Health Equity in the Patient Experience in Performance Measures.

The background materials for this meeting include an environmental scan online. For the next two days, you will hear from many esteemed experts; we have great panels put together.

We have worked diligently to include a variety of perspectives throughout the two-day meeting, including the viewpoint of previous PTAC proposal submitters who addressed relevant issues in their proposed models.

I want to mention that tomorrow afternoon we will include a public comment session; public comments will be limited to three minutes each. If you would like to give an oral public comment tomorrow, but have not yet

registered to do so, please email ptacregistration@norc.org, again, that's ptacregistration@norc.org.

The discussion materials and public comments from the March PTAC public meetings will be incorporated into a report to the Secretary of Health and Human Services on How to Develop and Implement Performance Measures for Total Cost of Care Models.

The agenda for today and tomorrow include time for the Committee to discuss and shape our comments for the upcoming report. Before we adjourn tomorrow, we will announce a request for input, which is an opportunity for stakeholders to provide written comments to the Committee on developing and implementing performance measures for total cost of care models.

Lastly, I will note that as always, the Committee is ready to receive proposals on possible innovation approaches and solutions related to care delivery, payment, or other policy issues from the public on a rolling basis.

We offer two proposal submission tracks for submitters, a line of flexibility depending on the level of detail of their payment

methodology. You can find information about how to submit a proposal on the PTAC website.

*** PTAC Member Introductions**

At this time I will invite my fellow PTAC members to introduce themselves. Please share your name and your organization. If you would like, feel free to describe any experience you have with our topic.

First, I will go around the table, and then I will ask our members that are joining remotely to introduce themselves. I'll start with myself. I'm Angelo Sinopoli. I'm a pulmonary critical care doc by training.

I have spent most of my career as a chief clinical officer in large health systems and building and driving large clinically integrated networks. Built a enablement company where the focus was care management but also defining and building quality metrics and performance metrics, implementing those across the networks, and so I have some direct exposure with this as many of us have.

I am presently the Executive Vice President for Value-Based Care at Cone Health System in North Carolina. Next, I will turn it to you, Lauran.

CO-CHAIR HARDIN: Thank you, Angelo. Good morning. I'm Lauran Hardin, I'm a nurse and Chief Integration Officer for HC2 Strategies. I spent the better part of the last 20 years working on models, innovation, and design for complex and underserved populations, and have been part of starting the National Center for Complex Health and Social Needs.

Currently work across the country with different communities building connected community of care approaches to underserved and complex populations.

CO-CHAIR SINOPOLI: I think next we'll go to Josh, who I think is on Zoom. Josh, are you there?

DR. LIAO: Yes, can you hear me?

CO-CHAIR SINOPOLI: Yes.

DR. LIAO: Great. Good morning, everyone. Joshua Liao, internal medicine physician and professor at the University of Texas at Southwestern Medical Center, where I also lead the Division of General Internal Medicine.

Over time I've had the opportunity to work on leading, implementing population health and care transformation programs for a large

integrated regional health system.

In that setting, I've also had a portfolio of work study and evaluating payment models relevant to and consistent with many that PTAC talks about in my research and working with a number of different decision-makers on how we design these programs. It's great to join.

CO-CHAIR SINOPOLI: Next, I'll start with Jennifer on my left, and we'll just work around the table.

DR. WILER: Good morning. I'm Jennifer Wiler. I'm the Chief Quality and Patient Safety Officer at UC Health for Metro. And we're the largest integrated health care delivery network in Colorado, serving patients throughout the Rocky Mountain region.

I'm also Co-Founder of UC Health's Care Innovation Center, where we partner with digital health companies to grow and scale their solutions to help improve patient care and outcomes. And I'm a tenured professor at the University of Colorado and an emergency physician by training. I also co-authored an Alternative Payment Model that was considered by this Committee.

DR. LIN: Good morning, I'm Walter

Lin, the founder of Generation Clinical Partners. We are a group of providers based in St. Louis, caring for the frail, elderly, and senior living organizations.

The founding mission of Generational Clinical Partners was to help senior living organizations transition into the world of value-based care. And I have a special interest in finding payment models that support clinical models to deliver a higher quality of care to this population.

DR. WALTON: Good morning. My name is Jim Walton. I'm a general internist by training. Started my career in Waxahachie, Texas, as a rural health physician and transitioned to caring for the poor and underserved at Dallas with Baylor Health Care System; and migrated my career into as a Chief Health Equity Officer for Baylor and then eventually became a CEO of a large physician organization that moved into value-based care called Genesis Physicians Group.

Just recently retired from there, and now I'm running my own health care consulting business, focused on Medicaid value-based payment models for rural Texans and folks in Louisiana. I'm doing some consulting work.

DR. BOTSFORD: Good morning. I'm Lindsay Botsford. I'm a family physician in Houston, Texas. I am also a Medical Director with One Medical, a national primary care group. And I think my experience with quality, I have served for years previously on the NQF[4] Primary Care and Chronic Illness Standing Committee. Also have my certification in Medical Quality. Good to be here.

DR. KOSINSKI: I'm Dr. Larry Kosinski. I am a gastroenterologist by training and spent 35 years in a private practice of gastroenterology, built the largest gastroenterology practice in Illinois at the time. I have spent the last 12 years of my life in value-based care.

I am the founder of SonarMD, a value-based care company for deployed into patients with inflammatory bowel disease. I am its founder and currently a board member.

I am also on the governing board of the American Gastroenterological Association. My focus is on developing solutions to bring specialists into value-based care both independently, as well as part of Population-

4 National Quality Forum

Based Total Cost-To-Care Models.

DR. MILLS: Good morning. My name is Terry Lee Mills. I'm a family physician by training with an additional focus on clinical informatics and hospice and palliative care.

I started in rural private practice in central Kansas, then moved into medical group leadership across several states, most recently as CMO of a regional provider and health plan focusing on MA[5], commercial, and individual exchange lives.

I've been throughout that path, focusing on quality improvement, clinical transformation efficiency, and value-based care, including metrics from several different perspectives, so I'm excited to hear the conversation coming up.

CO-CHAIR SINOPOLI: Thank you PTAC members. We have two PTAC members who are unable to join us this morning, Dr. Jay Feldstein and Dr. Chinni Pulluru. We do want to thank them for all the contributions they made prepping for this meeting today though.

So now, we'll go straight into our first presentation. Four PTAC members served on

5 Medicare Advantage

the Preliminary Comments Development Team or PCDT, which has worked closely with staff to prepare for this meeting.

Jen Wiler was the PCDT lead, with participation from Larry Losinski, Chinni Pulluru, and Jim Walton. I'm thankful for the time and effort they put in to organizing today's agenda. I know how much work they put into it.

We will begin with the PCDT presenting some findings from their analysis to set the stage and goals for the rest of the meeting for the next two days.

Additional background materials are available on the ASPE PTAC website. PTAC members, you will have an opportunity to ask the PCDT any follow-up questions after the presentation. And now, I'm going to turn it over to Jen.

*** PCDT Presentation - Developing and Implementing Performance Measures for PB-TCOC Models**

DR. WILER: Great, thank you, Dr. Sinopoli. And as you said, I cannot thank enough my colleagues, Dr. Kosinski, Dr. Pulluru, and Dr. Walton, in addition to NORC and ASPE staff who were instrumental in helping us put together our

presentation today.

So what we'd like to do is summarize the landscape assessment of this very broad space around quality measurement, not only development, but also implementation, challenges, and how they affect population-based total cost of care models and importantly, care delivery.

So our objectives for this theme-based meeting are to first, discuss performance measurement objectives, then to determine how best to measure what the desired outcomes are, because we know that's easy to say and really hard to do.

To discuss the issues related to developing performance measures for these types of population-based total cost of care models, including identifying the appropriate number of measurements, the types of measurements, and how to incorporate important components like equity and patient experiences we've talked about already this morning.

We'd also like to hear from our experts over the next two days about discussing approaches for linking performance measurements to payment and financial incentives and what are challenges and best practices.

So what we have done is summarize our previous experience and evaluated that PTAC has received 35 proposals for physician-focused payment models, and we deliberated on the extent to which 28 of those models in the past have met the Secretary's 10 regulatory criteria.

I think it's no surprise to anyone that of the models that we evaluated, nearly all of them that had been submitted to PTAC included some component of performance measurement.

And we found that 60 percent of them, through our deliberations, met Criteria 2 and 4, which are Quality and Cost, and Value Over Volume respectively. So what we'd like to do today is start with framing an approach to performance measurement understanding.

And again, an approach to how these measures can and should be used in population-based total cost of care models. So our working definition that we would like to propose for performance measurement and used for this analysis, is that performance measures assess and monitor all aspects of participants' performance within the models which include quality, both process and structure, outcomes, costs, and utilization.

We spent a lot of time thinking about how do we describe this very dense area around performance measurement and would like to propose this rubric. And really, these are the guiding principles and types of performance measurements that we think can and should be within population-based total cost of care models.

So on the outside of the wheel are the guiding principles that we believe should and are the driving forces of moving the gears inside. The gears are the measures to evaluate those principles.

And at the core is the patient experience and care delivery team effectiveness. So again, on the outside of the wheel, patient engagement, care coordination transitions, equity, efficiency, and pro-active, patient-centered, high-touch care.

We think those should be the guiding principles to the measures which are outcomes, utilization, cost, and quality, of which there are many that further delineate each of those sub-categories.

But what we thought would be helpful is giving a clinical example to specifically describe what we just showed. And as we know,

patients go through stages in their health journey from health maintenance, all the way through disease management and ultimately to palliative care.

And each of these stages conforms to occurrences or conditions that providers appreciate. Like in this example here for liver disease. If we overlay the wheel of guiding principles and metrics to evaluate this rubric that we just showed you, that could be one way that ultimately we develop clinical measures that are meaningful, both process and outcomes, costs and utilization.

Again, in this example, we show a patient with elevated liver enzymes who then progresses through end-stage liver disease and had those guiding principles of pro-active patient-centered high-touch patient engagement, care coordination transitions, equity, and efficiency may be applied.

So what we did next was do a landscape assessment of our current performance measures. And to start this landscape assessment, we used this approach.

First, we asked what care outcomes should be a focus in population-based total cost

of care models? Then, what process measures drive to that outcome?

Next, what current measures exist for evaluating this care? Next, what are the performance gaps in these current measures? And finally, how to link performance measures with financial goals.

So what we found in our landscape assessment by doing an analysis of information in the CMS Measures Inventory Tool, CMIT. We found out there are 24 Medicare pay-for-performance or pay-for-reporting programs.

Currently there are 618 performance measures that are used within these 24 model programs. And interestingly, what we found is that of these measures, 61 percent were unique, meaning used by only one program or model.

And we believe that what this acknowledges, is that there may be unique care delivery locations, conditions, or processes. However, what we found that was interesting, is that it may be challenging to scale these measures to different groups that participate in multiple Medicare programs.

And additionally when we did this assessment, we also found it interesting that 59

percent of the measures that are currently used were not endorsed by a CMS consensus-based entity. When we did this evaluation of these 24 programs, we also found, maybe to no surprise, that a majority of the measures, half, in fact, were related to the MIPS[6] program.

Now we recognize that participants get to choose at least six quality measurements, one of which must be an outcome measure from the full set.

And that CMS ultimately performs a calculation of performance and that participants are not scored on all of these measures. However, a majority of the current measures are located within or contained within this MIPS program.

When we looked at these measures, we also found that the distribution of the current measures is primarily focused on process measures, 52 percent, in fact. And an additional 39 percent were related to outcome measures.

Further, when we evaluated these 24 programs and models, we found, no surprise, that almost all of them had some linked payment. That said, the types of linkage varied from pay-for-

6 Merit-based Incentive Payment System

reporting to pay-for-performance.

Here's just a couple of examples of those programs. However, what we did find interesting in doing this assessment, is that there was no clear association between the number of performance measures and the percentage of financial risk across the 24 program models that were analyzed; which I think it's important to say, this leads to a number of questions, and it may actually impact physician and clinician participation in programs, which I'm sure we'll hear about when we speak to our experts.

Now there's a couple of different types of programs that exist, those related to quality and outcomes and those programs that are related to utilization and cost, which we included here as part of our assessment.

But mainly what we thought we would do is spend the majority of our time diving into what we believe are some of the challenges to developing and implementing these performance measures and the programs.

This is a summary of what we found. Again, this is not meant to be exhaustive, and what we expect over the next two days, is we will hear more and want to hear from our experts

around surfacing these challenges, really diving into where those opportunities are, with the hope that then we can identify best practices and figure out solutions.

But in our landscape assessment, we found these broad buckets of challenges that included identifying first, meaningful measures, ensuring that we have measures that are clinically meaningful to patients and clinically relevant to providers.

Where one might think that those things are correlative, but interestingly, they are not always. In addition, I think we all understand that these meaningful measures need to enhance value-based care.

We also found challenges related to the measured development process, the administrative feasibility of developing, not only developing measures but reporting on measures, the data collection infrastructure needed to do that, and the availability and timeliness of performance data, which is ultimately needed to inform changes of behavior, care delivery systems, and outcomes.

So let's dive into this a little bit more, each of those buckets I just described.

First, under meaningful measures and the challenges. Currently, there is little evidence that public reporting of measures is linked to improved overall quality of care in the United States.

Just one example of an assessment that was done of the CMS Hospital Compare program; when looking at risk-adjusted mortality for heart attack, heart failure, and pneumonia, there was no improvement in risk-adjusted mortality outcomes.

Second, where provider scores on performance measures may not necessarily be associated with patient outcomes. We were interested to find in one study of the MIPS program that nearly one in five primary care physicians in 2019 received a low performance measure score. However, their health-related outcome score was high, which is not intuitive. And interestingly, that it's not only not correlative, but it's the exact opposite of what one would expect.

And then, third, when we think about the patient-reported outcome measures or PROMs, we acknowledge that there this is a promising approach to measure not only patient symptomology

and their self-assessment of care, but also health status. But currently, there's limited peer review literature on what are the ideal PROMs across all different types of patient care conditions and clinical specialty areas.

The next challenge is around the link in resource intensity of measured development process, which is not insignificant. The development that we measure involves multiple steps that can take on average five to six years to complete.

Indeed, completing just the endorsement process may take up to six months between the time a measure is submitted for endorsement to the time when an endorsement decision is made. In addition, there's time and resources that are required to adapt these measures for use in value-based care programs.

For instance, a 2021 GAO[7] report showed that a stakeholder group that was working with CMS for three years, worked with CMS for three years to convert seven pathology-specific registry measures into the MIPS program.

Although one might think that that's unique to this specialty, there are examples

7 Government Accountability Office

across many other specialties where there is an aligned incentive to identify outcomes in process measures that are important to care outcomes, but that the process just takes a very long time.

The other challenge is around administrative feasibility. We found that quality reporting places substantial administrative burden on physicians and staff.

Indeed, just one study of physicians and staff, they estimated that 785 hours were given per physician annually to manage quality measurement, not just care delivery, but ultimately reporting.

And that the greatest amount of time was spent on entering information into the medical record with the only purpose for reporting quality measures to external bodies, not necessarily actually for care delivery. And, it's estimated that the time coordinating and managing quality measures, on average translates to $40,000 per physician, which is considered, as we all know, administrative overhead.

And really an opportunity for us when we think about cost savings, where we'd rather be focusing those dollars on delivering care to patients.

Next, under administrative feasibility, one additional challenge is measure consistency. And our group thought it was really important to surface this, because those of us who are in the field doing this work every day, this is actually a big pain point for us.

In a national survey of physician practices, 46 percent of physician leaders reported that working with measures reported that they were working with measures that were similar, but not identical, and this was a significant burden.

And I will give you just an example in my current day job. The risk adjustment methodology for the mortality metric of observed to expected, is different across three different types of programs, both within the Medicare space and outside of the Medicare space.

Yet, as my health care delivery organization is required to report on all of them, and then I have to explain to our Board of Directors why I have three different numbers for three different groups of patients that actually don't look any different from a demographic perspective.

Next, the analysis of this data, of

these 24 program models, found that 26 percent of the current performance measures within the CMS measure inventory toolkit or tools were used by more than one program or model, and many of them had different numerators and denominators.

I will note that in our presentation today, we have a very dense appendices that has lots of details of some of these things that I'm describing. And the reference list for all of the data that we're providing is in that and available.

Next, the data collection infrastructure is challenging. Currently, we found in this assessment that 54 percent of current performance measures are from electronic sources. And I think that that part is not surprising.

But what I do think we found interesting is that although some of these are through claims data, EHR[8] vendors, and the non-electronic clinical data space, it's worth saying that for instance, in this registry space, there may be some additional direct and indirect costs.

So the cost for participating in the registry and then the cost for the administrative

8 Electronic health record

oversight of collecting the data, sometimes within organizations manually, and then also submitting it.

We also found that 40 percent of current performance measures then are using multiple data sources. So again, administrative burden related to trying to not only collate the raw data, but to send it, and then ultimately the cost to bring that data back, aggregate, and analyze.

Next, the availability and timeliness of performance data was an area that we identified as a challenge. And of course, this is going to be impacted by the variability of the databases that I just described.

But, for instance, we found that it typically takes five to six months after a health care event to finalize Medicare-specific administrative claims data with updates that may continue well beyond 12 months.

In addition, the cost and utilization data that goes into the HCUP program, or the Healthcare Cost and Utilization Project, is available 18 months at the end of the year.

So that timely, actionable component is really challenging. Ultimately, when we need

to make decisions around how to do improvement work and when there's over a year of delay, that can be very challenging.

So those were the challenges related to developing and implementing measures. But we also thought as part of our landscape assessment, it was worth elevating the challenges related to linking these measures to payment.

Again, we used the same approach to summarize the different categories of work that we think needs to be done. And just to say it, each of these areas could be an entire presentation in and of itself, but just to go through it briefly.

Creating meaningful financial incentives for improvement that incentivize care that is high-value and evidence-based, you know, is the goal. There are different types of financial incentives that do work.

There is data that shows in the pay-for-performance space, for instance, in one study, clinics that had a pay-for-performance incentive increased the rate of recommended medication to prevent thrombosis from going from 12 percent to 6 percent, I'm sorry, excuse me, going from 6 percent to 12 percent, and that

actually large incentives may have a greater impact.

We found additional data in one study that showed that when there was an over 5 percent of salary or usual budget tied to performance measures, there was three times the effect of the program than on smaller incentives. But what was interesting is that this correlation of amount of incentive was not consistent across the peer-reviewed literature.

We found another study by Rodriguez, et al., that found that actually smaller incentives were linked to greater improvement, one related to a provider communication program as opposed to larger incentives.

So again, there's variability on does money make a difference, yes. How much money, actually, it looks like it may be variable. So we're going to be really interested to hear from our experts to hear if they have any opinion, you know, about an experience in that space and give us some recommendations.

In addition, there was a challenge around timeliness of payment. In one study we found that physicians significantly preferred, no surprise, to have their bonus payments made in a

more timely way, six months instead of 12 months.

And not only did we evaluate what was the impact around financial incentives, but there was also a body of literature looking at financial penalties. In one program that was in the surgical care space, found specifically that there was a positive impact on patient care when penalties were used.

But interestingly, there was no impact on patient care when incentives or rewards were used. So again, I think that's an interesting space for us to dive into with our experts.

So we understand that ensuring equitable outcomes is a desired outcome of population-based total cost of care programs. And linking payment to performance is one component. But what we noted is that these pay-for-performance programs may disproportionately penalize providers that serve lower socio-economic classes or vulnerable communities.

For instance, safety net hospitals, when there's been previous assessments that have shown that when safety net hospitals were disproportionately penalized in the CMS Value-Based Purchasing Program and the Hospital Readmissions Reduction Program, there was then in

2019 an HRRP update to stratify these benchmarks to try to acknowledge those challenges.

There are a number of different methodologies that are currently being used to not inappropriately penalize groups who are providing care to these vulnerable communities, but there's still not great literature around how to do that in a cost-effective and high-quality way.

Finally, preventing unintended consequences we thought was important to mention. Pay-for-performance programs may unintentionally create perverse incentives, and these were just three that we wanted to call out.

The first was that by creating focus on certain measures, there may be a hyper-fixation on care delivery for those measures where there is lack of focus on other care that is important, so an inappropriate measure fixation, for instance.

There is also an acknowledgment that measures may create a perverse incentive to divert care or focus away from important clinical areas, or to just focus on healthier patients to prevent penalties for caring for, for instance, more vulnerable patients as we just discussed.

So gaming the system, or create shifting of care patterns and avoidance in treating disadvantaged, underserved, or high-cost patients, which may result in colloquially, patient dumping.

We acknowledge that there's a challenge around how to create a risk adjustment methodology to acknowledge the last two challenges that I just spoke about with regard to equity and preventing unintended outcomes.

Risk adjustment, we have talked about a lot in previous meetings, and I actually think there's more to dive into that we hope we can over the next two days. That said, we know an entire meeting could just be dedicated to this.

However, briefly we thought we would, in our assessment, landscape assessment, we identified that 12 out of the 14 CMMI models, so 86 percent, use a risk-adjusted methodology on which 30 percent apply the CMS hierarchical condition categories, risk scores. And the other 8, or 71 percent, use different risk stratification and risk adjustment methodologies.

Again, that creates a challenge when doing data and analytics creating appropriate comparative groups and makes one wonder, is there

an ideal methodology that exists if there are so many that are currently being used and where is that opportunity?

Benchmarking is also challenging then, because risk adjustment leads directly into then comparisons, both internal and external. We know that national benchmarks do not account for geographic differences in patient populations and may unfairly penalize certain types of providers.

In our last meeting, we actually had a robust discussion about this with regards to rural care delivery systems and providers. And based on our analysis of 14 selected CMMI models, 43 percent of those programs used benchmarks that are related to national data rather than regional, local, or provider historical payment.

With regards to benchmarks, there is also a known challenge that we wanted to make sure that we acknowledged. And that's around the use of performance thresholds. There's this idea of an absolute threshold, which is consistent and transparent for all providers, but it might not promote improvement for providers that already meet these thresholds.

So high-performing organizations typically will continue to be high-performing

when these benchmarks are used. There are different types of thresholds which are relative thresholds that do promote continuous improvement of organizations.

But it may reduce collaboration between high-performing and low-performing groups and actually create persistent gaps and encourage, let me say this, it would not encourage collaboration, which is ultimately what is needed in population-based total cost of care models.

And this is actually the predominant model in the CMMI models in which we noted that 86 percent had the relative threshold benchmarking approach.

So again, I wanted to thank my colleagues on the PCDT team, and NORC and ASPE staff for helping us to do this landscape assessment. Again, there is lots and lots of detail behind what I both presented and did not present today in our appendices.

But we really wanted to conclude by focusing on where we started. And this is what we think the relationship should be between the guiding principles and the types of performance measures within total cost of care population-

based models.

And again, focusing on the core, the patient experience and care delivery team effectiveness. We think if we use this rubric in thinking about how to not only do model development, but implementation and assessment, that this is a way for us to help our collective goals.

So in the next two days, we hope that we will have the opportunity to focus on the things that I have just discussed, developing objectives for the performance measures for population-based total cost of care models, what do we want to measure in these models, and how we hope to hear about that from our experts.

We want to hear more about the issues related to selecting and designing measures from folks who actually had that experience. We really want to hear about best practices to measure development, utilization, and financial and quality outcomes.

And then ultimately hear about this unique component around linking performance measurement to financial outcomes and what has been successful and not successful in the past and how that can inform moving forward. And with

that, I will turn it over to my PCDT colleagues for any additional comments.

DR. KOSINSKI: Jen, you did a fantastic job. I don't know how much more I have to add to it, but a couple of points just to emphasize. The first one is time, the time to develop these measures and implement them whether we did it in a fee-for-service world, or in a population-based total cost of care environment, we've got to figure out a way to shorten the time period it takes to actually implement them.

And implementing them, meaning they are actually in the workflow of care without a physician having to do something outside of that care in order to document it. We also have to make sure that process does lead to outcomes. This is very, very important. We spend way too much time on process measures that have never been demonstrated to result in an outcome.

My third point would be, we not only have to have these apply to primary care physicians, they certainly have to be applied across the specialty space. And we can't forget the patient, those patient-reported outcomes, measures are critical.

And then finally, to close it, we

can't just deploy these and throw them out into space, we have to re-evaluate them, we have to make sure that what we've developed is actually producing the outcome that we intended it to produce, and if it isn't, we need to be changing them. Thank you.

DR. WALTON: My only emphasis would be, by the way, great job, was that physicians are increasingly, you know, ever since these measures connected to value-based work had gotten launched, physicians kind of communicate that this is often times an administrative paper chase through the computer and that they're not necessarily relevant.

So I think the data supports what we're hearing from the field from our colleagues. But the most, but the thing that I really want to elevate was that doctors, just like patients, are practicing in milieus that are high-risk and that's captured often times now in the area deprivation index.

And I think it really would be helpful, and I'm glad to see that we were able to elevate that here, that digging deeper into the impact of ADI or other measures that could kind of help us index for our colleagues, our

physician colleagues, the environment with which they're trying to make progress on patient-reported outcomes. And so I thought I would just elevate that.

CO-CHAIR SINOPOLI: Thank you all. I think, unfortunately, we are running out of time here. That was a, and that's going to generate a lot of great questions for the next two days, that was a fascinating report.

And I know just as you were going through it, just lots of questions going through my mind and things I wanted to ask, but we'll make sure they get asked over the next couple of days.

So Jen, and PCDT team, I want to thank you for all that hard work I know you put into that. It was pretty detailed work. So at this time, we're going to take a break until 10:30. Please join us to hear from our great lineup of speakers, starting then. And the next one will be on Developing Objectives for Performance Measurement for Total Cost of Care. So we'll see you back at 10:30, thank you.

(Whereupon, the above-entitled matter went off the record at 10:22 a.m. and resumed at 10:32 a.m.)

*** Panel Discussion: Developing Objectives for Performance Measurement for PB-TCOC Models**

CO-CHAIR HARDIN: Welcome back. Before the break, Dr. Wiler and the PCDT shared our starting point for this public meeting and some of the questions we want to explore. And now, I'm very excited to kick off our first panel discussion.

At this time, I ask our panelists to go ahead and turn on video if you haven't done so already, and we're very fortunate as well to have two presenters in person today. In this session, we have invited four esteemed experts to discuss how they develop objectives for performance measurement for total cost of care models.

After each panelist offers a brief overview of their work, I will ask a few questions and then PTAC members will have any opportunity to ask any follow-up questions. The full biographies of our panelists can be found online along with many other materials for today's meeting.

I will briefly introduce each of our guests and give them a few minutes each to introduce themselves. After all four

introductions, we will have plenty of time to ask questions and engage in what we hope will be a robust discussion.

So first we have Dr. Cheryl Damberg, who is the Director of RAND Center of Excellence on Health System Performance. Cheryl, welcome and please go ahead.

DR. DAMBERG: All right. Thank you for having me. It's a pleasure to be here and I can't actually see anybody in the room. But let me start by just giving you a very brief overview of some of my background that's relevant to the discussion today.

So over my career I've been engaged in performance measurement, and I was actually thinking about this last night. That this started back with one of my very first jobs at HHS[9] working on the Healthy People objectives for the nation and looking at measurement of performance of the health system at large.

But I have spent time working with purchasers. I used to work for the Pacific Business Group on Health, now the Purchasers Business Group on Health, leading efforts to do performance measurement and shift to value-based

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payments, getting the private sector to pivot in that direction.

I have also had decades of experience developing and applying these performance measures in practice. And so understand the complexities of development of measures, as well as their implementation.

More recently, I've been involved in a range of studies looking at trying to understand the impacts of the use of measures and financially incentivizing providers for their performance.

I have also been trying to understand their response to performance-based accountability. Particularly in the context of total cost of care models and understanding what they're doing to the cost curve, as well as maintain or improve their performance.

Lastly, more recently I've been exploring the challenges that providers face in redesigning care to get to high performance. So next slide. So we were asked to consider a few questions for today's panel meeting.

And, you know, as I think about performance measurement and using performance measures to drive delivery system transformation,

I think we have to be clear on what are our key objectives. And I don't think it's just to measure performance.

I think what the objective here in my mind is that we would encourage systems that are caring for our population to build a measurement infrastructure so that they internally can monitor and improve their performance and in the process, change care delivery through an ongoing learning process.

And I think the measurement that we collectively use, whether it's private sector payers or public sector payers, it provides a really strong signal about where these organizations should invest resources related to transformation activities. So I think we have to sort of carefully think about where we want them to invest.

Also, I think there's sort of this tension implied between what I'm going to call macro level measurement versus micro level measurement.

So one can sort of go into the weeds, measure lots of things, versus measuring sort of broader constructs and allowing health systems to dig deeper to try to understand what are some of

the drivers.

And I think the total cost of care measure is one good example of that. And I think if we stay focused on some of these macro measures, they may be sufficient to drive transformation and be less burdensome to systems and providers.

In terms of the types of incentives that are needed to facilitate improved outcomes, I think one thing to consider in any performance measurement dashboard is the need to have a broad set of measures to cover the range of quality dimensions that are in play, but also importantly to avoid gaming.

When there's a small number of measures that focus on a narrow set of things, this can create an environment that allows providers to game and focus on a very narrow set of things. And, you know, we would lack understanding of what's happening in a broader sense related to the quality environment.

I think we also need to be emphasizing more health equity measurers. We see time and again, the lagging of performance among certain subgroups of the population, and I think we need to do more to tie performance measurement and

payment and accountability to try to do better with these subgroups.

Importantly, we need to be doing more to measure patient-reported outcomes and using that information to change how we deliver care to patients. And, most importantly, and if we want to shift to the next slide, this point is made on the second slide.

I think the critical thing here is that measurement is only one piece of a larger puzzle, and that other strategies and tools are needed to actually drive system change. And I would say first and foremost, some of the, what I've been learning from my work and in interviewing health systems and provider groups around the country, is that payment reform is happening too slowly for them to actually invest in transformation.

When you ask them what percent's at risk, generally they tell me a very small percentage, one, two percent of their total revenue flow. And I think they had expectations that there would be more rapid transformation to these models, and it's been slow going, at least from their perspective.

And the payment reform is really

needed to support this care redesign and innovation. And another thing is, you know, changing up how we design insurance to drive value. So there are a number of things that should be considered in concert with performance measurement.

On some of the issues on the table, so I sort of listened in a little bit toward the end of the last one. This issue of burden comes up repeatedly, about do we have too many or too few measures. So this is where I think we have to be judicious in thinking about what are the important areas to measure and what can provide some of these macro signals.

I do think that outcomes are very important and something we should focus on, but we have to recognize they can be harder to measure, either because they require more clinical detail, they take longer to observe, potentially they require collecting data directly from patients. But I would say we need to do more to push to better measure in that space.

I may be a different voice in the room. I still think it's important to measure these various processes of care. Certainly many of them are tied to evidence-based outcomes. And

in some prior work that we did around the hospital value-based purchasing program for CMS, we actually did find improvement in outcomes.

And I think one needs to be careful reviewing the literature, the relationship between process and outcomes, because many of those studies have significant flaws that don't actually tell you what's happening. And I can say more about that later. So I've touched on disparities and patient experience. But one thing, and I'm hoping Eric [Schneider] is going to touch on this, you know, we've had outdated processes for performance measurement construction and reporting.

And you know, I think we're at this critical juncture where we can do better. And this will enable a broader set of measurement leveraging, you know, the electronic health record, AI[10] tools, and so on. So I think we're at this, you know, pivotal point where the landscape may change significantly around performance measurement.

And then lastly, I would note that, you know, there's this tension between measuring at like the organization level versus the

10 Artificial intelligence

individual physician level, but a lot of the actions that need to take place to actually improve performance are not sort of right at the front line with the individual physician.

And in my conversations with organizations who are trying to drive system change, a lot of that change happens at the organization level.

So I think we need to be mindful of where we're targeting these various incentives and what type of behavior we're trying to change. So I will just stop there, and I think you are moving on to Helen next?

CO-CHAIR HARDIN: Thank you so much, Dr. Damberg. We're really interested in hearing your insights in the question period as well. Next we have Dr. Helen Burstin, who is the Chief Executive Officer of Council of Medical Specialty Societies. Please go ahead.

DR. BURSTIN: Great. Thank you so much for having me today. It was really a pleasure to hear the earlier presentation by Dr. Wiler on the team. So many of the reflections were things Eric and I were noting, we could have sort of easily jotted down many of the same things, but thank you for the detailed analysis.

It was, I think as you will hear, reflected in a lot of our comments as well.

So as mentioned, I am the Chief Executive Officer of the Council of Medical Specialty Societies which is really an organization of organizations. We work to advance the expertise in the collective voice, especially societies really in support of physicians and the patients they serve, very importantly that last part is not -- is quite intentional in our mission.

We currently represent 53 Specialty Society members across medicine, primary care to surgery to everything in between. So very importantly, this isn't just a reflection of subspecialty medicine, but just broadly understanding it from the physicians' specialty perspective.

Collectively, those organizations represent more than 800,000 individual physician members and other clinicians as well. Specialty societies, and we've talked a little bit about the burden already today, play a significant role in both the development and the testing of quality measures.

And I'd like just to come back to the

testing issue which is a huge pain point on the path to implementation. There are currently really no dollars out there except for some foundation support for quality measurement.

These are not inexpensive measures to build, as you've heard, the idea of spending a half million dollars on a measure and then a several year process ahead of you to get it through approval and, you know, finally getting it into practice is a difficult and heavy lift. About 20 of our societies have clinical registries.

Some of them have multiple, for example, ACC[11], and that American College of Surgeons, each have multiple clinical registries. We've seen a significant change over the last several years. There's really a move towards using much more information that emerges from digital sources, as well as electronic health records, even practice management systems.

It is still a very heavy lift, and most of the societies still rely on data, folks who really help with the data, intermediaries, which are expensive, difficult, and costly. So that translation piece is, really continues to be

11 American College of Cardiology

significantly difficult.

Just about myself, I have a very long history in quality and equity measurement. I was the former Chief Scientific Officer for a decade at the National Quality Forum in the past. I'll also mention just interesting being in this room.

It is 20 years since I led the first National Healthcare Disparities Report at the Agency for Healthcare Research and Quality. And I think we all thought putting out those data stratified by race and ethnicity would change everything, and very sadly, very little has changed in both equity measurement, assessment, and improvement.

So just, it's hard to not be in this room and reflect on, we actually did the launch right in this room 20 years ago. So with that, let's go to my next slide, please. I just have one slide of key takeaways. You'll have lots of time for discussion.

I think very importantly as we think about the role of physicians in this space, and I say specialists really broadly here, both primary care, as well as specialty providers, specialists in general.

We have to be accountable for measures

that likely are attributable to our performance. But as we really think about these population-based total cost of care models, really important that even if you're not directly attributable, thinking through what your role is in terms of how that's reflected in the team-based population health measures I think is going to be critical.

For example, looking through some of the other lists of measures, measures of access and timeliness directly make sense, when you think about it, through the lens of what a specialty, a specialist might bring to a population-based measure, for example.

And I think as we think about what's next and what are the kind of measures that we need, specialty measures that reflect appropriateness, shared decision-making, and patient-reported measures, I think are particularly, they're difficult, but I think they are also the ones that potentially support collaboration across time, across settings, across clinicians, in population-based total cost of care models.

And so I think, hopefully, there are opportunities for us to think about how to take, for example, many of the clinical guidelines and

appropriateness criteria that are already embedded in the work of our specialty societies and think about how they actually can become part of these models; going forward. I think there is some interesting collaborative strategies there.

We have to think about the strategies to include specialty-specific measures that derive from rich clinical data, particularly in clinical registries, as well as digital quality registries, digital quality measures, but really, really importantly, developed for and by clinicians.

Clinicians really looking and reflecting on, you know, if it's difficult to collect or it's important to collect, is the juice worth the squeeze, is this a measure that I'm going to want to look at, turn to my colleague on the right side of me, the left side of me and say, "How did you do?"

Because actually that measure is meaningful enough that I want to look at it and see how I can improve performance. And unfortunately a lot of the claims-based measures we have currently don't answer that, would not pass that test.

There are things we just sort of look

at, and it's difficult to really assess what it means clinically in terms of my role, in terms of quality improvement, or clinical improvement from the perspective of the physicians.

And then finally, I think very importantly and this came out significantly in Dr. Wiler's performance, the idea that we have measures that are meaningful to physicians, and I would add here, and patients, and that provide actionable information that can be used to drive improvement across patient-focused episodes is where we need to go. Those are difficult to do.

I know several of our studies are currently developing new measures in that space, but again, the time crunch, the lack of test beds for testing measures, the difficulty of getting them into documentation, the continued difficulty of really creating digital quality measures given where we are right now is still a leap.

And so anything I think we can collectively think about what we can do, you know, in a coordinated way across our different sectors is where we need to go right now. The current status quo is not acceptable. It doesn't work for anyone as I think you elegantly pointed out in your presentation, Dr. Wiler, and by your

team.

And it's really time to think differently, and hopefully this is an opportunity. So thank you.

CO-CHAIR HARDIN: Thank you so much, Dr. Burstin, really looking forward to hearing your perspective through that 20-year lens of working on change in this area.

So next we have Dr. John Bulger. He is the Chief Medical Officer of Insurance Operations and Strategic Partnerships at Geisinger Health Plan. Please go ahead, Dr. Bulger.

DR. BULGER: Great, thank you. So, my name's John Bulger. I'm the, that mouthful of a title, and I bring a number of different perspectives today. It's really, appreciate the opportunity to talk and thank the Committee for that. And it's actually, it's great to do this with Cheryl and Helen and Eric, and I think we'll have a rich discussion.

So my primary role now is as Chief Medical Officer at Geisinger Health Plan. And if you don't know about Geisinger, Geisinger is in Pennsylvania, it's in North Central Pennsylvania. And I included the map just to give some flavor

of where our clinical footprint is, which is the blue area.

From a health plan perspective, we're statewide in Pennsylvania in Medicaid, and that's about half of our business. And then we also have 100,000 members in Medicare Advantage, and then have commercial, both ACA[12] and non-ACA commercial plans, so it's really across all lines of business, it's about 600,000 members, government and non-government programs.

So I have that perspective. I also play a role, and that's part of the long title, within our clinical enterprise, and I help lead our ACO[13], so work with performance measurement and quality measures a lot and what we're reporting in many of the, with the ACO and several other CMS demonstration projects, total cost to care projects.

I used to be, prior to going to our health plan, I've been at Geisinger 26 years, I was the Chief Quality Officer at Geisinger, and in that role was primarily responsible for all of the quality reporting that Geisinger did, both inpatient and outpatient, and did a lot of work

12 Affordable Care Act
13 Accountable Care Organization

around quality measurement.

And most recently as I had there, I was a former of the NQF's CSAC[14], which is the committee at NQF at the time that all the measurement reviews came up through, and spent a number of years on that and a number of years on many of the subject matter committees as chair of the re-admissions committee.

So I come at this with a really, a number of different viewpoints as to where we are. Next slide. So, and I don't want to take up a lot of time, and I somewhat cheekily maybe I said, you know, the first takeaway I have is keep it simple, and that's why I tried to keep the slides simple.

But I think we heard already today, that the amount of time that providers put into this, and I can say from wearing my health plan hat in talking to providers, anything you need more than a few minutes to try to explain to them, and certainly if you need a couple hour meeting or you need a bulk of a document to give them to try to explain whatever the program happens to be, whether it's a P4P[15] program or

14 Consensus Standards Approval Committee
15 Pay-for-Performance

whether it's how you're doing your value-based program and what the measurement is, you've pretty much lost them after the first few paragraphs or after the first five minutes.

So keeping it simple, I think, is the most important thing. I think there is a need to focus on outcomes. I think where we have good data that ties process to outcomes, I think it makes sense to use that process, but it's the outcomes that matter. And when we're looking at what we want people to report, we really do want to focus on the outcomes.

I think equity is important, and Helen just talked about that. I think it helps us when we're measuring to measure in many different ways.

So you want to make sure that the denominators, and this is where sometimes it goes against keeping it simple, but where the denominators include the groups that you want to make sure that you're not missing from an equity standpoint.

And it's one of those areas where I do believe, and I will talk about in a second, that if you aren't measuring that, it won't be managed.

And lastly, I think, the goal of measurement in total cost of care programs is to protect the public. And in my days at NQF, we talked a lot about the use of measures, and I think the use becomes very important.

So the question is are you using them for reporting or are you using them for improvement or are you using them for accountability or are you using them for payment? And I think what you're using the measures for means a lot to physicians, a lot to other providers, and changes the way those measures are used.

So if they are being used for payment, it's a much different story than if they are being used for improvement. Now sometimes we like to think that we're using them for both, but I think you need to understand when it changes the payment, it changes the way providers look at those measures.

And I think there's a danger when you do that because you end up essentially studying for the test. So providers figure out how to do well in the measures, and that may or may not play a role in whether patients are getting quality and equitable care. So I think in total

cost of care programs, you've already set up the program from a total cost of care standpoint.

And in almost every case, if you do a good job from a total cost of care standpoint, you will have high-quality care. What you are looking for, I think, when you are measuring that, is to protect either areas of the public that are under-represented or the public in general to make sure that you don't end up with gaming the system and that studying for the test piece.

And you know, I'll end just to say many people attribute to Deming, the notion that he said you can't manage what you can't measure, which he actually didn't say. That one of things he did say was one of the seven deadly sins, or the seven deadly diseases of management is running a company on abysmal figures alone.

And I think I like to, you know, there's a statue outside of the National Academies of Science of Einstein, and I think he puts that well: it's just not everything that can be counted counts and not everything that counts can be measured. I think the goal is to try to bring those together.

And that's why for me total cost of

care programs make so much sense, 'cause again, I really do believe that doing the right thing for the patient is in the long run, almost always the lowest cost. And then you need to wrap things around it to make sure again that the system is one that is true and isn't gaming. So again, I thank you for the opportunity to talk today. I'm looking forward to the discussion.

CO-CHAIR HARDIN: Thank you so much, Dr. Bulger. Really appreciate the focus on simple clarity. I'm looking forward to hearing your perspective from the diverse roles that you've had.

So finally we have Dr. Eric Schneider, who is the Executive Vice President of Quality Measurement and Research at the National Committee for Quality Assurance. And also, a previous submitter of The "Medical Neighborhood" Advanced Alternative Payment Model proposal. Please go ahead, Dr. Schneider.

DR. SCHNEIDER: Great. Thank you very much and thank you to the Committee for the opportunity to be here today. It’s really a pleasure. And thank you, Dr. Wiler, for what I think could be a really useful reference for this current state of where we are. It actually is way

more detailed than anything I've seen. So it's wonderful to have that resource available to us.

So I'm coming today, nearly 30 years ago, I was a fellow at NCQA for one year and I did a project with NCQA on the digital future of performance measurement. So why were we doing that in the 1990s when the internet was barely a thing, the web browser had just been invented, and cell phones were still flip phones?

It was because we realized right away as we were starting to develop quality measures based on health plan claims data as part of a response to the HMO[16] movement, that that was not going to be a sustainable model.

That claims alone were not going to get us the data we needed to accurately measure quality in a way that would be useful to providers providing care at the front lines. And I speak as a primary care physician who practiced and taught primary care for 25 years.

So we wrote a report at that time on the digital future of performance measurement and published a paper on the health information framework and what were the seven features needed. And I decided that that wasn't going to

16 Health maintenance organization

happen in my lifetime, because none of the features that we really needed, health data standards, health data infrastructure, really existed, or I thought could exist in my lifetime.

The good news is I'm here to talk about this still, and I think seven of those features now do exist. So if we go to the next slide, I will talk a little bit about NCQA and its mission.

Our goal is to improve the quality of care, we're nonprofit, and we do that through measuring health outcomes, clinic quality, and patient experience, promulgating standard measures.

We accredit health plans in Accountable Care Organizations, so increasingly, and we recognize physician practices and some specialized care models. And I would say our model also is sort of needing an upgrade to reach into the digital future. And I will say a little bit more about that in a moment. So if we go to the next slide.

The durability of HEDIS, the Healthcare Effectiveness Data and Information Set, I always trip on that because it used to be the Health Employer Data and Information Set, but

it's Healthcare Effectiveness, is a set of 70-plus measures that health insurance plans use to measure and report on quality.

It's widely used, as you can see here. 203 million Americans are enrolled in populations that report quality using HEDIS, so that's 60 percent of the population.

And it constitutes 70 percent of the measures that CMS put into the Universal Foundation when it looked across the agencies and the programs and said, "What's a core set that's really vital and important?"

And this speaks to John Bulger's point about keep it simple, keep it focused; and Cheryl's point about macro signals and how to manage those. I think, interestingly, the discussion about population-based total cost of care goes back to what we were thinking about in the HMO era, the 1990s, that the idea of a population-based approach is that there's an accountable entity that's responsible for a membership or a population.

The way that population can get defined differs across settings. But I think one of the points we probably, or I hope the Committee will focus on is sort of what is that,

what is the implication of that.

Because the origin of HEDIS actually was in that sort of insight that a population-based total cost of care approach actually imposes a budgetary constraint that doesn't exist usually in the system. And that creates downward pressure on spending and the concern that quality will be eroded as a result of that.

The theory we have is that by imposing that financial risk, we actually motivate that's tied to the clinical risk that exists, that healthy populations will actually cost less. And so we want to see an increasing health of the population as a way of reducing the costs, and this creates the right incentive, this mechanism creates the incentive for that.

But the big worry, and I think we've seen this play out to some degree, is that the reverse occurs, that the financial risk becomes the central focus, that the stinting on delivery happens that people get excluded, members get excluded from care, and we end up with worse health outcomes.

And I say that because during my time at the Commonwealth Fund prior to coming back to NCQA two years ago, two facts sort of became very

apparent to me, especially comparing the U.S. to other high-income countries. The first is that there is strong evidence that our poor health outcomes in the U.S. are tied to inequity in the way we deliver care.

And the second is that the cost burden on patients and families with the way we're currently organizing our payment systems is eroding trust among people, and that impedes their timely access to care, and it results in delayed diagnosis and worse outcomes than might have been possible otherwise.

So that's a bit of a wind-up to a question which I struggled with actually as I was thinking about this presentation is: What should we require as sort of a minimum entry criteria for an organization that would take on population-based total cost of care payments or a payment model?

And I think two things, for sure, there are probably a list, a longer list, but one is this notion of impaneled or attributable members. Not attributed to, but where the organization really is responsible for the population, whether they're in the office or not in the office, so empanelment.

And then second is, and others have spoken to this, the ability to integrate care across the continuum, and I think you've identified that as important. We currently still have a system of primary care operating independently of specialty care, operating independently of behavioral health, operating independently of the community-based organizations who can provide for the health-related social needs of the population. And that really has been kind of vexing us for some time. So if we go to the next slide.

So as I thought about that in that perspective, I thought what are the most important things that differentiate a population-based total cost of care model from any other approach that one might design in performance measurement?

And these are pretty much in priority order. If we really want to improve health outcomes, equity probably has to be the first consideration. I know in the model it's there, but it's sort of one of the attributes, a quality.

And I've been persuaded by the data and the comparisons that I've been involved in,

that disparities and unmet social needs, reducing disparities and addressing unmet social needs are really vital if we want to make and see progress.

And a total cost of care model, whether it's to an insurer, or to an ACO, or to another organization that's bearing that risk, really should be very laser-focused on those objectives.

In HEDIS set, we have pioneered, I guess, with first year experience of stratifying the HEDIS measures by race, ethnicity, and we'll be sharing more on that as the year goes by. We also have introduced the social needs screening and intervention measure, which I know CMS has a similar version of.

But we really tried to emphasize the intervention part of that, that it's not enough to just screen, it's actually important to intervene.

Closely related is the access to care, and Helen mentioned the availability and timeliness that's come up in other contexts, but what does it mean to measure that type of access? So access to specialty care is a particular challenge right now. Some simple measures, they seem simple, but we've been trying to implement

them for 20 years, and we can't because of our data systems.

But following up after an abnormal test result, which seems like one of the most basic functions of a functioning health care system, is still, we've had several runs at this over 20 years at NCQA, and it continues to be extremely challenging to implement.

Measuring delayed diagnosis is another area that can get at the access issue. On experience, so I'm going to experience because of this trust, this erosion of trust problem.

And so, in a total cost of care model, the consumer, the patient, the family is extremely sensitive to the idea that rationing is occurring under that model, so there need to be measures to address that experience.

And in particular, something we've never tackled well is the care of people with multiple chronic conditions or complex care needs. And we've been working for about a decade on a person-centered outcomes measure, which a different approach really.

We described in a paper we published in 2014, I think it was, that you, there's the guideline-based evidence-based care model, but

then there are the things that primary care doctors are trying to do with their patients to achieve goals, life goals that a patient may have.

And it is possible to document those goals. We've actually demonstrated that in some of our pilot work. It's possible to document those goals, to measure progress toward those goals between clinicians and patients. And I think that innovating to try different approaches is going to be vital if we want to do total cost of care type measures.

And then finally, in the clinical effectiveness, we're really, I think, sort of on the precipice of having the health data ecosystem that I described earlier on that could support better clinical data to support more meaningful measures.

And the health data exchange standards that the Office of National Coordinator has been putting into regulation, the VHRs[17], the info blocking regulations that are sort of trying to create an environment where data, health data exchange can occur, and our ability to digitally specify, deliver, and report measures is

17 Virtual health records

something that NCQA is actively working on right now.

But again, I think it has to, and actually, safety and reliability is another area that we've just not done a good job measuring. Again, that probably comes back to the idea of following up after abnormal test results, the kind of basic business processes that create safe and reliable care.

We don't have great measures of that, but again, the technologies, I think, are getting there. So I guess I will conclude by saying that we kind of thought we could fake it on claims data for 30 years. We can't. I mean, we can get only so far in a claims data environment.

We really do need to make investments in the health data infrastructure that could create the clinically relevant measures usable at the front lines, usable by population health managers, and could support many of the objectives, I think, that you pointed out. I do think we have some opportunity to innovate on person-centered measures.

And then finally, I agree with other panelists, and maybe we've all been agreeing about everything, which we didn't coordinate

this, so that's kind of interesting that we've come to many of the same conclusions that measures that incentivize care coordination and team care are really probably vital if we're going to succeed going forward in the total cost of care framework. Thank you.

CO-CHAIR HARDIN: Thank you so much, Dr. Schneider. Your experience and background also round us out in a very interesting way. Really looking forward to the dialogue. So next we're going to move to some to core questions.

And I just want to alert the Committee, there will be a section for you to ask the panelists questions as well, so start thinking of those. If you do have a question when we get to that section, please tilt your nametag up so I am aware of that.

But first, we're going to start with some core questions for the group. And in the interest of ensuring balance across the different perspectives and questions, I want to encourage the panelists to keep your response to a few minutes, and I will call on you in order to answer each of the questions.

So our first core question is: What are the main goals of performance measurement for

total cost of care organizations? For example, to drive change through financial incentives, to provide actionable information for providers, or to inform beneficiary choices. Let's start with Eric Schneider.

DR. SCHNEIDER: Sure. Well, I think I touched on some of this in my opening remarks. And I do think that coming back to the total cost of care, this is a, this, we have imagined that the same measure could be usable at various different levels of the system.

And I think that in this context, really focusing on the organization level. We are frontloading a lot of this or offloading a lot of the work and labor to produce this and respond to it to individual clinicians or small teams or small practices.

And that's just really not, in a financial risk model, you can't put that risk on the individual providers in the same way that you can on a larger organization with a larger population where they can manage both the financial and the clinical risk.

What we're missing, I think, in that context is the, again, the nuanced data necessary to really understand the risk and the health

needs of the population beyond all the insights that people can gain in a small practice or in direct clinical care.

We see some amazing practices out there, primary care practices, and Federally Qualified Health Centers, and other organizations that are doing tremendous work. But they're operating without a kind of network around them and network of support, so I think that's one of the, I hope that was responsive to the question.

CO-CHAIR HARDIN: Excellent. Helen?

DR. BURSTIN: Yeah, I think we're going to be all building on each other's comments, so for sure, I agree with everything Eric has said. I will just add that I think some of this really comes down to, and Angelo and I co-led a webinar recently with the state innovation folks.

And it was really interesting about this concept of what a provider is. This keeps talking about providers, is really unclear, and it's really different. And I think when you are only talking about physician-based payment, I want to broaden that.

Because I think the reality of clinical practice, it's not all doctors, this is

really about clinical care. Health care professionals' performance versus the providers' performance, we're thinking about a system, are often very different.

I think we really have to think thoughtfully of these population-based total cost of care models to really think about what everyone's role is in that broader model. And what is the responsibility of the clinical care team, how do you integrate within the broader vision of, for example, what you're reporting at the system level back to a group.

So I think thinking about measures then, that get at some of that clinical effectiveness work that Eric mentioned at the bottom of his list. Those still can be directly relevant if we can get to really important, clinically relevant measures.

For example, for oncology-rheumatology, one of our members is developing a measure looking at patients with RA[18] and their number of symptoms and joints affected, right, very logical connect that to treatment. We've got a grant program currently with some of our registries developing diagnostic feedback

18 Rheumatoid arthritis

measurement.

Something really clinically relevant would be incredibly important to a system because it really crosses what needs to happen from a patient's perspective in terms of access and timeliness as well.

So I think very much thinking about getting to measures that reflect, I think, you know, what's listed out here in that question, actionable performance. And then thinking about at what level you are considering those.

Actionable performance for your clinical care team may be very different than actionable performance at the system level. And I think we need to keep those connected but separate, because I think the measures that drive those may, in fact, be different.

CO-CHAIR HARDIN: So helpful. Cheryl, let's go to you next.

DR. DAMBERG: All right. So Helen just stole some of my thunder, because I agree with her related to sort of actionable for whom, and you know, what type of measure best serves their ability to take action.

I think that the primary goal for performance measurement, it's really to produce

information for driving change within a health system, such that you can produce, you know, better care for patients and help them achieve better outcomes.

And you know, I think one of the challenges that happens in this space is that we're trying to do multiple things for multiple stakeholders. And at the end of the day, while I was one of the early parties to produce public report cards on performance for consumers, I think that space, you know, continues to remain challenging, to produce the kind of information that consumers can actually use to make choices.

Whether it's around choosing providers who are lower-cost for the same type of service, same quality of service or, you know, finding organizations and providers who deliver better care. I think that space continues to challenge us.

But, you know, fundamentally, I think what we're trying to do is we want all providers in the space to be "A" level providers. And so I see this as information to rise or to raise all boats.

And you know, we use financial incentives to try to, you know, garner the

attention of this system, but at the end of the day, my objective for performance measurement would be to help providers have information to understand how they're doing, where they can improve.

And then, you know, they, as a community, can determine within the confines of their constraints, their abilities, and the resources they can bring to bear how to drive improvements.

CO-CHAIR HARDIN: Thank you. And John, let's go next to you.

DR. BULGER: It's a tough group to go last in. I was actually writing down rising tide lifts all boats, right when Cheryl said it so, and I do think that's a good way to characterize it. I will just break this up quickly. I think from an accountability standpoint in total cost of care organizations, we started to look at it more from a gaining mechanism.

And again, this is an accountability, and I think I would agree with what Eric said from a, at the organizational level where you're trying to look at measures.

Some of those processes that lead to outcome, some of those outcomes, and I do think

this was said earlier by Cheryl, is you have a kind of balanced portfolio of those measures. But they're a gate, if you will, so they're, as I said in the beginning, to protect the public and make sure that you don't end up with gaming in the system.

And then I think you have a secondary piece which is, and I think everybody has already talked about it and I think Helen said it well, is where you are able to get the public information to be able to make informed decisions with the hope that if you set the program up well, you have increased the quality across the board. So that, you know, the baseline quality we have within the system is better.

And then I think lastly, I think you have measures that may or may not be reported. But we have really good robust measures that the organizations that are in these programs can use to make themselves better.

Because that's really where we'd like, or where I'd like the work to be being done. I'd like people spending time on looking at their own organizations and having measures and having robust data sets that, as was noted, aren't just claims measures, they're EHR measures, and

they're patient experience measures from surveys, but they're also patient-reported outcome measures, and you're able to loop those altogether.

And I think the things we've been able to do at Geisinger that are the coolest things we would do is where we're the payer and where we're the provider, and where we have all that data in one database because it just gives you such a richer look.

And again, to make yourself better, not because you want to publish that or you want to be accountable for that, but that's what we're looking at every day to see how do we get better for the people we serve?

CO-CHAIR HARDIN: That's very helpful. Next we're going to go to another core question. We want to hear about your approaches for measuring performance-related to the objectives of total cost of care models, and you've started to dive into this already.

So the question is: What are the basic types of performance measures that would be most appropriate for measuring participating organizations' performance relative to the desired characteristics of total cost of care

models? Please provide examples of specific performance measures that might be particularly useful. Cheryl, let's start with you.

DR. DAMBERG: Okay. So it would be performance-based total cost of care. I mean, first and foremost, you're going to measure total cost of care. And I know that there's been a desire in the market to try to tamp down on low-value care.

But I think again, it's this tension between macro versus micro. I think it is helpful to have some low-value care measures out in the space. But I don't think that that is necessarily what needs to be measured in the context of a total cost of care model.

That starts to get into the drill down space, so first and foremost, total cost of care. But I think something that Eric touched on, Helen touched on, this issue around access to care, timeliness of care, and I would also add denials of care.

You know, we see in many spaces, particularly in say Medicare Advantage, you know, a rising concern that people, you know, the denial rate is quite high. And this is creating a significant burden for physicians in delivering

care.

And again, there's this tension between trying to reduce the spend, but also we're creating a lot of friction points in the system that may not add value, so I'm going to expand that space.

I also think, you know, we need to focus on patient experience. We learn a lot when we talk to patients and learn about their care experiences with how to change the system to be more patient-centered and to deliver care that not only meets some reasonable level of expectation, but can help them manage complex health care conditions.

Because you start to move in the direction, as Eric noted, of building increased trust and connection between patients and providers to co-manage a health care condition.

And also to learn about what are some of the underlying barriers to a patient being able to succeed, whether there is socio-economic barriers or other types of barriers. And then lastly, you know, we have to keep doubling down on our focus on equity.

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

DR. BULGER: Yeah, and I think it's a great question and that's a great answer. I'd like to come back to the, I do think the balanced portfolio methodology is the best way to do this. And then, I think, actually, you know, to Cheryl's point, in the world we'd like to get to around total cost of care measures, is if we got where we wanted to be, you wouldn't need prior authorization.

So that you would, 'cause there is a huge amount of waste in the system to have to ask to be able to do something. But you would create a system because, so you would have total cost of care at the top, and you would have these fail-safes that we've talked about to make sure that people weren't gaming the system, and then providers would decide in conversation with their patient about how to treat patients and whether a test or treatment should be done as opposed to needing to ask someone else.

And that the total cost of care model, with its quality gates, would make sure that that was happening all the time. I would like to say, you know, in the, from specific examples, I think looking at some of the kind of classic claims-based measures of utilization per thousand, I

think does become important in some of these models.

And again, not so much to, from an accountability standpoint, but to help you manage what you're doing. Because in a perfect world, you'd like to see something where primary care physician visits goes up and specialty visits, potentially, goes up, but you have decreasing emergency room visits and decreasing inpatient visits per thousand.

And, you know, if you're running that, if you're in that model, you may put programs into place, like say, a care management measure or some team-based program and be able to measure against that and say does this get the information that, or does this move those in the direction we want them to move in?

So it's one of the things we've seen a lot in many of the care management programs we've put into place. And we've seen most specifically recently in Pennsylvania Medicaid where we've been able to push care to the patient's home and away from the hospital.

And in the end, total cost of care decreases because those hospital-based areas are much more expensive as we know than the home-

based areas.

The last thing, just in this piece is I think it's important too that we look at standardizing the way the data goes into the system. Because one of the issues I think we have now is that different provider organizations or providers themselves, bill in a different way or we have different definitions of what's an inpatient procedure or test or treatment versus what's an outpatient.

And when you're trying to compare providers to providers, it becomes difficult many times to compare provider A to provider B or understand what provider A is doing versus provider B, because we have the definitions of how the inputs come in. And in many ways that's the way we bill, and fee-for-service can be very different from provider to provider.

CO-CHAIR HARDIN: Thank you so much, John. Eric, what would you add?

DR. SCHNEIDER: I think the one thing I would add, two things. I guess, one is that we do have measures available, they are not perfect, they need, we need better data again.

And control of some very common health threats, so diabetes control, control of high

blood pressure, depression screening, really focusing in on some of those. And maybe this reflects that I sat in a school with public health for many, many years.

But when you look at the ability of our public health system to measure those important outcomes, and you say maybe we ought to re-architect some of what we do in the clinical care delivery system, integrate that better with the public health system and figure out ways of sampling so that we can understand what's happening with populations on some very really important markers of health and that can reduce mortality and morbidity over time. Maternal outcomes is another area that I think that we want to focus.

So that's one point, and that would, we'd have to consider re-imagining how we would actually deploy that measurement system, because I don't think our current health data exchange infrastructure could support it, but we could design it.

The second point, this is just elaborating on John's point, is that the mix of services, that understanding the relative spend, and you've, total cost of care you can measure,

there are some challenges even around that.

But really understanding the mix of the services provided, what's going to primary care, what's going to emergency services, what's going to inpatient services, specialty services.

Because managing two organizations could have the same total cost of care and without knowing the outcomes, one of them could be doing a tremendous job, and the other could be doing a terrible job in terms of the mix of services offered with like excess of emergency room use. And we also know, I guess, in that context, we have to be careful not to be too optimistic that it can take two to three years to see these shifts.

So some of the return on investment conversations sort of say, well, what savings can you produce for me next year or within three years? And re-orienting the system and the mix of services, it's difficult to see that having the kind of impact on these health outcomes that would be within a two-to-three-year timeframe, we really should have a longer time horizon.

And I think this is one of the flaws of many of the studies of payment system models in general, is they didn't really allow enough

time for the interventions to have their effect.

CO-CHAIR HARDIN: It's a key point. Helen?

DR. BURSTIN: John's right, it's really hard going fourth, much of what I want to say has been said. But I'll just say, I want to emphasize something that goes back to one of the slides from the presentation earlier, which was the issues around unintended consequences.

Total cost of care has a number of intended consequences we already heard about. John's point about gated quality measures, really thinking about knowing, looking at costs.

If you've achieved a certain level of quality, it's really important, huge concerns about stinting of patient care that I think are, keep a lot of clinicians up at night about who's not able to get care and really want to emphasize the point that Cheryl mentioned about care being denied.

I think that if you have stinting, care denials, prior authorization continues just to be a huge burden, minimal relief so far from Congress, but huge burden on clinicians in really thinking about how we can really think about this.

I would hope within a context of a system, are there ways, for example in a population-based total cost of care model, to do something differently internally that might take some of that pressure off of your clinicians who are having to fight that constant battle?

Lastly, I just want to make the point that I agree that total cost of care is often at the system level, but I think as you think about the physicians and the other clinicians within your system, thinking about how that relates to them is still really important.

It's hard to feel like you are part of that actionable process, if in fact, it's measured at such a high level that you can't see what you do within that.

So kind of breaking that down and thinking about are there measures, for example, that look at shared decision-making or appropriateness that get us closer towards looking at ways that an individual clinician can play a role in total cost of care?

And then, want to just emphasize something I put in my slide at the start which is that so much of this really does happen now across clinicians, across, you know, across

settings.

And so really thinking about how you fit within a system that might, for example, include post-acute care or home care. And this just very broader vision of what a system is and what's population-based care and sort of being able to reflect how your quality fits within that, I think is going to be critical, which is why I think we still need those clinical quality effectiveness measures to allow different specialties to see where they fit within that paradigm. Thanks.

CO-CHAIR HARDIN: Integration is key. I'm going to ask one other core question, and then open it up to the Committee and give you a chance.

So for the next question, we want to hear about the differences between performance measures for total cost of care models and current performance measures in Medicare value-based payment programs and alternative payment models.

So the question is: What are the differences between performance measures needed for population-based total cost of care models and current performance measures used in Medicare

value-based payment programs and other Alternative Payment Models?

John, let's have you start this one.

DR. BULGER: Sorry, trying to get to the mute button.

CO-CHAIR HARDIN: No worries.

DR. BULGER: Great question. And I want to play off of something Eric said. And I think one of the biggest differences is I think if you're truly in total cost of care models, and I agree completely with what Cheryl talked about, is that, you know, moving at a snail's pace into these models isn't helping anybody.

It's certainly not helping patients, but I don't think it's helping providers, because it's allowing some of them to keep their heads in the sand, and others that want to move more quickly aren't able to move more quickly.

But these measures, the measures in total cost of care models really are long game. And I think right now, somewhat out of necessity, and given where we are, but somewhat out of quite frankly, I think, just being able to get past of the current state and think about a potential future state, we're not able to do long game models.

And you have, I think, a good example is the Medicare Shared Savings program, where you have very immediate year-over-year measures and the process by which those measures are calculated, and sometimes what those measures are, change on an annual basis.

And this total cost of care, population-based total cost of care models aren't short game models, they're long game models. They are things that are going to take, you know, three, five, or more years to see things happen.

So you need measures that recognize that, while also kind of having measures underneath that to be able to make sure people are moving in the right direction. You kind of need leading and lagging indicators, if you will.

And I think, you know, that piece is a piece that we really need to think about, because we haven't been able to, I think, in the measurement community.

And then I think providers haven't been able to get past it. It’s a little bit of a, you know, the hamster wheel of over and over with the same measures over and over, and you're thinking, you know, month-to-month, year-to-year, as opposed to thinking over time, you know, how

are we going to change the health of the population in I think really, a public health way. So to me, that would be the thing I would highlight around, what is the big difference.

CO-CHAIR HARDIN: Thank you. Eric, let's hear from you.

DR. SCHNEIDER: Yeah, I think there are a couple things that are difficult in the current model. The risk adjustment issue is the one that's probably kind of front and center for a lot of folks right now.

But I do think we really do need a, in a population-based total cost of care model, you've got to be able to assess risk for the population, and to do that well. The Netherlands has a system actually of re-allocating funds among the insurers based on the risk of their populations in any given year.

So that the notion there is to reduce the risk gaming that can go on of trying to push people out of the model or bring healthier people into the model, push sicker out of the model.

And so another solution there is you can do the cross-sectional approach, or another solution is to be able to follow the people through their journey and understand whether that risk

selection is occurring or not between organizations.

So if someone dis-enrolls from the population-based total cost of care, if a person dis-enrolls and moves to another care setting, whatever that may be, maybe they become homeless, that you know that, that the system knows that, the system can account for that.

Because right now, there's still, and in any risk-based payment model, there's going to be this natural tendency, it's a lot easier to sort of cherry-pick your way to a lower-cost model. So I think that, I might just sort of emphasize that piece, which we hadn't really talked about much.

CO-CHAIR HARDIN: Thank you. Helen?

DR. BURSTIN: Great, thank you so much. So a few reflections. I think that very much the idea of thinking about how we have measurement at the team level, I think, is an important consideration.

Those may not look like the same kind of measures we have now. We talked about a lot of these early on, measures that more reflect collaborations, communication, access, communication across specialties, across the

system, I think are going to be critical.

I also think it's really important that we consider the ways that care has innovated and make sure that the measures go along with that. So for example, very few measures really reflect telehealth. We have a really hard time collecting data on what happens in a telehealth encounter to know whether it was in fact high-quality.

Hospital at Home, there are just numerous examples like that where we have to start thinking about where as carers in the vetting, where are the ability to look at those kinds of measurements and make sure that we're appropriately capturing those.

I think it's also really important that we think about how we get to some of the outcomes that matter. I think, just an example here, I think many of these, for example, critical outcome measures are often reflected in clinical registries, often still very difficult for those measures to be used as part of these processes.

One of my favorite expressions is that data travels at the speed of trust. I think there's not a lot of trust right now in the

overall system of how those data will be used.

Will they be used inappropriately, and how do we create those sort of principles and guardrails that allow us to collectively work together to build on measures already developed for and by clinicians that represent what they would consider the highest important outcome measures that they want to be and will get their benchmark data back on, because it then allows them to reflect on how they can get better?

We have numerous examples of that, where not only do you get benchmarking, but if you don't do well on one of those performance measures, you then get linked to your specialty society's CME[19] to say you didn't do very well on this, how are you going to improve?

So I think, thinking, I think broadly about how we bring in those registry-based measures which also get at some of that intrinsic motivation, it's not all about money. Some of this is also the intrinsic motivation of showing people their data compared to their peers, and understanding where they fall short, I think are huge opportunities overall.

And again, I think just broadly

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thinking that many of the quality measures we have now are the same ones we've talked about for years. We've been talking about blood pressure control, diabetes control, et cetera, for years and years.

Not that we've done especially better on them, I wish we did, but I think we do need a broader lens on what happens in care, and I think that's a place where particularly Specialty Societies can really help think about how that comes together. Thanks.

CO-CHAIR HARDIN: Really interesting. Cheryl, what would you add?

DR. DAMBERG: I'm going to plus-one on what my co-panelists have said. But you know, as I was thinking about this question, I don't know that the performance measures differ, but I think kind of what gets done with the information and how the information is used.

So I thought a little bit about what John was saying about the long game and this issue of knowing you're responsible for a population because I think to some extent what's happening in a number of Medicare's performance measurement and value programs is, you know, it's essentially the unit of accountability is the

individual.

The individual hospital, the individual provider, such as in MIPS. And while it's important to measure their performance, it doesn't always feel to me that the information then is used kind of by the organization in a collective sense to drive system improvement.

And I think the difference between these population-based total cost of care, you know, accountability-type structures, is that you start moving away from a siloed approach to something that looks more like an organization can respond and think about how to transform care delivery.

And you know, it's not clear to me, say in the MIPS program, that physicians are actually looking at their performance and doing much that's any different.

Particularly since they can self-select the measures and, you know, that provides its own opportunity for gaming. And so I feel like in many ways we have a bifurcated world where you have now roughly 50 percent of physicians who are employed by health systems or hospital systems.

You know, they're part of large

organizations that can bring different types of resources and organizational supports to the table to help improve performance.

And then you've got, you know, what remains of the small practices, and, you know, a lot of those can be in rural environments. And, you know, again, what's their ability to be able to respond to a set of metrics, you know, even if they know their performance.

So, at the end of the day, I don't know that we want sort of different measures for different spaces, but I think the ability of the end user, if you will, to be able to act on them and make change differs tremendously between those environments.

CO-CHAIR HARDIN: So helpful. So Committee members, I want to encourage you to tip your name tent up if you have a question. This is a great opportunity to tap into the expertise of the panelists. And Larry, let's go to you first.

DR. KOSINSKI: I have so many questions, but I -- my first one's going to be for Cheryl because you really triggered a thought process with me with your first bullet.

And I have to say, I totally agree

with you that the core objective is not just to measure performance, but to move health systems towards building a measurement infrastructure on their own. So what does CMS do?

What do commercial health plans do with their ACO agreements? How prescriptive do they get inside these organizations to help them build this infrastructure?

When an airplane door flies off a 737, the FAA shuts down every 737 until it's been corrected. Whereas when something happens inside of an ACO, be it Medicare ACO or a commercial ACO, that doesn't happen.

Where's the border between building that infrastructure and being overly prescriptive? How would you implement this first bullet you gave us?

DR. DAMBERG: So I think the government is loath to be over-prescriptive, and I think that's always kind of a difficult space for them to operate in.

I guess my observation of having watched the world unfold over the past two decades is that a lot of the performance measurement that commercial payers and government payers, whether it's Medicaid or Medicare, have

put out there, have led health systems to invest in building their own measurement infrastructure.

Some are farther along than others. Some have the resources. So, you know, these physicians who are in small practices, you know, have, you know, not been able to build that kind of infrastructure.

But, you know, for many of them very large systems, and John, you can speak to what Geisinger is doing. You know, they've built very robust dashboards, and they're measuring not just primary care, but you know, have delved into the specialty care space.

Although I would say, you know, when I looked at the types of measures that they're measuring internally and incentivizing their providers on, the specialty care space is usually the weakest link.

And I think to Helen's earlier point, you know, we need to sort of do better in, you know, working with the specialty physicians to build a set of measures, and you know, build out that dashboard because I think that really is the weakest link that I see right now in what I would call the internal infrastructure and performance dashboard of health systems.

DR. KOSINSKI: So you would favor incentives or a payment structure to a health system based upon evidence that they're building that infrastructure?

DR. DAMBERG: No, I think if you put the performance measures out there, so let's say we had a better set of, you know, specialty measures, I think the systems will build their own internal systems around that because you know, they are interested in securing the financial incentive, right?

And so they need to be able to measure and track that in real time to figure out whether they're going to land and whether they need to pivot, you know, to try to improve their performance.

So you know, my own personal view is I don't think you need to be overly prescriptive. I think you need to send the right directional signals.

DR. KOSINSKI: Okay.

CO-CHAIR HARDIN: Eric, I see you're comment.

DR. SCHNEIDER: Yeah, I couldn't help digging in on this just a little because the health data exchange part of this is so central,

and in some ways we've done ourselves a favor by not getting this right until now.

But because the health technologies have advanced to where it could be extremely low-cost, and the government is already doing what I think would support what you're describing, which is to create the health data standards, the exchange capabilities, the same thing that powers the rest of the internet, same thing that allows any browser to attach to the internet.

That technology can now be brought into health care safely with bright privacy protections and other considerations. And so I think it actually ends up being industry-led rather than the government sort of creating a mandate.

It's more creating the conditions under which everyone is doing their work and supporting that. So TEFCA[20] is a Trusted Exchange Framework mechanism that's just getting stood up.

There are six organizations participating in the TEFCA Exchange Network. The health data standards are advancing sort of year by year.

And a lot of what seemed like it was

20 Trusted Exchange Framework and Common Agreement

going to have to be like people investing or individual organizations investing in systems now is looking like, just get your system mapped so it can participate in the health data exchange through fasting the health care interoperability resources and using computing power, which didn't exist.

Cloud computing power, those standards all are five to 10 years old at most. So there's some technological changes that as we're thinking about this design, we actually want to build toward that.

If we try to build for today's system, we're going to miss that boat, and that's driving a lot of our strategy at NCQA as well.

CO-CHAIR HARDIN: Go ahead, Helen.

DR. BURSTIN: And just one very brief comment that very much builds on what Eric has said as well. I think if you want to build out, if you want to ensure systems all have the right approach to developing their qualities, reporting systems internally, the dashboards that Larry asked the question about, really important as part of that you also measure the burden on the clinical teams.

They may say they have a system and it

works great, but the burden can all roll down to the clinical teams to in fact be collecting those data because a lot of what you're talking about, Eric, is wonderful.

And it's still, you know, the future is coming and still is, right? We're still waiting for that to sort of happen at the point of systems being able to use those systems.

But I think, you know, being able to pair, for example, measures that look at staff turnover or burnout within a health system to these dashboards would also be appropriate.

There's nothing that says it has -- it's always about patient care. It can also be about the health of the clinician community, and the costs of turnover are tremendous in health systems.

And so really thinking broadly about what you might measure to get that full perspective, I think is an important consideration.

CO-CHAIR HARDIN: Excellent. Let's go next to Jen.

DR. WILER: Actually, that was a great segue to the question I'm going to ask, which I'll just say might be an unfair one. If you had

a magic wand, we've heard in the past around the use of mandatory fill in the blank.

So my question is going to be, if you had a magic wand, what things might you make mandatory? And to get you thinking, the things we've heard in the past are multi-payer programs.

I heard maybe mandatory empanelment or participation in a program, maybe a mandatory measure set, maybe mandatory removal of prior authorization, maybe mandatory creation of specialty care dashboards, maybe interoperability, maybe turnover.

I want to give you the opportunity to talk about what things you think are so important, again, not thinking about the fill in the blank regulatory, political, cultural headwinds, but what might be essential mandatory elements for success. I think that was obvious, but.

DR. SCHNEIDER: I'll take a first crack at it. I actually think the multi-payer participation arrangements would be valuable because there is so much movement throughout the system of people and providers.

If anything some of the mandates

already exist around ONC[21] and health data exchange. The information blocking rule sort of says that you can't -- you have to make the data about a patient available in electronic form through open API[22] architecture.

The same thing that powers the internet. Everything else we do that organizations' electronic health records have to create that capability.

And then to the extent that EHR vendors, of which there are still many, but a few dominant ones implement that, then it becomes easy to participate in that sort of multi-payer environment because there are also standards for health insurers around the care and blue button standard, which enables that same exchange.

So if I had -- if I were going to -- if I had to pick one, I would pick the multi-payer participation and through the Trusted Exchange Framework or some other mechanism that creates this liquidity of data that would support not just performance measurement, but a whole bunch of other administrative simplification and burden reduction.

CO-CHAIR HARDIN: Helen, did you want

21 Office of the National Coordinator for Health Information Technology
22 Application programming interface

to go next?

DR. BURSTIN: Sure. That's a really hard question and hard to have a simple response to it. I guess I'm a lumper by nature, so I'll say mandatory is anything that increases relevancy and decreases burden.

And so I think the ways to do that are multiple, but I think in particular, thinking about ways to get at consistency of measures with decreased burden and higher relevancy, I think it should be -- that should just be where we go because otherwise people are just spinning their wheels, creating measures that don't in fact serve any useful purpose.

So eliminate measures that don't add value, focus on the ones that do, and figure out how to do them in a way that's easier and more consistent. And I'm sorry, that wasn't one thing.

CO-CHAIR HARDIN: And Cheryl, I'm going to go to you next.

DR. DAMBERG: I agree. This is a hard question, and I think I'm at a plus-one what Eric said in terms of multi-payer participation, not just in terms of trying to align what providers are being asked to pay attention to and devote

resources to.

But also, you know, the interoperability and exchange of information that can work to coordinate care across settings and enhance care delivery and hopefully potentially reduce low-value care.

You know, in terms of other mandatory type features, you know, I think what I've struggled with, and I'm sure that this group has as well, is, you know, CMS covers, you know, a very large complex, you know, array of health care settings.

And, you know, they're trying to send signals to providers in multiple settings. And I think we historically have done a poor job of identifying good care coordination measures and measuring that across our system.

And I think, you know, what I would like to see, and I don't know how you mandate this, but I think we have to again, you know, rethink sort of the ongoing siloed approach to the performance measurement that's happening across all these different settings, not just in Medicare, but you know, in the commercial space as well.

So, I know that there's not sort of a

hard there there, but, you know, I think care coordination is something that needs to be front and center and kind of a core mandate because people touch so many different settings, especially as they get older and they need more complex care services.

CO-CHAIR HARDIN: Thank you. And John, would you like to add?

DR. BULGER: Sure, yeah. It is a tough question, and I think the other I think it was as Helen noted the simplification piece. And I think this notion of getting everybody involved and in a multi-payer fashion, I think I would agree with both those.

I would say if I had to do something mandatory, it would be a mandatory glide path toward total cost of care models because I really think part of why we are where we are is because of the fee-for-service system.

And we really have a fee-for-service payment system for services, and we have a fee-for-service, pay-for-performance model for quality payment.

And I think many times providers look at both of them as widget models, if you will. And I think, you know, we're not making widgets,

we're taking care of patients.

And I think that those models are much of what's holding us back. I think if we could get a guide path, as I said, to where we're going to go and not -- and agree to it, stack hands on it and say, we're not going to go back on that.

So I think, you know, the classic go back was we had a glide path with mandatory bundles several years ago, and that stopped, and that I think set us back years in how we take care of patients, but also set us back years in those areas about how we were looking at quality assessment.

Because I just think of what we were doing when we knew those mandatory bundles were going to happen and talking about it from a quality assessment standpoint, and much of that went out the door when those went away.

And I just hand that -- I take a -- I've taken a very different view of the way I look at things, whether -- when I'm wearing a health plan hat, when I'm have a total cost of care responsibility for a population versus maybe when I was Chief Quality Officer and was looking at a program, and not to pick on programs, but a value-based purchasing for the hospitals.

And it was a very transactional look at the value-based payer program. Whereas the total cost of care program on the health plan side is really looking at, you know, how do I get the -- what's the quality, you know, from my members, but what subsets of measures do I need to be able to drive that quality and to get people?

I think Helen said it great earlier to get people to trust and work together for a common goal.

CO-CHAIR HARDIN: That's great. I'm going to add a follow-on question that was submitted. So it taps into what you've already been talking about.

So this question focuses on measuring aspects of system transformation. For example, care coordination and team-based care. So what should be the mixture of quality, outcome, patient experience, process, and utilization or cost measures for actually measuring system transformation?

Or should it be the same? That's the question submitted. Who would like to start?

DR. SCHNEIDER: I'm feeling bold today. I'll go. I do think it probably switches

the focus more toward the outcomes and equity and other system level kind of outcomes.

And the reason I worry about that is there's also a lot of care model innovation going on right now. Some of it won't persist, but there are companies getting into lifestyle coaching and management support that are still operating independently of the health care system.

In some ways they don't integrate well. When they try to integrate, what they can do is provide a PDF to people that they can bring to their doctor, which isn't kind of a workable.

So, it's an interim solution, but it's not what we'd like to see ideally. But I think Helen made the point earlier about the telemedicine and the virtual care models in behavioral health.

It's almost a mandatory sort of not mandatory, but it's a clear path that we have to go toward to meet the needs of the population. And then the innovation around who's providing the care, community health workers, peer counselors.

If we over index on process measures, we kind of start to impede that innovation, which

could create a better team-based care environment, better care coordination if we enable it.

So we don't want to sort of get in the way of it with by over-engineering process measures.

CO-CHAIR HARDIN: That's great. Helen?

DR. BULGER: Yeah.

DR. BURSTIN: Generally agree with what Eric pointed out, particularly around equity and thinking about care coordination as measures that are really important, obviously at the total cost of care level for system transformation.

I'll just emphasize what I said earlier. I also think, you know, a critical part of health system transformation is actually ensuring that we take good care of our clinicians.

So let's not forget about that and the burden that this all places on them and figure out how to do this in a way that both is not a huge burden to them.

But at the same time provide information back to them measurement-wise that sort of allows them to build on their intrinsic

motivation to take better care of patients because it's relevant and actionable. Thanks.

CO-CHAIR HARDIN: And John, it looked like you were trying to comment. Am I reading you correctly through the Zoom?

DR. BURSTIN: Yeah, I think, I mean, I think it's a great question. To me, it's the same as other things, but what I would say is that in the total cost of care model I don't think that you are necessarily going to -- you're going to report on that transformation if you choose to report on it because you are reporting the research or you're reporting to make the world a better place.

But it, you know, those -- there shouldn't be accountability measures in my mind that get reported for those transformation. Now, I think, you know, using the example of what we've done at Geisinger at home, at Geisinger, which is an at-home model where we take care of the sickest of the sick at home.

We do that because it makes sense in the total cost of care model. And we probably wouldn't have done that if it was a fee-for-service-based model because it wouldn't have made sense just to bill per service for that.

But if you're in a total cost of care model, it makes complete sense because it does a better job taking care of the patient and thus decreases the total cost of care.

But we measure all kinds of things to see how that model is working to make sure that it is actually decreasing total cost of care because you could get in the trap of providing a very expensive care set, and it actually costs more than the care, and you essentially end up wasting that resource.

And the other piece in the health care system, we have finite resources, whether it's physician resources or nursing resources or all other pieces of the puzzle for resources.

So we need to measure to make sure that for each time we're providing that care, we're actually doing something. And I think lastly, I would say you need to look at equity, and you need to look at the patient's experience with it.

Because in that program, for example, if you -- if they're going to let you into their home, they need to have a great experience, or the next person they're not going to let you into their home, and you're not going to be able to

get them the care they need.

So I do think there's -- it's that broad portfolio of measures, but it's not mandated by someone else. Just the general, the model, because you're now in a total cost of care model. It will end up creating innovation around the measurement and how you look at those programs.

CO-CHAIR HARDIN: Thank you. We have only five minutes left. Walter, is it a lightning round question we can go to?

DR. LIN: Yes, it is. I'll try and make it quick. Just wanted to thank all panelists for a really rich and informative discussion. I've learned a lot.

I wanted to just maybe end on this concept of a balanced portfolio of measures that John brought up. You know, I think all of our panelists, it's probably safe to say in terms of measures under total cost of care models.

First among equals would be the total cost of care. We also talked a bit about stinting, rationing, patient sensitivities to that. What other kind of guard rail measures or balanced portfolio measures would our panelists include in kind of the top level most important

measures to achieve that balanced portfolio of measures?

CO-CHAIR HARDIN: Eric?

DR. SCHNEIDER: I guess I would go back to the safety reliability conversation because I think in the hospital setting, we've come up with better measures of safety and reliability, but I don't think we've done that as well in the broader ambulatory setting population, you know, care at home.

I, you know, the care at home actually is an interesting example because there are -- anyone who tries to operate a Hospital at Home program is going to definitely build in those safety measures as part of the endeavor.

So it really does go back to Dr. Bulger's point about you'll actually build the measures you need, and safety and reliability would be one I would add.

I also want to second Helen's comment about the staff and workforce in making sure that they're feeling that the care is safe and reliable.

DR. BURSTIN: Just building what Eric said, the first thing I wrote down was patient harm. So I think there's like a little mind meld

happening here on this side of the table.

I think patient harm has got to be there. We've got to really always keep in mind as much as we're saying we're improving outcomes; we still have significant safety issues in this nation.

And so thinking about issues, a balanced portfolio should include measures around harm. I think it should include measures around equity coordination.

And I think since so much of the discussion is about thinking about, for example, a specialty portfolio, for example, I think getting at measures of appropriateness both in terms of eliminating low-value care.

But at the same time ensuring high-value care is provided and that we're not having stinting, and we're not having difficulties with access because of prior authorization health plans. Thanks.

CO-CHAIR HARDIN: And Cheryl?

DR. DAMBERG: Yeah. So I would plus-one what's been said. I think it's particularly important to look at access issues. You know, whether that's in the form of denials or just, you know, wait times.

You know, I've had a recent personal experience of being referred to a specialist and not being able to make an appointment for a year. And I have very good insurance, and you know, so there are a lot of complexities in play in the marketplace right now.

And you know, one of the types of measures, you know, when you think about care transformation, I think Eric touched on this earlier about, you know, where are the dollars going? And is this sufficient, you know, revenue going toward primary care?

And I think, you know, and Helen touched on the burnout issue. You know, I think that, you know, we have greater demand than we have providers to provide the set of services.

And so, you know, then noodling on, do we start to introduce some other structural type measures looking at, you know, the physician supply or the clinician supply that's available to care for patients within the system?

And, you know, you can look, and I've started to do some of this work on the Medicaid side at, you know, the adequacy of provider networks.

And oftentimes, you know, patients who

most need care are living in what I would call ambulatory care deserts. And so I think this whole issue around access is going to be paramount within the context of total cost of care models

CO-CHAIR HARDIN: And John, would you like to add in as well?

DR. BULGER: Sure. I think, and I agree with all of that. I think it's all well laid out. I think I'd just add at the end here that I think some measurement of churn, so some understanding of the ins and outs within the covered lives or the, you know, the panels or however you want to look at it, that takes into account obviously death and other things that would not necessarily be in control.

But the notion of are you creating a system that you're trying to gain by moving people in and out and trying to cherry pick, or have you created a system that patients can't get access, that they have to move to someone else?

But I think some measure of churn would be important in these programs.

CO-CHAIR HARDIN: I want to thank each of our panelists for very valuable, rich dialogue. We've covered a lot of ground today.

We want to encourage you, you're welcome to stay for the rest of the day, and we want to thank you so much for your valuable time.

It's really helped to inform the dialogue. At this time, we're going to take a break, and we will resume again at 1:00 p.m. Eastern. So please join us then.

We have a great lineup of guests for our first listening session of the day. Thank you for joining us.

(Whereupon, the above-entitled matter went off the record at 12:09 p.m. and resumed at 1:02 p.m.)

*** Listening Session 1: What Do We Want to Measure in PB-TCOC Models, and How?**

CO-CHAIR SINOPOLI: So welcome back. I'm Angelo Sinopoli, one of the co-chairs of PTAC. I'm pleased to welcome three experts who have experience in leveraging payment features to encourage some of the innovations that we've been discussing today.

You can find there are full biographies posted on the ASPE PTAC website, along with their overview slides. At this time, I ask our presenters to go ahead and turn on your videos if you haven't already done so.

I'll briefly introduce our guest and then give each presenter time to share their perspective on the topic. After all three presentations, our Committee members will have plenty of time to ask questions.

First, we have Dr. Thomas Sequist, Chief Medical Officer at Mass General Brigham. Tom, welcome. And you can start.

DR. SEQUIST: Oh, great. Thanks so much. So I'll just take a brief minute just to give a little bit about my background so you can understand where my perspective is coming from.

So I am the Chief Medical Officer at Mass General Brigham, which is a full hospital system here in Massachusetts and New Hampshire. In that role, I oversee quality for our system, patient experience, equity, many -- all of the topics that we're here to discuss today.

I have also had a 20-year career as a health services researcher and have done a lot of research into the science of quality measurement. And so hopefully what I'm going to be able to do is give you some of my perspectives of 20 years of working in a delivery system, overseeing population health programs, and hospital quality programs during that time.

And seeing the evolution of a lot of the important work that has happened in our field. So let me just start off with, and you'll see my slides tend to be a little bit less dense.

And because I just am hopeful to share with you some important concepts, at least from -- important from my perspective, and from the -- I'm going to give a heavy delivery system perspective on this.

So the first question in the space of quality is what are we hoping to achieve? I mean, we measure quality for the primary purpose of improving. That should always be our goal.

We have secondary goals of measuring quality to ensure accountability to help patients and providers make choices around care as well. But our ultimate sort of North Star should always be, we're trying to make care better.

How I think of defining quality is that we are trying to do really four things. We're trying to achieve the best outcomes possible.

That's not just survival, but that's functional status, physical functional status, and emotional well-being. The second thing we're trying to do is ultimately deliver the best

experience to patients.

That includes service excellence, but also respect, dignity. And I think increasingly recognized is doing that through a lens of empathy which sometimes can be lacking in a very busy and stressful care environment.

And then lastly, equity in everything that we do, whether it's in the services that we provide and the way we communicate with people and ensuring that we are avoiding and fighting against structural racism in health care.

Finally, we are trying to do all of this with as little waste as possible. The challenge really in quality though has been, how good of a job have we done in achieving this?

I think one of the issues is we think about quality measurement, pay-for-performance programs, and financial incentive programs, which include value-based purchasing programs and total cost of care programs, is how have we prioritized the things that you see here on this slide?

So have we put first and foremost the notion that we are going to improve patient outcomes through all of the designs of programs that we have?

Are we then going to deliver the best

experience possible and ensure equity in everything? I think what we've often done, if we can go to the next slide, is we have probably done those approaches that work around outcomes, around experience, around equity, and in cost control.

We probably approach those things through separate pillars. And that's been a challenge as I'll talk a little bit more about. So ultimately, over the past 20 years, what have we really achieved?

Slower than we would like, improvements in the translation of evidence-based care for those conditions, especially those conditions that cause the most morbidity and mortality.

So when we think about cardiovascular disease, cardiometabolic disease, and now increasingly new pandemics like the substance use disorder pandemic that's swept across the country.

The second is that we've had limited transitions to a high-functioning service industry. So when we think about, you know, whether or not patients feel that they get a coordinated care experience, that they understand

the communication that is happening to them -- with them, that they do they feel empathy in the messaging that's delivered to them, and ultimately can they, at a base level, access to care that we are providing across our delivery systems.

I think across the country, we've had a limited transition to this focus on service. And then lastly, which, and I think is actually one of the most important things that we could all talk about when we develop quality measurement programs and incentive programs through CMS and other payers, is that we have seen, despite probably now 30 years of research in health inequities, we have seen persistent and now even worsening health inequities.

And we don't need to focus only on health inequities that we saw emerge as a result of the COVID pandemic. And we saw obviously horrific inequities come out through the result of the COVID pandemic.

We also see worsening inequities across the board, whether it's in, you know, trainees and development of physician professionals and nursing professionals, right?

We are not seeing gains in the

diversity of our workforce, but we are also seeing -- we're seeing inequities in cardiovascular outcomes and other important outcomes.

So and total cost of care is very, very important for us to have a functioning health care system, obviously, and to be able to achieve the goals that we want to achieve.

But one of the things that we need to think about is that, like I said before, these goals that we have around outcomes, experience, equity, and total cost of care, they need to be aligned and worked on in a collaborative manner.

I think when you get down to the level of the health system, you'll find that any ACO or integrated delivery system or hospital network system or ambulatory multi-specialty group practice will find themselves with multiple competing priorities.

If you are an ACO participating in multiple of the CMS programs or commercial payer programs, you'll find yourself focused on at what's home hospital metrics and rehabilitation metrics.

Some programs in the hospital quality space that are disease specific, some in the

ambulatory space that are more holistic around episodes of care.

And the priorities that get sort of brought upon us in these settings can make it hard to sort of coordinate the work that you're doing. I think also if we are truly to focus on an outcomes orientation for our delivery system work, what we find is that you are often focused on financial planning for that year.

And in a pay-for-performance framework, that really is for that year while the clinical outcomes goal that we hope to achieve is maybe five years on the horizon.

So if we are hoping to reduce overall cardiovascular morbidity and mortality, or let's say just say mortality at the population level, that is a five-year-plus endeavor.

However, the finances built around pay-for-performance programs actually don't support that long of a timeline and can make it challenging to really bring together our financial goals and our clinical outcomes goals.

So ultimately, then what happens on the ground is you just have confusion around the direction that we should be following around incentive programs.

That remains one of the challenges. It's not a new challenge. It's related to the common challenge that you will hear that there are many, many different quality measures.

But it's not just that there are many quality measures which can be managed, although there are some expenses associated with that. What's the bigger challenge is the alignment and the coordination of them.

How do we as frontline clinical teams sort of spend our day? And frontline management teams, how do we spend our day? So I just want to kind of reemphasize something that I'm sure that everyone has seen before, which is how we talk about quality.

So if we take a, like a very traditional view of quality, we might break it down in two zones. One would just be content areas. That would be like the traditional sort of IOM[23] model from the late '90s, which would say effectiveness and timeliness and safety and equity and experience and efficiency.

Those are the sort of the content areas. And then there's this other way of thinking about quality around structure, process,

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and outcome. I put up the structure, process, and outcome because I think sometimes in our models of quality measures, we sort of mix up the concepts of the content that we're talking about, whether it be safety or experience, and the model or structure, process, and outcome.

When we think about structure, process, and outcome, the goal that we should really always have in mind is ultimately we should always be building towards improving outcomes in our measures.

So when we have structures and processes, we should be developing quality measurement programs that actually lead us down the road towards a better outcome.

And I think sometimes we've fallen short of that, and we've gotten stuck on the structure and process side. I think, you know, more than 50 percent of the quality measures in CMS programs these days are actually in the structure and process bucket.

And so far, fewer of the measures are actually in the outcome bucket, which is actually what our ultimate goal is. Next slide. So how do I think we can promote better patient outcomes in population-based total cost of care programs

over value-based programs?

So the first point I was making on the prior slide, we really should be strongly evaluating programs for inclusion of outcome measures over process measures and structure measures.

That doesn't mean that any given year there always need to be more outcome measures and process and structure, but we should be moving structure and process measures along a pathway that always leads to outcome measures.

The second thing we should be focused on is bringing clarity around what is a quality measure versus what is a utilization or an access measure.

We increasingly, especially if we want to control total cost of care and we are incentivizing physicians, physician group practices, or even hospitals, we shouldn't confuse the notion of complete utilization metrics with quality and outcomes measures.

But the third thing I would say is that we want to start to synchronize and be inclusive for hospital and ambulatory metrics. We have to really start to understand that the hospital-based value-based purchasing program

from CMS actually does have direct implications for our ambulatory HEDIS metrics.

And make sure that we are syncing those programs together. And then lastly, we have a much longer history of primary care quality measures than we do ambulatory specialty care, yet most ambulatory care is delivered in the specialty space.

We have to be able to understand how to move the dial further down the path for specialty care in terms of measuring outcomes in the ambulatory specialty area.

So we go to our next slide. How do we promote experience? In total cost of care programs, I think we have to really start to value communication, coordination, and empathy as outcomes unto themselves.

They don't, you know, these patient experience measures whether we're talking about HCAHPS[24] measures or other versions of patient experience measures.

They don't have to specifically link to a clinical outcome to be valued, a patient's experience and service actually is important unto

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itself.

We should, in that vein, then be focusing on more objective reports of care over subjective ratings of care. So rather than saying, how would you rate this hospital one through 10, focus on the actual activities that happen in the hospital from a patient report like, were your medications explained to you at discharge?

And lastly, how to promote equity in total cost of care? We have to really, because that gap is growing, despite all the literature around this space, we have to really start to obsess over closing that equity gap in outcomes.

That means really set it as the highest priority in all of our performance measurement programs. One of the things that we have to avoid doing in all of our performance measurement programs is implementing programs and then learning three years later, how big was the inequity that was created by the implementation of the program.

We know enough now that we can predict when inequities are going to develop as a result of performance measurement and incentive programs. So we have to really be on top of that

in a prospective way. We need better data.

We need to understand not just race, ethnicity, and language. We need to understand all the social risk factors that go into predicting clinical outcomes.

We need to avoid measures that keep us stuck in that structural space. So measures that focus on things like creating equity improvement plans are not the way that we are going to move the needle for really what I consider to be an urgent crisis in public health, which is this equity gap.

And in particular, the gap created by structural racism in and across our health care systems. So we really need to avoid those structural measures or getting stuck in those structural measures.

And then lastly, being thoughtful about risk adjustment, and especially as it relates to reimbursement and outcomes. I won't go into all of the details on this, but it's really important for us to understand when we take race, when we take some of the risk factors, social risk factors that we can use as Sarah gets in the CMS data, whether it's dual eligibility or

other sort of CDC25-designated area risk indices.

We have to understand that those levels of risk adjustment and when we try to make -- apply risk adjustment in that setting, all that does is sort of bake in and standardize the current inequities that we have.

If we're going to really address inequities in the space and do it through risk adjustment, we have to acknowledge that we need more resources than are currently being delivered to even the best hospital systems right now to care for, let's say Black and underserved populations.

So we have to be much more thoughtful about that if we're going to take on equity overall. Thank you.

CO-CHAIR SINOPOLI: Thank you. That was great information. Appreciate all of that. Next, we will have Dr. David Meltzer, who is the Chief of the Section of Hospital Medicine, Director of the Center for Health and Social Sciences, Chair of the Committee on Clinical and Translational Science at the University of Chicago, and Fanny L. Pritzker Professor of Medicine, Department of Medicine, University of

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Chicago Harris School of Public Policy and the Department of Economics, and a previous submitter to the Comprehensive Care Physician Payment Model, CCP-PM, proposal. David?

DR. MELTZER: Great. Thank you so much for allowing me to present. I really appreciate the opportunity from PTAC and ASPE. Just to say a little more about my background before I jump into the topic of measuring the desired characteristics of outcomes for population-based total cost of care models.

By way of introduction, I'm a practicing general internist, both a primary care physician and a hospitalist. I want to take this opportunity to thank Dr. Burstin and Dr. Schneider for being my clinic preceptor and one of my residents way back when I certainly wouldn't still be practicing after all these years were it not for your teaching.

I'm also a PhD in economics, and I'm a professor here at the University of Chicago where I run our Section of Hospital Medicine. My research focus over the years, oh, you can go to the next slide.

My research over the -- over many years has really focused on the value of medical

specialization. I used the inpatient general medicine services at the University of Chicago as an opportunity to study the effects of specialization with the development originally of hospitalists.

I studied the effects of hospitalists and outcomes and found really limited evidence that hospitalists made a big difference. And this led me to wonder why hospitalists had grown if they really weren't so much better.

And I came to the conclusion a lot of this was because of the changing nature of primary care with falling hospital volumes for traditional, general internists so that it just no longer made political sense for them to block their mornings to see patients in the hospital.

But I also realized that this caused a compromise in the doctor-patient relationship, particularly for patients at high risk of hospitalization.

And this allowed me to develop the Comprehensive Care Physician Model or CCP model in which primary care physicians focus their practice on patients at increased risk of hospitalization so they can care for them both in and out of the hospital.

And I studied this through several randomized trials at the University of Chicago Medicine, and the results of these will form a lot of my comments today.

And I'll just point out that the University of Chicago exists on the south side of Chicago. It's an actually very competitive health care market, and one that serves a lot of very socioeconomically vulnerable populations.

And so it's an area where sort of success of these models is maybe particularly challenging but important. Next slide. So let me talk a little bit about the results of our CCP studies.

The first of these was a CMMI-funded 2,000-person randomized trial that compared CCP to standard care with different doctors in and out of the hospital within Medicare patients at the University of Chicago who were at high risk of hospitalization.

We found really striking results. In terms of HCAHPS scores, the rating of the primary care doctor increased from the 20th percentile at baseline when people entered the study to the 95th percentile for CCP.

It actually increased also to the 80th

percentile for standard care because we got these folks who weren't happy with their doctors, a new doctor, but a different one in and out of the hospital.

In terms of utilization, their key finding really was a 15 percent decrease in hospitalization. This was evident in self-reported data, which is what I have here.

We've also analyzed it in Medicare claims now. And what that shows is same pattern overall of 15 percent decrease, but actually a 30 percent reduction in non-dual eligible.

So patients just with Medicare and not Medicaid. And in those with Medicare and Medicaid, the dual eligibles, we saw a 10 percent decrease, so much smaller and not statistically significant.

The reasons behind this smaller decrease in the dual eligibles I think are very important for this discussion today. A big part of it is that there was an artifact really due to what turned out to be two-fold greater retention of high-risk patients in traditional Medicare compared to managed care in the CCP program as opposed to the standard care arm.

And that happened in the context of

Illinois' Medicare, Medicaid alignment initiative, where basically the dual eligibles were involuntarily enrolled into managed care, and they could only opt out.

And the sick patients decided to stay with us because they thought they were getting better care from us, and that was not truly in the standard care arm.

So we had sort of adverse selection. I'll come back to that in a minute. The other big reason I think the original program wasn't as successful in duals was the failure to address unmet social need.

Now in 2018, we came to PTAC to propose a per member or per month payment model to support the growth of CCP. And it was recommended for limited scale testing, but you know, with Primary Care First and a variety of other things, that never happened. And, of course, COVID.

One of the next studies we did really was to develop an intervention to address unmet social need. This was originally funded by the Robert Wood Johnson Foundation.

We called it the Comprehensive Care Community and Culture Program, or C4P. It's

screened. In addition to CCP, it added screening for unmet social needs, a community health worker, and a community-based arts and culture program to activate patients.

In our pilot work for this, and now a subsequent PCORI[26]-funded 3,000-person RCT[27], comparing C4P to CCP versus a Partners-like Care Coordination Program.

Our interim results are showing that C4P dramatically reduces hospitalization for CCP even for the duals and especially for the least activated patient.

So we think this really is an important addition to this to meet the needs of vulnerable patients. Next slide. So in the next few slides, I really want to address one of the questions of the day, which is these performance measures for population-based total cost of care models.

I'm of the belief that measuring both outcomes and care processes are critical goals for performance measure in these models. If we want to improve outcomes, including controlling costs and patient satisfaction, we have to

26 Patient-Centered Outcomes Research Institute
27 Randomized control trial

measure them if we wish to improve them.

I do wish to highlight there's some reasons for concern. There may be instances in which improving measures for populations most easily accomplished by sacrificing them for some subgroups for whom it's much harder to move things.

One of the particularly extreme versions of this is that in many instances, improving measured outcomes can be more readily accomplished by avoiding high-risk or high-cost patients than improving outcomes for the ones you keep in the program.

This is particularly true for costs where a handful of people often account for the majority of costs, and avoiding them is far easier than doing the job we should be doing of actually addressing their problems.

I also want to highlight that linking performance measures to payment can have some complicated consequences. In fact, disincentivizing measure improvement.

We've seen this in patient experience measures where, for example, we get rid of the top category of excellent and fill it with very good. And that's considered a better measure

than really looking at excellent experience.

We've seen in our own institution that the harder we work to capture outcomes for vulnerable populations does not improve our outcome measures.

And I think these are the wrong incentives. I also want to say that I think these populations -- this idea that population-based total cost of care will improve care or reduce costs, has to be considered a hypothesis.

There are alternatives, including real fee-for-service reform promoting competition. Not that these are always mutually exclusive, but I think it's really important to be open as we think about this.

I also think it's really critical in thinking about how we measure care as we think about the goals of the performance measurement and why we're doing it.

I think measuring care is important as a mechanism to temper overemphasis on outcomes and incentives for gaming systems. So sort of process.

It's important for testing hypotheses about how to improve care. I also think measuring process of care is critical for

increasing the likelihood that practices that actually improve outcomes are followed.

So when you pay for care coordination or you pay for defragmentation, you clearly direct people towards that. And I want to emphasize that we may wish to pay for process as opposed to paying for outcomes depending on our confidence in the validity of each measure.

What are some of the other goals of performance measures, and what strategies are effective? It's critical to measure these effects in subgroups, especially the vulnerable ones.

Given program design, for example, high-cost patients where there's incentive to skimp on care. Issues of causal inference are critical in evaluation.

I think we do far too few RCTs, far too few demonstration projects with robust controls. I think we need to really look for clean natural experiments.

And I think it's critical to try to avoid programmatic interference. Our experience with CMMI in the context of the Innovation Award, it points to these problems.

It's also important in performance

measure to think about mitigating the risks and payment models. Whether there are selection issues, as I've highlighted, or rewarding suboptimal processes, I'll point out that when we pay for care coordination, we in a sense reward people for creating fragmented care that requires coordination.

And then finally, I think it is important to advance the science of patient-centered care and measurement. Goal attainment is a great example of a measure where much more is probably needed to really make it practical. Next slide.

A couple of other things really to highlight as important issues to address in measuring outcomes. I think it's measuring a patient experience, population health, and cost.

There are a number of overall concerns that are critical. It's critical to measure all these outcomes in the vulnerable subgroups defined by medical, social, and payment-based risk factors.

And I think it's important to stratify those by market structure because there are very different outcomes in different markets depending on the structure of competition.

I think outcomes like how well is a program doing in retaining vulnerable subgroups, what are the outcomes of people who transition out of programs would be really important areas.

And then finally, thinking about outcomes of the population. What is the relevant population? Is it people enrolled in your plan? Is it a county?

How do we make people accountable for care that they have very little to do with if we make the populations broader? There are also some domain-specific concerns that I think are critical in patient experience.

We can have minimal measures like HCAHPS measures and patient experience. Simple measures. Even there, we have issues like top coding, and then we have aspirational things like goal attainment where measures are even harder.

In population health outcomes, we know it's hard to move general health measures, and this makes it very tempting to focus more on disease-specific measures.

And there are only so many of those we can have. I think prioritizing those linked to identifiable clinical opportunities. One example being mental health, maybe some very important

ones.

And then finally, in costs, you know, we can't just think about Medicare A and B or total cost to Medicare, including managed care. We have to think about Medicaid.

We have to think about the hidden costs to stakeholders, including managed care organizations and providers and to non-medical stakeholders, the social service delivery system and jails and housing and so on.

And then finally, and by no means least importantly, I think it's really critical to do more to measure the work life of health care providers. What are the quality and effects on the relationships that these providers have with patients, with their colleagues, with provider organizations, with payers, and with policymakers?

We've seen huge rates of burnout. And when we see that burnout, we lose providers who we need, and we sacrifice continuity of care, which seems to be a key driver in positive patient experience. So let me stop there. Thanks.

CO-CHAIR SINOPOLI: Thank you, David. Those are fascinating insights. Lastly, we have

Dr. Franklin Gaylis, who is Chief Scientific Officer at Genesis Healthcare Partners, Executive Medical Director at Union Health Partners, and voluntary Professor of Urology at University of California, San Diego. Franklin.

DR. GAYLIS: Thank you so much. And I greatly appreciate the opportunity to share our experience implementing a pay-for-performance quality improvement payment model, which would seem so easy, yet so difficult.

I've had a deep interest in quality improvement for more than 30 years, and it's a pleasure to be part of this presentation. Next slide, please. Some background.

Genesis Healthcare Partners. The group within our -- which our work has been in operation for 13 years has 110 physicians located throughout California, is an experience with both two ACO models and the novel pay-for-performance pilot, which I'll delve into in more detail.

The goals of our quality improvement intervention was first to create a cost-effective care-based practice to improve the treatment of patients with low-risk prostate cancer, develop four meaningful performance measures and two interventions which were implemented.

Firstly, provide feedback to our providers, our physicians, audit and feedback, which we call transparency in a pay-for-performance model.

The implications of firstly identifying meaningful specialty-related performance measures, and obviously this is a urology-specific specialty model, and explore the possibility of hybrid models between organization level and provider level measures. Next slide.

Prostate cancer is the most common non-skin cancer in men in the United States, and it's the second leading cause of cancer deaths. And the overtreatment of low-risk prostate cancer, which we refer to as indolent or slow-growing disease, tends to do more harm than good.

And despite recommendations to adopt conservative management, which is active surveillance or watchful waiting for more than 20 years, both the adoption and the quality of active surveillance for low-risk prostate cancer remains suboptimal.

And the disease disproportionately affects Black men who tend to present with more aggressive disease and have higher mortality rates compared to white men.

Black men tend to experience less access to prostate cancer treatment, longer delays between diagnosis and treatment. And some of the factors responsible include mistrust of the health care system, poor physician, patient communication, lack of patient knowledge of the disease and treatment.

And it's an expensive disease to manage. The cost estimate for 2020 was $18.53 billion, with an additional $8.4 billion loss in productivity between their men and their spouses.

Next slide. As this cartoon depicts, we still have an enormous challenge in implementing evidence-based knowledge into routine clinical practice as estimated 17 years.

In the field of implementation, science seeks to speed things up, and our project reflects implementation science approach. Next slide. And this challenge has been recognized by our urology specialty as noted in this editorial that it takes historically 17 years to adopt proven interventions.

And that research increasingly shows that our best treatment advances may not be implemented effectively in diverse settings and populations, and which results in inequitable

access and effectiveness of care.

And that we urologists and physicians in general have major problems with implementation. Next slide. This slide serves to show a chronology of our group, Genesis Healthcare Partners, in quality improvement interventions.

Back in 2011, we formed this large group of 25 physicians, and one of our initial objectives was to mitigate the overtreatment of low-risk prostate cancer.

And in 2011 through 2012, we implemented a best practice, which included passive education. And this resulted in minimal improvement.

In 2013, we implemented an anonymized physician audit and feedback dashboard, which resulted in significant improvement in the adoption of active surveillance for low-risk disease.

And then if we fast forward to 2022 through a collaborative with the Prostate Cancer Active Surveillance Project and United Healthcare, we implemented two interventions.

First, a transparent physician auditing feedback, and secondly, a pay-for-

performance value-based model resulting in even more improvement. Next.

This slide shows the dashboard that we used more than 10 years ago that was published in the journal Urology. And you can see in the left-hand column there's a physician listed but in an anonymized fashion.

And we created benchmarks, which you can see in the key below, core suboptimal and optimal at the time. And the first column reflects our adoption of conservative management, which was, if you look at the bottom row, 32 percent between 2011 and '12. That's 13 years ago.

We then implemented the dashboard, shared physician performance with our respective physicians. And one can see that between the second and third years, there was a dramatic improvement from 39 to 58 percent.

Between the first and second year, passive education was used with minimal improvement, but when physicians were compared to each other with audit and feedback, that resulted in a dramatic improvement. And the next slide.

Fast forward to 2022. This slide reflects the four quality measures that we

developed in collaboration with the PCASP[28] and United Healthcare.

The first was documentation, which may be considered a structured measure where EHR-embedded templates or structured notes were placed.

And this prompted physicians to directly re-stratify and document how they were caring for patients to mitigate the need to do retrospective chart analysis, which is laborious.

We set a benchmark of 90 percent. The second measure was conservative management or observational management of men with low-risk disease.

And we set the benchmark there at 75 percent. The last two measures, confirmatory PSA testing more than two PSA tests per year, and a confirmatory repeat biopsy, which is a second biopsy after the initial biopsy.

To ensure we have the right diagnosis to put a patient on conservative active surveillance management, we set the benchmark for the latter two at 75 percent.

I should note that measure 1 and measure 2 of EHR-based primary clinical data

28 Prostate Cancer Active Surveillance Project

retrieved, and measures 3 and 4 were based on claims data.

One should also note that the payment incentive was determined by the entire group meeting all four quality measures and was paid to the group, not to the individual physicians.

Next slide. And these are some of our data. This is for measure to the adoption of conservative management for low-risk prostate cancer.

One can see in the rectangle at the bottom the total for all three groups within our large group, 83 percent adoption, which is a dramatic and heartening improvement compared to past performance and also compared to national standards, which were -- which are about 50 to 60 percent according to published data.

In the next slide, we look in a little more detail at measure 1, which is the documentation according to payer type. And you can see in the right-hand top rectangle, we had excellent adherence in the UnitedHealthcare patients who were both eligible or not eligible for the P4P program compete compared to other payer patients.

And that was a result of additional

interventions, which included, as I've mentioned in the left top box, meeting with office managers, reminders to physicians without outstanding incomplete charts, calling physicians or emailing and monitoring the data.

It was a laborious task, but in order to meet the measures, we had to do this extra work. And as I mentioned in the last slide, we had an 83 percent adoption overall for all patients irrespective of payer.

And one can see the two rectangles at the bottom on the right-hand side reflect only United Healthcare patients who are eligible or not eligible for P4P.

If you do the math, only 12 percent of the entire cohort, 12 percent were eligible for the P4P program, yet we saw a significant improvement in adoption of active surveillance.

Next slide, please. Next slide. We decided to go back to get a baseline in 2019 so we could compare all three groups that had been more recently introduced to the Genesis group.

And our baseline was 65.5 percent adoption for low-risk disease, which was measured in 2019. It improved dramatically to 83 percent in 2022.

And in 2023 last year we were at 86 percent. The pilot project ended last year in 2023. And our preliminary data, because these are EHR-based data sets for 2024, we're at 92 percent.

So the trend continues, which is gratifying. Next slide. I'd just like to pivot to the cost of implementation and some of the savings, and some of these matters have been addressed in earlier presentations I heard.

It's an expensive effort and endeavor to implement these data retrieval efforts. An automated electronic data capture and an analytic system required a more than $220,000 build, which included the creation of templates in the EHR, the data capture process implementation, refreshing of dashboards.

The savings potential is significant because the cost of initial radical treatment for low-risk prostate cancer, which is radical prostatectomy radiation compared to conservative management, is 45 times greater.

And increasing the rate of conservative management from what I just showed as our baseline of 65.5 percent to our 83 percent, which we observed in 2022, would reduce

the average three-year cost per patient by more than 25 percent.

And given that about 300,000 men are diagnosed with prostate cancer in the United States each year, of nearly 60 to 75,000 have low-risk disease, the potential cost savings to payers with conservative management is considerable, estimated to be between $150 to $200 million over three years.

However, this is nuanced because we know with time, low risk will progress and unfortunately convert to active treatment. Next slide.

Addressing some of the challenges to implementation firstly and has been addressed on numerous previous presentations. Relevance, the measures have to be relevant, relevant to our colleagues. The ease of implementation.

We need to minimize physician effort. We just heard the last speaker talk about burnout. We can't burden our physicians with more effort, and that's why we created templates and structured notes to create structured data sources for the data.

Changing group culture and buy-in requires leadership to drive change. Defining

these four measures that I just shared took three, two years to agree on the measures and thresholds with internationally reputable prostate cancer researchers.

The reporting mechanism required significant IT investment to capture, measure, and report, and this was quite costly. Next slide. I want to just pivot for a moment, and I apologize for this busy slide.

However, we believe that data speaks of this slide volumes and begs the question, what quality measures are relevant to urology practice? These data reflect what's being reported by urologists in MIPS.

And if you just focus in the yellow highlighted top in the rectangle MUSIC4[29], which is equivalent to our measure 2, which is active surveillance or watchful waiting for low-risk prostate cancer, was reported by two urologists.

In contrast, if we look at the bottom rectangle, the cross-cutting measures, controlling high blood pressure, tobacco use, screening, body mass index measurement screening, look at the numbers reported by 5,000 urologists, 3,000 more than 1,000.

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29 Michigan Urological Surgery Improvement Collaborative

These are easier to report, but you have to ask the question, do they reflect the quality of care being provided by a urologist specialist? Next slide. And some final thoughts.

The implementation of quality improvement program using the specific interventions, which I shared, transparency, audit, and feedback, as well as a payment incentive has great potential.

What we experienced was scaling these programs is a challenge. Only one group participated in the UHC program, or acceptance by other payers was a challenge.

Only United Healthcare participated. Five other large payers were invited, but elected not to participate. We strongly recommend that the government should be participating in taking the lead and encourage the private payers to follow suit.

The programs that we establish need to be practical, relevant, and easy to implement. And the funding needs to be accessed to implement such programs, which is critical to the start-up expenses which we experienced.

And as I've heard previously, we

should -- we -- based on what we saw, perhaps we should be paying for reporting as this is most challenging and costly.

And measuring and reporting often leads to the result known as the Hawthorne effect. That is when people are being monitored, their work product tends to improve. Thank you for your attention.

CO-CHAIR SINOPOLI: Thank you. And thanks to all the presenters today. So PTAC members, please feel free to ask questions throughout the conversations.

And just remember to flip your name tag up or Josh since you're on Zoom, if you can just raise your hand in Zoom if you have questions as we progress.

So I'll start out with the first question. So what do we want to measure in total cost of care models that will ultimately lead to the quadruple aim, which includes outcomes, experience, and how care is actually provided. So if we could start out with Franklin.

DR. GAYLIS: Well, I think it needs to be disease-specific. And in our example, you know, measuring the appropriate care for low-risk prostate cancer, we wanted to mitigate the harms

of overtreating prostate cancer, and therefore we chose active surveillance or watchful waiting as conservative management.

With regard to patient experience, we have employed the rater8 system, which includes the net promoter score. So we routinely manage -- measure patient experience.

And the cost I commented on, there's dramatic significant cost benefits to what we are doing, but I think there's a caveat that's important to note, and the similar model was presented to the PTAC several years ago, and one of the issues was how do you protect patients?

And I think tracking these patients to make sure that if they progress on treat, on active surveillance, conservative management, we capture them in a timely fashion that we can still provide them curative therapy.

So I think that's -- some of those are essential items to this particular model.

CO-CHAIR SINOPOLI: Thank you. How about David?

DR. MELTZER: You know, I think we want to measure many things. We don't want to just measure outcomes. I appreciated Tom's comment that sort of getting to outcomes is a

great thing.

But I think that path from structure to process to outcomes, I think it's extremely important along the way that we look at those. And one of the challenges, of course, is there are many steps along the way, and we can't measure them all.

And I'm appreciative of the idea that disease-specific measures are often sort of cleaner and, but they're narrow. And so I think we need to be thinking carefully about what are the cross-cutting processes that really drive care and that are relevant across multiple diseases and multiple outcomes.

And, you know, they include to me things like relationships with providers, whether people are having regular visits in primary care, whether they're avoiding hospitalization, those sorts of things.

And so I'd like to see us have a balanced approach that's driven by an understanding of the risks of gaming and the processes that can drive improved outcomes, as well as measuring outcomes.

CO-CHAIR SINOPOLI: Thank you for that. Franklin.

DR. GAYLIS: I think I just commented.

CO-CHAIR SINOPOLI: I'm sorry. Thomas.

DR. SEQUIST: Did you want me to go next, or?

CO-CHAIR SINOPOLI: Yes. Yes.

DR. SEQUIST: Okay. Yeah, just listening to this, I mean, I think these are -- this is a hard question, right? And I think you sort of have this -- I think you -- we're sort of stuck between two choices, I think.

So one is what David is saying is, you know, pick a broad-based kind of structure, or even better, a process measure that we think will impact care across the board.

And trust in that was in -- that that's going to improve the outcomes that we're all desiring. If you take like more of the outcome's approach, what I would say is, so that's option -- that's one option.

Another option is to take an outcomes approach, but then how do you, you know, you do want to avoid it, you're only looking at a couple conditions, and you're not really looking at the health of the whole population.

One of the ways to think about that is to be really specific about what contributes to

the biggest morbidity and mortality problems across your population that you're focused on, and really focus your measurement in that space.

And it may be that focusing on that gets you to, you know, 50 percent or 60 percent of the total morbidity and mortality in population. But if you will have optimized care for that percentage, you will have done a lot like in your population-based care model.

I don't think there's a right answer here between those two choices. They're just different approaches. What I think is not the right answer from a delivery system standpoint is having two different programs taking two different approaches.

That's really challenging when you're on the ground, and you're being sort of asked to do one thing, which is focus on these sort of broad-based process and structural measures, and then from a different program given very targeted outcomes for a very specific disease. That's really hard.

CO-CHAIR SINOPOLI: Thank you. So I think the next question digs a little deeper into what we just discussed. And we heard this morning a lot about a balanced portfolio approach

of a mixture of what we're measuring.

And so the question is, what is the appropriate mixture of outcome, patient experience, and process measures to directly measure system change?

And how organizations provide care with the thought in the background of, there's been concern of too many metrics out there, too many things to measure, too expensive, too much administrative burden?

So how would you all approach that question in terms of prioritizing what's important? And so we'll start out with David this time.

DR. MELTZER: Sure. I think it comes down to the question of kind of why we're measuring these things, and I highlighted a couple in my remarks to temper over emphasis on outcomes and the potential to gain the system.

In those instances where we think gaming is particularly at risk, I think we want to go, at least partially make sure we've got the process along with it to test hypotheses about how to improve care.

If we are not sure that a process is important, it may be more important to measure it

in order to understand if it really does correlate with outcomes to drive change, to make sure that care practices that we do think improve outcomes are being followed.

No better way than to pay for them. And I think ultimately as we balance these, we need to look at the confidence we have in the outcome's measures and their value and those that we have in the process measures and, you know, overweight, those things we're more confident in and underweight those probably we're not.

And I think that's how I would put together a balanced portfolio.

CO-CHAIR SINOPOLI: Okay. Thank you. Thomas?

DR. SEQUIST: Yeah, I don't know that there's like a number, like there's a pie chart that shows that it's, you know, one-third this, one-quarter this and, you know, one-quarter that. I don't think that that's the answer here.

What I would suggest though is when we -- I -- as I look at like our programs over the past couple of decades, I, just going back to the -- one of the points I made earlier, I just worry that we get stuck in the structure and process realm, and we're often not -- and we really,

really optimize those.

And you can see some structure in particular process measures that have gotten close to 100 percent say like in the HDA[30] space, and yet we're not, you know, preventing cardiovascular death at the, you know, to the same degree of improvement that we're seeing in those process measures.

And so my only sort of advice here would be, it's not that there has to be a certain percentage of them, measures in a portfolio that are outcomes versus process, but we have to force those process measures to be pointing towards an outcome measure.

Like, and if they're not pointing towards an outcome measure over time, I think we're not like following the model correctly of quality improvement.

And then that leads to, you know, people just hyper-focusing on process measures, and I don't know if they're not really gaming it, but you can, you know, process measures can be made to improve in such a way that it doesn't actually improve the outcome measure that they were intended to be linked to.

30 Healthcare Distribution Alliance

I just think it's really important for us to always keep in mind what is the link that we're hoping to achieve between your process measure we have and the health status that we're hoping to achieve, and making sure that we are validating that link repeatedly over time.

CO-CHAIR SINOPOLI: That was great. Thank you. Franklin.

DR. GAYLIS: I just want to make the point that I don't think there's a one-size-fits-all, and I think we have to recognize that speaking as a specialist, a surgical specialist in urology compared to primary care, what's relevant and important to the patients that we are treating is very different.

And, you know, within our group, we've got multiple subspecialists even with urology. So with a physician who's treating female urine incontinence as a specialty, there needs to be certain validated questionnaires to measure the outcome of their treatments.

An oncologist, a surgical oncologist would be looking at surgical outcomes and, you know, perhaps 30-day readmission morbidity mortality.

So I think this is where we've had

challenges. I've been in the field for over 30 years, and still we do not have standardized measures that are uniformly applied to urology.

And that's why you see a lot of cross-cutting measures being reported on. Process measures has been discussed in my -- in our example of active surveillance.

They're important, and they do lead to measuring an outcome. We want to make sure, for example, the patient on active surveillance remains on active surveillance and doesn't have progression of their cancer and dies from it because they weren't actively and appropriately monitored or surveilled.

And that's where like the two PSAs of confirmatory biopsy, perhaps an MRI, these have to be customized. So these processes may -- process measures do lead to hopefully better outcomes.

CO-CHAIR SINOPOLI: Great.

DR. GAYLIS: Thanks.

CO-CHAIR SINOPOLI: Thank you so much for all those comments. So as we move more and more toward a total cost of care model and even global payments, how do the performance measurements that we're measuring today differ in

the value-based purchasing programs from what it needs to be in a total cost of care model? And so I'll start out with Thomas on this one.

DR. SEQUIST: Sorry about that. Yeah, I mean, I don't -- I'm trying to -- and I thought about this as we initially talked about this panel and now having heard everyone's comments, I don't think that it's necessarily so much about the difference between value-based care programs and total cost of care programs and the quality measures.

I think it's more of a generic question about what direction do we think quality measurement is going, and how can we improve it? I don't want to like sound like it's completely broken, it's not.

I mean, I think there's been a lot of really great movement in this space over the past couple of decades to improve care. To me, the thing that can improve most in these total cost of care programs is a couple things.

One, one of the things David has said a couple of times, which is really, really important, is to make sure that we're designing them in ways that prevent folks from gaming in a way that would adversely impact underserved

populations.

Whether that's through selection processes or care management processes once they're in your clinical programs. It's just really, really important in any program that starts to look at cost that we have up sort of barriers or guardrails, I guess guardrails around underserved populations of any form.

Whether they be folks who don't speak English, folks who have lower incomes, or from different racial backgrounds. That's one thing that I think is just really critical that's been a problem in value-based care programs. It would be a problem in any sort of total cost of care program.

So I don't, again, like I don't think that's you -- that's a sort of a difference between those two models, but it's really critical as we move forward in these total cost of care programs that we have that very closely in mind.

And then the second thing I would say, sorry, I'm babbling a little bit, but the second thing I would say is that it's just really important that we understand and have alignment on the -- on for the folks on the ground in the

different ways we're being incentivized to improve care.

So I think we should choose, like from all the things we're talking about, like, right, with process measures, outcome measures, the links between them.

How does service excellence and patient experience fit in? I think it's really important that when the messaging hits the ground level, so an individual hospital, a doctor's practice, that we pick one conceptual sort of approach on quality measurement so the teams on the ground can actually design their interventions in a way that doesn't feel so chaotic or spread out.

Right now I think there's just different messaging around what's important. Is it structure process? Is it outcomes? Is the patient experience? How does the cost measure balance? And it's challenging.

CO-CHAIR SINOPOLI: Perfect. Thank you. Franklin.

DR. GAYLIS: Yeah, I think the principles of quality measurement where it's structured process outcomes that we've been discussing extensively can be applied across, you

know, all disciplines subspecialties.

But I think we have to understand that each specialty is very different in what's relevant to their practice, what's relevant to their patient, what's relevant to the physician.

And you know, for example, if we just look at prostate cancer, and we had a few groups participated in the OCM model, the Oncology Care Model, and they had to drop out because things changed.

And there was, this was treating patients with advanced prostate cancer. And what happened was a lot of the new drugs, which are very expensive, came into development and were available, which hadn't been taken note of in prior experience.

And as I've been speaking about early-stage prostate cancer is a very different setup. We've got active surveillance versus surgery versus radiation, whereas in advanced disease, you're talking about very expensive therapeutics like androgen deprivation and chemotherapy and novel agents used in oncology.

So I still think one has to dissect it out a little more and become specialties-specific as we design these value-based models of total

cost of care models.

CO-CHAIR SINOPOLI: Thank you. David.

DR. MELTZER: I guess I'd like to highlight that population-based total cost of care models may differ from traditional value-based purchasing programs, both in the population part and in the cost part.

So one first question is what is the population? What are the denominators in each of those, and how fixed are they? How fluid are they? And how are we dealing with the changing denominators?

I would interact that with market structure in an area where you're the dominant provider and there's very little competition. Gaming has a very different character than a market like the one we are in.

And then in the total cost of care domain, I really want to point out how important this is particularly for socially vulnerable populations where there are a variety of social services where utilization is very much integrally connected with medically utilization.

But even for more affluent patients, things like decisions you make in your 50s and 60s about how to manage your prostate cancer may

affect the urinary incontinence you have years later with consequences for your ability to live independently and costs, for example, to Medicaid.

And so we really need to think in a more integrated way about these things if we're going to reach this sort of goal of population-based total cost of care, and dealing with both what is the population and what are the costs seem, to me, critical differences.

CO-CHAIR SINOPOLI: Perfect. Thank you. Lauran, do you have a question?

CO-CHAIR HARDIN: Sure. I'm going to ask a follow-on question based on that and starting with David, but everyone is welcome to answer. I was really intrigued when you were talking about the subgroups that you're seeing in the most vulnerable high-cost populations you're serving.

I'm curious what patterns or archetypes you're seeing in those, who those population subgroups are, and how that's informing what measures you're considering that would advance equity and total cost of care models.

DR. MELTZER: For sure. I can

highlight one in particular that sort of speaks volumes. Young Black men with end-stage renal disease.

Huge high cost of care, horrible you know, outcomes far too often come into the program with really serious illness, often very much sort of neglected care, tremendous unmet social needs.

And I will tell you that that population in our group, it's about six percent of our total population. And it accounts for an absolutely huge amount of costs, an absolutely huge amount of morbidity and just screams for attention.

And I will also point out that Alternative Payment Models, you know, for end-stage renal disease were very active in this region during the period when our study began.

And I think that there were profound incentives for selection. And the other thing I'll say is this is extremely difficult to study. Our RCTs are 1,000 patients per hour, basically.

So that's the scale of the RAND Health Insurance Experiment. Our intrinsic underlying variability in some ways is less than the RAND Health Insurance Experiment because the level is

so much higher to begin with.

We have very few low utilizers. That much said, a handful of people, and I literally mean numbers like this are enough to drive utilization between arms with selection enough to matter in a scale, in a study of that scale.

And when I say we don't do enough RCTs, I really mean it, and we don't do enough scale. And I can't tell you how blessed I feel to have been able to work so many years on such a complicated RCT because I've learned things that I don't think I honestly ever could have learned in observational studies.

And I'm trained as an economist. We love to analyze data like that, but sometimes an RCT is just invaluable.

CO-CHAIR HARDIN: Tom or Franklin, would you want to comment on that or no?

DR. GAYLIS: I'll just comment on what David said about RCTs. I've been part of the PCASP, which is a national consortium of academic and community urologists trying to do an RCT comparing transparency feedback to the pay-for-performance model because we have some, a fortuity of data. And it's just very -- it's been very difficult to get funding. We've been

working on it for six years. We were hoping to submit another P01 grant in the next coming months. But to David's this point, it's critical to understand what implementation science really makes a difference. And just going back to our model, you know, I really think that our physicians know that they're being measured and monitored is truly not appropriate performance of active surveillance adoption. This is the financial incentive.

And one other point I just want to make is that getting the data is a huge challenge and I'm in private practice. We're in a community group. We don't have the resources of the bigger University of Chicago. These are extremely an exorbitant amounts of money that we've had to invest with no compensation whatsoever to drive or move a $200,000 investment in IT to pull the data. And you can't get the data if you do retrospective analyses because physicians' documentation in the EHR is poor. We can't get clinical stage of disease to risk stratify. So you know, it's nuanced. There's so many variables, but I think these are really good points for discussion.

DR. SEQUIST: I totally agree with

David on the sort of archetype condition with end-stage renal disease. The other area that I would just highlight that is very extensive, but it's spread out probably -- it is spread out amongst a much larger population, but is a challenge in the space of equity is substance use disorder, housing security, and food security. These things all like sort of come together and then end up getting managed in our Emergency Departments, which is from a total cost of care perspective. But even probably more importantly from a care perspective, not what anyone desires.

You know, and I would say the thing -- one of things where we see the greatest inequities actually in our system is not specifically only related to race and income, it's actually related to language. And so when we have patients who don't speak English as their primary language, and you are really trying to drive towards complex care management, you really do realize how critical and how just everything is built 99.9 percent around English across the system. And whether you're running care management programs, whether you know, any kind of program that we're running, it's been -- it's been very hard to sort of overcome that

challenge.

So at this point, I mean I think there are these conditions like end-stage renal disease, super-expensive, very high-complexity in terms of management. There's this other background set of issues that is contributing to inequity that are very expensive as well that's been a real challenge for us.

DR. MELTZER: If I could just add something on top of Tom's comment. Just to be clear, these young men with end-stage renal disease I'm talking about, the vast majority of them are dual-eligible, tremendous unmet social need. So these populations overlap profoundly at least in our environment.

DR. GAYLIS: And if I may make a comment regarding the inequity in the Black population, which we've seen, the men tend to present with much more advanced, more aggressive disease. And there may be a biological component which we think, but a lot has to do with access to care. So we only see the patients when they are already in their advanced stage. We're not dealing with them. And that's where there needs to be attention, how to screen them for prostate cancer. At least it's a controversial subject,

prostate cancer screening, but at least have that discussion and offer them screening.

CO-CHAIR SINOPOLI: Thank you for that discussion. That was great comments. So how should patient caregiver and patient-reported outcomes be utilized? And how important do you think they are? And I'll start out with Thomas on that one.

DR. SEQUIST: I'm sorry. When you said how could patient caregiver, you mean like someone in the home? I just want to make sure I understood the question. Or do you mean like physicians or nurses?

CO-CHAIR SINOPOLI: No. I mean like a home giver, relative, friend --

DR. SEQUIST: Like a family member.

CO-CHAIR SINOPOLI: Yes.

DR. SEQUIST: Well, I mean I -- So with my, you know, personal take on emphasizing outcomes, I mean I think that those outcomes are critical. And if we sort of separated them out into there's the patient-reported clinical outcomes and then the patient-reported experiences of care. If we talk for a minute about the patient-reported clinical outcomes, I

think, you know, PROs[31] and PROMs, these things actually provide such a window for us to actually get at something that David was talking about earlier, which is they can be applied across many, many conditions. You know, we have many patient-reported outcomes that can be generic across multiple conditions.

But if they're important health status indicators, we then have patient-reported outcomes that can actually be disease-specific as well. And they help us in ways that the clinical outcomes measures that we get from medical records, they just can't help us on. So if you take an example like total hips, total knees, you know, we have typical metrics that would -- if a patient were to get hospitalized, I know we've shifted -- have shifted away from hospitalization -- But let's say just for an example, you were to hospitalize a patient to get a total hip. The measures that we would typically report on would be, you know, 30-day mortality rates, 30-day readmission rates, infection rates in the hospital, surgical site infections, and such.

And none of that is really the reason the patient got their -- their knee done. Right?

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31 Patient-reported outcomes

The reason they got their knee done is to walk up the steps and you know, play tennis or play with their grandchildren or whatever it is that they -- functional thing they were hoping to achieve or have less pain. None of those are captured in our traditional quality measures. So patient-reported outcomes have this like fantastic potential, I think to advance this field.

Now they are challenging to collect, right? By that, I mean there's a lot of science around them like, you know, survey developers have created them for years. So that part's not a challenge. Literally the practical implementation of them in the clinics. How do you collect them, and what time -- what timeframe do you do it? I think a bunch more work in investment would be really helpful to better understand how you take what are really scientifically well-developed patient-reported outcomes and turn them into patient-reported outcome measures. Meaning like how, when, and where do you collect these things? And how do we set our targets and incentive packages around them? That, this space is a little bit lagging on. But again, like I can't emphasize more, I believe those to be so important for the future

of quality measurement.

CO-CHAIR SINOPOLI: Perfect, thank you. David.

DR. MELTZER: Yeah, I agree. I'll add a couple of things. First of all, with respect to the practicalities of collecting data in patient-reported outcomes, I can't speak to it in any context. But in the context of the university, one of the things we found incredibly valuable is engaging our students in that data collection. I could never have done the research studies that I've done were it not for our undergraduates who volunteer or work as work study students and add data collection bandwidth to our studies. And that has been invaluable. That's very expensive to do, but it's critical.

And I'll also point out that although it's very tempting to think that technology is going to be the solution here, for a lot of these most vulnerable patients, technology is not necessarily always accessible. And so we've really found that's important. I also want to highlight the mixed method approaches are very important. We've done some wonderful qualitative research that has really both inspired the design of the program and helped us evaluate it. And

then patient-engaged research. Our program is constantly evolving based on the feedback from our patient and commission advisory boards. And those sort of qualitative insights and contributions really do make a difference. So I think PROs are critical. And some of these data collection and engagement issues are key parts to that.

CO-CHAIR SINOPOLI: Great, thank you. Franklin.

DR. GAYLIS: Yeah. I agree with both David and Tom that patient-reported outcomes are critical. And in my specialty, having done a lot of radical prostatectomy surgeries and knowing the consequences of urinary incontinence, sexual dysfunction, you have to have validated questionnaires. And in private practice, again, that's where I am, we provide the bulk of urology services across the country, where are the infrastructure, the resources, the support to routinely measure these PROs, get the data. And then what do you do with the data? You have to assimilate the data and make it actionable. You have to give it back to the providers. See how they are performing because you may have physicians who think they got, you know, perfect

results during surgery that when you show them the data, it really can improve quality.

But it's that infrastructure that is really lacking. And you know, my colleagues here fortunately have big institutions to support them. Many of us in private practice have to create this ourselves, and I'm harping on that because it's critical. I feel this is where the payers and the government need to be supporting infrastructure, whether it's through municipal, through American College of Surgeons, which has a great program, but you have to invest as I understand through expensive nurses to collect the data. And with current reimbursement, it's just -- it's just impossible.

DR. SEQUIST: Let me just tag onto that. This is the -- I think we are -- our system is the largest collector of PROMs in the country. This is the most expensive measure that we -- that we collect by far. The infrastructure needed to do it is -- it's more than nurse chart abstractors for NSQIP[32] or Society for Thoracic Surgery or such. It's just expensive, but again, invaluable. Like once you have those data, they're very, very powerful to drive improvement,

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but very expensive.

CO-CHAIR SINOPOLI: Thank you for that. So PTAC has had a lot of discussions about how to engage specialists and had a lot of discussions about can we nest specialty bundles or specialty services within a total cost to care model in a broader network? So could you all comment about how you might structure the metrics associated with specialists within a broader clinically integrated network and maybe in particular around things that might traditionally otherwise be a bundle? Does that question make sense? And I'll start out with Franklin on that one.

DR. GAYLIS: Well, I have limited knowledge and experience how we would create a bundle. But just looking from the practical standpoint of my colleagues, what are they treating? They're treating BPH, benign prostatic hyperplasia. They're treating prostate cancer. They're treating kidney stones, incontinence, sexual dysfunction. And we often have individual colleagues that sort of focus in one area. So as a group, perhaps we could create a bundle that we -- we have to again, it's not a one-size-fits-all. We can't paint this room with one little

brush. And I think we have to -- I think it should start organically at the specialty level.

In my case, it may not be applicable to primary care. But I think there needs to be a recognition that whether it's urology or gastroenterology, we're very different specialists. We see very different diseases. They're very different metrics. There are very different patient needs. They're all so common. We heard about -- we talked about equity and access. But the actual disease and the measurement and bundling and putting us at risk, it's a huge challenge from my perspective as a community practitioner.

CO-CHAIR SINOPOLI: Perfect, thank you. Thomas.

DR. SEQUIST: So I think one of the -- if I were to sort of break this down into like little buckets of questions that need to be answered, first I would say, this is a critical area. Like we can -- we're not going to solve sort of total cost of care unless we can move solidly outside of primary care and into the specialty care space.

And I don't -- I don't think that -- well, I think that many of the specialty areas

would be, you know, would be welcoming of better performance measurement. But I think we need to break it down into a couple of spaces. So one is, are we hoping to measure total cost of care across an entire system, across an entire ACO, let's say? Are you looking for – are we looking for total cost of care down to an individual physician? The reason that's important is because for any given episode of care, that care is often increasingly spread across many different physicians. And that's where you get sort of bogged down and like who are we assigning the bundle of care to? And then people spend a lot of time one that, right, sort of figuring out who is the primary caregiver in this bundle of care? And who do I assign it to?

I think it's easier to think about it from a whole system standpoint and just say how we do treat this hip fracture, like from start to finish? Like how much did it cost, and what was our performance on it? If we want to go down to the physician level, I think we will continue to get bogged down into some of those measurement issues.

The second thing that I would say is really important for us to really sort of tackle

head on or just address up-front is are we talking about procedural-based care or medical-based care? We often think about bundles in terms of a procedure. That is a very clear, sort of time zero. And then we can measure t-10 days or t-30 days of their care. And then t+ whatever, three months of their care like I had for a knee or prostatectomy or otherwise.

And what we need to also get into because there is a lot of cost associated with it and important performance aspects is the medical delivery of care. So I'll give you an example. A patient gets referred like to a specialist because their inflammatory bowel disease or ulcerative colitis isn't getting better. And that specialist changes some of their immune therapy. When did that episode of care start? When did that bundle of care start? If we can't get better at like defining the sort of stop and start points on these things, we're going to miss a whole bunch of medical specialty care, which is a very large volume of care and expense.

And increasingly as we think about specialty pharmaceuticals that are pretty expensive, but very effective in some of these conditions like inflammatory bowel disease, we're

going to miss out on measuring that whole aspect of care. So my short version of that is shift some of our attention, I don't know if it's away from the surgical space and into the medical space, or it's just create extra bandwidth to start looking at that medical space because there's going to be a whole lot of cost. And it's going to be in the form of pharmaceuticals.

CO-CHAIR SINOPOLI: Great insight. And we've had a lot of discussions around that very point. So, David.

DR. MELTZER: Yeah. As I mentioned in my introductory comments, one of the major areas of focus for my work has been understanding the value of medical specialization. And I think one of the real challenges we have is there's a sort of centripetal force that pulls apart medical practice. Some of that is the growth of knowledge and expertise. And some of it is the unfortunate market realities of profits being more readily available to groups that control access to a particular type of service. The former is more understandable than the latter. But I think they're both important.

And I think the consequence of this equality measurement is that we very often think

about trying to find quality measures that come out of a specialty, rather than encourage integration of the specialty with primary care. And there are a lot of reasons that can be valuable. Long-term follow-up of symptoms is almost certainly going to be in the primary care setting. There are contextual valuables that are relevant across diseases in primary care that might be very difficult and costly for a specialty to connect. So I'd really love it if we could figure out a way to articulate the idea that quality measures should be broad and interconnected across conditions. And build an infrastructure that recognize those synergies and encourage them.

CO-CHAIR SINOPOLI: Perfect. Thanks for that insight. And not surprisingly, we have an inflammatory bowel disease doctor that wants to ask a question.

DR. KOSINSKI: Yeah. But I'm not going to ask about IBD. David, I totally agree with what you -- what you just said. But the three of you, we chose the three of you for this session because we knew you brought real world expertise to the table. And in listening to the three of you, you all have stripes on your

sleeves, but you all have scars on your backs from what you've gone through in trying to succeed. And none of you are young anymore. It's taken years to accomplish what you're doing.

So this Committee has a voice. And in using that voice, what can the -- what can the publicly funded entities like CMS do to use a quote "to remove the on the ground confusion around the direction of incentive programs"? If each of you had your wish list for what you wanted CMS to do, what would each of you recommend?

CO-CHAIR SINOPOLI: Start out with David.

DR. MELTZER: Oh, gosh. I feel like I need about a month to really think over the answer to that. Great question. But since I don't have it, I'll just try. You know, I think a lot about the new generation of people who are going to come in. And I think about the resources that they're going to have available to build the sorts of opportunities to learn that I've had. And I think it's a much more difficult environment for young investigators than it was before.

The funding lines for K awards are not

great. The funding lines for RO1s are even worse. There's much less margin in academic medicine than there was before. So funding is even more important. The temptations in leadership are, you know, more immediate sometimes and clinical leadership because the pressures are higher. The ability to do long run investment. I think we are making historically damaging under-investments in clinician investigators.

We have tried to create a more competitive health care environment for academic medicine, which I think is great. But those resources that used to come from those margins are increasingly not available in order to produce that next generation. So I think we need to invest. And I think that, that investment needs to be broad-based. I mean I'd love to see NIH[33]'s budget go up, but I would also love to see CMS' research and development budget go up.

And I think with that, there also needs to be a careful understanding of the quality of the information that's generated and the type of support that's provided. I will be forever grateful to CMMI for being one of their

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round one Innovation Awards. I would have never, ever in a million years been able to do what I've done for the past decade were it not for CMMI.

And those Innovation Awards, I think were really impactful. I honestly believe they could have been even more impactful if, you know, the monies had been used with a little more emphasis on high-quality evidence generation. But that is not a criticism of the overall endeavor. I would love to see the R&D development for Medicare increase order of magnitudes.

CO-CHAIR SINOPOLI: Thank you. Thomas.

DR. SEQUIST: So at least I got an extra few minutes in to think just for what was a really, really hard question, but a really good question. I think the thing that comes to me for top of mind is I would really love to see CMS take on in a real way with like a very clear strategic plan, how we're going to address health equity. I feel like it is the biggest public health crisis that we have right now from an overall quality performance.

Health equity is going to continue to be the thing that pulls down our performance as

we are not able to perform well for people who don't speak English or lower-income patients. And I don't think that I've seen in my mind, a plan that actually sort of is on par with how big of a problem this is. And so that plan, both in terms of an investment and an urgency and sort of a CMS sort of using its influence to push our various sectors of the health care system. And I can go into like lots of detail around that, but I think that's like my highest level thing that I would want CMS to take on.

If I were to -- I'll just like – like if I ever do anything -- I'm looking at the time here, I'd just like for 20 seconds rattle off. If CMS could push to say we're going to fund for the kinds of services that address social risk factors in a real and meaningful way, that would also push the commercial payers to also go in that direction for things that -- to David's point around the evidence, we'd have evidence in many ways, but we can't get parents to pay for them.

If CMS could push electronic health record vendors to go in directions of development that actually support care for underserved populations, which doesn't happen right now.

Right? It's always – it's always an afterthought. If CMS could push in the space of really sort of language access, I think that, that's going to be critical for equity. And we really need to push hard in all these different sectors of the health care system.

CO-CHAIR SINOPOLI: Perfect, thank you. And Franklin.

DR. GAYLIS: Thanks. You know, I was excited when MACRA[34] was legislated and approved in 09, I think it was 2015. And I said here, we're going to get a system that promotes quantity. And nine years later when I see what my colleagues are reporting, I think it's -- it's really disappointing. So even though we're a small specialty and probably other small specialties like gastroenterology, I think there needs to be more inclusion and universal approach to whatever the metrics -- the approach that gets more physicians involved. I just think a lot of us are being left out, particularly in the community practice.

And I think the government needs to coordinate with the panelists to make a real effort to come up with programs that are across

34 Medicare Access and CHIP Reauthorization Act

different payers. This was our struggle, where we could get one payer to participate. And that's why the pilot, you know, couldn't be completed last year. And I just would lastly ask for the government to recognize how complicated and it was mentioned, the cost of reporting from health that pays $40,000 per patient -- for physician per year was in one of the earlier presentations this morning. And we cannot absorb these costs. The cost of the -- to develop the infrastructure and it's there.

And you heard one of the comments on the EHR, there needs to be coordination and elaboration between EHR companies to get structured data fields -- to pull out the data and structure mechanisms. These are tremendous infrastructures that need to be invested in. And particularly as I speak from the community practice world, we need help. Thank you.

CO-CHAIR SINOPOLI: Thank you for that. And I want to thank all the presenters for a great session this afternoon. And you all are welcome to stay on and listen to as much of the meeting as you would like to. We're now going to take a 10-minute break until 2:40 p.m. Eastern Time before moving on to our next listening

session where we'll hear from experts on selecting the designing measures for total cost to care models. So thank you, and we'll move to our break.

(Whereupon, the above-entitled matter went off the record at 2:31 p.m. and resumed at 2:42 p.m.)

*** Listening Session 2: Issues Related to Selecting and Designing Measures for PB-TCOC Models**

CO-CHAIR HARDIN: Welcome back. When planning this meeting, PTAC wanted to prioritize hearing from those with experience developing and implementing performance measures to facilitate value-based transformation. As such, we invited four experts from across the country for this panel. You can find their full biographies posted on the ASPE PTAC website, along with their overview slides.

At this time, I ask our presenters to go ahead and turn on your video if you haven't already. I'll briefly introduce our guests and then give each presenter time to share their perspectives on this topic. After we hear your introductions and perspectives, I'll be opening it up to the Committee members so that they have

plenty of time to ask questions. Committee members, if you do have a question, please tip your table tent name tag up, so that I'm aware of your interest.

So first, we'd love to hear from Krishna Ramachandran who is the Senior Vice President of Health Transformation and Provider Adoption with Blue Shield of California. Please go ahead, Krishna.

MR. RAMACHANDRAN: Yes. Thank you so much. Krishna Ramachandran, I work under Blue Shield of California for their value-based care efforts. And my perspectives on this topic are shaped by my past experiences as well. I've spent time in the payer side, the provider side, and the health technology space, and so those are the perspectives that I bring to the table today.

Let's jump to the next slide. Blue Shield of California is an independent member of their Blue Shield Association. We're a nonprofit health plan dedicated to providing Californians with access to high-quality health care at an affordable price. Our North Star is to create a health care system that is worthy of our family and friends that is also sustainably affordable. We're the only major health plan to voluntarily

cap our net income to 2 percent of our revenue, returning the difference to our customers and communities we serve.

And since establishing this pledge in 2011, we've returned $817 million to our customers in the California community, and for the last three years we've also invested $97 million into our communities through our foundation, whose mission is to support lasting and equitable solutions that make California the healthiest state, as well as to end domestic violence.

My next slide gets into just our value-based care strategy. We call it Pay for Value with Blue Shield of California. A few dimensions that I wanted to highlight for you all. One, we want to make sure that our programs reach, you know, as many providers as we can that are in our network. We want to make sure this is exceptional and expedient for both the member, as well as the provider. We certainly aspire to achieve a 90+ percentile for our key quality measures. And then of course, making sure that our programs actually bend the cost trend, which is a critical priority for the nation there.

The next point gets into some of the

challenges we face in looking at measuring performance and improving performance as well. And then I had a chance to listen to some of the previous presentations as well. As you'd expect, you know, our provider feedback has fallen into a few buckets. One is certainly the volume of measures. There are too many measures to track, and some of these measures are same thing, but different. And so you still have to track and measure performance across many dimensions.

Then of course there's movement and benchmark as well over time. And so, harder to sort of track how are our members and providers actually improving. Engaging specialists certainly is a key topic, which I know came up in past presentations as well. How do we bring specialists along in the process, particularly in the population health models?

Third one is just delivering timely actionable accurate performance reporting. That is delivered to providers in a way that they can do something with is key. And then some of the variability in terms of patient attribution, members that come in and out of these programs, particularly with our PPO[35] populations. And then

35 Preferred Provider Organization

ensuring that the models reflect risk and conditions of the members as well are some of the challenges we've heard from providers.

My next slide gets into what have we done, what approaches Blue Shield of California has taken. A key element is just actually partnering with many stakeholders, starting from the purchasers of health care. So these are employers, our proxy associations like purchasers, Business Group on Health, providers themselves, specialty societies, and then other payers that actually harmonize our measures. And I'll give you some examples in upcoming slides as well.

Engaging with specialty associations and societies on making sure their input and their perspectives are incorporated into our models. Investing in technology and analytics, I know I mentioned this particularly with meaningful use and advancing interoperability in these efforts, but there's just more we can continue to do to invest, but also make these meaningful and actionable and sort of useful in real life. And then figuring out a way of getting these analytics into provider workflows so that it's not an added burden for our provider

partners.

So I'll give you an example on the next slide, which is how we brought together our stakeholders, our purchasers, providers, and payers, particularly to harmonize measures, but also beyond as well. How do we harmonize how much we invest or the approaches we take in investments? How do we harmonize approaches to practice transformation and resources we can bring to the table? And so this example is a California Advanced Primary Care multi-payer model where we led the efforts to bring together multiple stakeholders, including purchasers, Business Group on Health, and the Integrated Healthcare Association, which is a stakeholder community on providers and payers as well. And working with our competing payers as well to create a model that we think will help us have a unified approach in how we come to the market in terms of quality measures, payment models, as well as practice transformation. So we're really proud of that work and will actually launch it later this year after, you know, many months and years of sort of working together on structures there. And that's an exciting element for us there.

The other one, next slide we can go, is just how we collaborated with specialty associations, as well as just medical societies as well. A highlight is just the work we've done with our cardiology, American College of Cardiology for our cardiology episodes of care models and the work we've done with the California Orthopaedic Association for our ortho models, as well as broader work with the California Medical Association, which is helpful for our primary care models. And then work we're doing at Dana [Safran]'s organization on innovating with their team on speeding up measure development as well, which we think will be a good feeder into our existing value-based care models as well. So definitely excited about the work we're doing across these associations and national organizations as well.

My next slide gets into investments we're making on data and technology. We've been a long-time proponent of the benefits of data sharing and data exchange. We launched Cal INDEX about 10 years back, which is sort of a health information exchange, which became -- evolved into Manifest Medex, which is one of the largest health information exchanges in the nation, over

16 million members there. We actually were big advocates for the California data sharing framework, which is how do we have policy work in order to exchange data across all the stakeholders, payers, providers in the eco system? So that actually went live in California in January this year, so we are excited to, you know, to liberate the data across stakeholders and communicate value to further validate as well.

And then we're also investing internally to integrate the data we're getting from these various sources, whether it's health information exchange like Manifest Medex or San Diego Health Connect or the Los Angeles health information exchanges. But also technology like Epic Payer Platform, which we are live with. I know my partner, Vivek [Garg] from Humana is invested as well in that.

So bringing real-time exchange between providers and also being able to use that to drive internal workflows from a payer perspective, but also being able to deliver some of these insights into provider workflow so those that are in value-based care arrangements with us. So I'm definitely excited for that work

there.

My next slide is takeaways, which is you know, harmonizing measures is key, but it takes a lot of collaboration with purchasers, providers, and other payers. And so we are really committed to doing that. Ensuring that we have the right set of stakeholders and the right, you know, people at the table, including our specialty partners from the specialty associations. And then the power of data and actionable analytics, the right model, and the right people are not enough. We have to make sure that the right actionable insights are surfaced, and surfaced in a way that is not just, log into yet another portal. How do we actually deliver these insights into practicing providers' workflow, so we can actually move the needle and the numbers in the front -- the front of the physician or the care managers and inform them as well.

So, excited to continue the conversation. Thank you for the opportunity to share perspectives.

CO-CHAIR HARDIN: Thank you so much, Krishna. I'm sure our Committee members will have many questions for you. Next, we'd like to

go to Dr. Dana Gelb Safran who is President and Chief Executive Officer of the National Quality Forum. Please go forward.

DR. SAFRAN: Thanks very much and good afternoon to the Committee members. I'm really pleased to have a few minutes to talk with you today. Sorry, I was just setting my timer here, so I don't go too long. And I come to you in the role that you see on the slide, but also my past background, which is what brought me before you a couple of years ago is as one of the architects of the Blue Cross Blue Shield Massachusetts model called the Alternative Quality Contract, which was credited with catalyzing value-based payment in the U.S. and even internationally. So a lot of what I'll share today comes from my experiences both in the design, but more importantly, the oversight of that work and supporting providers from across the Massachusetts network who came into that model. And that was over 90 percent of providers.

So if we go to the next slide, what's captured here, very recent information from a survey that NQF did out into the health care ecosystem to understand what are the biggest challenges that organizations across all

stakeholder groups -- payer, provider, purchaser, patient advocates, policy makers -- what are the perspectives on the state of quality measurement and its uses today? And I don't think probably anything on this screen surprises you. It didn't surprise us. But this really highlights the challenges that NQF is focused on today. It takes too long and costs too much to develop new measures. That there are too many measures and cacophony. The fact that the measurement is so often seeming to be burdensome without benefit. And so our work -- NQF's work is really now focused a thousand percent on addressing these issues. So I'll say a bit about that over our time together this afternoon.

If we go to the next slide. This highlights something I believe I shared with you when we met two years ago and comes from the work of the Healthcare Payment Learning and Action Network. Some subcommittee that I had the privilege of leading together with Glenn Steele, then CEO at Geisinger. And that committee's work kind of coined this notion of big dot measures. Saying that value-based payment really demands a shift from the little dot measures that we have today that really represent the transactions or

the processes of care that are really a byproduct of a fee-for-service model of paying for care to the more appropriate bigger dot measures that we need under value-based payment.

And that we pointed out by moving to bigger dot measures, we address parsimony because we need fewer measures. But also importantly, we lay out what are the outcomes that the value-based payment model is looking to achieve? And let's leave the process and how to achieve those outcomes to those who provide care and not micromanage that. So that was what was laid out back in 2016.

Let's go to the next slide. I would say that what you see on the right side here is the Alternative Quality Contract measure set that I developed in 2007 as we were preparing to launch the AQC. It launched in 2009, so this was our design phase. And what you see is -- you know, it was at the time, the most comprehensive quality measure set in any health plan provider model. Pay-for-performance was still relatively new in 2007. It's generally, you know, a small number of measures, very small dollars. And here we were expansive. Ambulatory care, hospital care, process outcome, patient experience in both

settings.

And you know, what is the case is that unfortunately value-based payment measure sets today look nearly identical despite over a decade of agreement consensus. And that 2016 report from the LAN[36] saying we need the outcome oriented big dot measures that really are more in keeping with the goals of value-based payment.

And so on the left side, what I highlighted there, and I won't read these to you. I know you received these in advance and you can see for yourself, but the issues that we need to address, we need measures that represent the outcomes that matter. We have to address the issue of data sources and burden, but also timeliness. And I know you heard earlier today some discussion about what is the right unit for measurement. And I'd love to share some perspectives about that, but certainly we need the contracts themselves to focus at the organizational level. But we also often times need measures that get down to lower levels that either are part of the contract or importantly that the contracting organization, the ACO, is holding its provider partners accountable for.

36 Health Care Payment Learning & Action Network

So we can discuss that. I look forward to that in our exchange.

Alignment, I imagine you've heard a lot about today. You'll hear more about it from us. And it's critical. We have heard for a decade or more that failures of alignment across payers are in measures that are used are one of the biggest barriers to provider adoption and a great source of frustration, burden, and disillusionment with the measurement field. And then finally incentive structures that we'll talk a little bit more in a moment.

So let's move to the next slide. And here I'll just say a few words about Aligned Innovation. You heard our Blue Shield California colleague referencing participation in this work. Aligned Innovation is designed to address the challenges that we've just been talking about. To accelerate progress toward a next generation of measures for value-based payment that fill high-priority gaps and that represent the outcomes that patients and clinicians say matter most.

And what you see on this screen are what are the real four differentiating factors of Aligned Innovation relative to traditional

measure development. So first and really importantly to the conversation we've been having is prospective alignment. We have 14 payer and purchaser organizations from across the country who are agreeing to -- in public and private sector by the way, some state Medicaid, many Blue plans, other national health plans, as well as large purchasers like Walmart participating. And aligning that we will agree that these are the highest-priority gap measures that we really need for our value-based payment models and other population health efforts in improving health equity. And if we build it, we will use these measures as-is. We won't adjust them and tweak them as has happened so often with measures today. And also importantly, for every measure introduced, we'll retire two or more measures in an effort to begin to reduce burden.

So the prospective alignment is a really critical aspect of what we're doing. A second is that once those priority gaps are identified, the outcome measures that we move forward developing really come from what patients and clinicians tell us are the most important results they're looking for from care relative to those priority gap areas. Today we're in our

first cycle of work developing outcome measures for behavioral health, specifically for depression and anxiety in children, adolescents, and adults. And maternal health outcome measures, specifically two measures that experts say if successfully achieving high performance would significantly reduce severe maternal morbidity and postpartum death. And in so doing, improve health equity in maternal outcomes.

The third differentiator is that unlike traditional measure development, which typically happens with a pretty small, pretty homogeneous group of providers, we have a purposeful broad selection of providers who are coalition members bringing to the table and who represent every care setting from FQHCs[37] to academic medical centers, everything in-between, large and small, urban and rural, and who sit with the measure developer to enable us to front load the discovery and solving of clinical and operational objections to measures that typically don't even get identified until far downstream, and then cause rework and delays and so forth. So that's a really important third differentiator, and the inclusiveness and kind of

37 Federally Qualified Health Centers

human center design is critical.

Finally, all of this occurs in a 24-month period from end to end from that prospective alignment until having a measure that's ready for our stakeholders to use, having had input from across the country from providers. And that contrasts with a six or more year traditional timeframe.

One final feature of Aligned Innovation that I'll just highlight if we go to the next slide is we do in addition to having the coalition and that network of providers who are involved, we also have what we call our Multistakeholder Advisory Council or MAC. You can see the five pillars of participation and representation from stakeholder groups, all of the different centers at CMS and the accreditors, payers and purchasers, patient and consumer advocates, HIT[38] and professional societies with expertise relevant to the areas that we're working on in a given cycle. This contributes to the human-centered design and to ensuring that these organizations, which really represent the end users and enablers of the measures being developed, feel that they've had input into the

38 Health information technology

measurement process every step of the way so that they are waiting in the wings to take the measures and use them in their programs when the measures are ready at the end of the 24-month period.

So two final gets if we go to the next slide. The additional area I wanted to highlight and also work that NQF is doing but separate in some ways from Aligned Innovation is how do we ensure that the data infrastructure in our country enables the goal of richer clinical information without added burden, right? The burden that we hear today from the use of EHRs is the trade-off from moving away from claim space measure, very low burden, but getting more clinically rich information has created burden. And so what I've highlighted here are four areas that I think begin to address this, each of which represent core work for NQF right now and nationally.

So if you think of the first bullet as kind of the back end part of EHRs and facilitating the ease of reporting information out, FHIR[39] is absolutely critical to that. And

39 Fast Healthcare Interoperability Resources

ONCs work on USCDI[40] and USCDI+ is central. Making sure that prioritized in those data standards are the data elements needed for quality measurement, in addition to the data elements needed for interoperability for clinical care.

Second, I think of as kind of the front end. How do we make the richer data available from the EHR without adding burden on inputting things into structured fields? Here I think AI methods, including natural language processing, are going to be extraordinarily important to the very near and longer-term future for quality measurement. And NQF is proud to be doing some work with AMA[41]on this topic with generous funding from the Moore Family Foundation and starting with how the clinical record and the narrative in the clinical record can be used for diagnostic excellence measurement.

Then of course, there's the importance of beginning to integrate patient-reported measures into EHR and really facilitating the ease of longitudinal tracking for that. I hope we'll talk more about that. There's so much to

40 United States Core Data for Interoperability
41 American Medical Association

be said there in the importance of that area of measurement, but it's cumbersome today. And then finally, pioneering the methods through which to evaluate measures that are derived in these new ways, especially measures derived with AI and NLP[42], very different from traditional measured development. And we will have to have new methods for evaluating the reliability, the validity of those measures. And that's central to the work NQF is doing today.

Finally, and I'll leave you with this – last slide please -- are just a few of what I view, and this is largely from my time at Blue Cross Mass on the AQC, but also my time as a MedPAC commissioner over six years. I would say these are seven key elements that I believe are really important design features that have been proven to enable ongoing performance improvement to be motivating of that ongoing performance improvement. And that's central because we know and we've heard and I showed in the first slide, so much of the way measurement is occurring today is creating a real sense of burden and disengagement. And I think some of these best practices for how we design value-based payment

42 Natural language processing

incentive models really can help support as they did in my 12 years at Blue Cross Mass leading the AQC, support ongoing motivation for significant improvement, including on outcomes and total cost of care. So I'll stop there and I look forward to our discussion. Thanks.

CO-CHAIR HARDIN: Thank you so much, Dana. Another very rich presentation. I'm sure our Committee is looking forward to asking questions. So next, we'll go to Dr. Vivek Garg who is the Chief Medical Officer of Primary Care at Humana. Please go ahead, Vivek.

DR. GARG: Good afternoon, everyone. Can you hear me okay? Yes. Well, thank you for the opportunity to be here today. My name is Vivek Garg. I'm here to share some thoughts around patient and caregiver experience in the context of population-based payment and care delivery models. I'm a primary care physician and internist who's worked within consumer-focused startups and primary care and health insurance such as One Medical Group and Oster Health. And then more recently worked in national medical groups focused on vulnerable patients covered through Medicare and Medicaid such as Caremore Health and now my role at

CenterWell Primary Care. CenterWell Primary Care is the senior-focused primary care group under the umbrella of Humana, and we serve about 300,000 seniors nationally across almost 300 clinics.

So I thought I'd start with a little bit of satire from Mark Twain because in all of the environments I've worked in, we're awash with data. We have claims data, clinical data. We connect to health information exchanges like Krishna mentioned. And we surface all of it through operational dashboards and actuarial analyses so that we know what our patients need, both prospectively and retrospectively as much as possible. But as Mark Twain suggests here, data can be like garbage. If you collect it and don't know what you're going to do with it, it starts to smell, particularly to clinicians. So how we use data to drive in certain action and ultimately to improve patient and caregiver experience is what's most important.

Go to the next slide. I thought I'd ground us quickly in how groups like ours try to achieve the quintuple aim and bring it into action and visibility for our clinicians and caregivers. We are entered on a balanced scorecard, something

like this, not exactly like this, that includes a set of metrics and goals that cover broad domains of population imagery. In this example, you can see population engagement. How well are we engaging our panel's primary care patients? Sometimes you can look at it as just did everybody have their annual comprehensive exam? And then you can also do deeper cuts around specific segments of your primary care panel for people who you may need to see more frequently and assess whether that's happened.

It's also very important when you're growing or when there’s churn so that you can make sure that new patients are getting access to timely and comprehensive care. In addition, this helps us identify unengaged patients who often face structural and other barriers to accessing primary care and allows us to develop clinical interventions that helps us meet them where they are. Obviously with the support of the data interoperability that Krishna and Dana mentioned.

Secondly, patient experience, which I'll expand on in the following slides. Many groups like ours actually orient around net promoter score. As you all probably know, this

is a simple customer loyalty metric that spread from other customer service industries into health care. Patients get an anonymous survey to fill out after a clinic appointment. They rate how likely are you to recommend this practice to family or friends on a scale from 1 to 10 with 10 being great? And you only count the 9s and 10s. And then you subtract for people who score 6 or below. So it's a very harsh discriminating total score around the likelihood to recommend your practice. And it can be very controversial for clinicians because patients view their experience very holistically and rightfully so. So they may love their clinician, but they may struggle with the phone system or how long the referral to the specialist is taking or parking or if they came late, could they still be seen? So these are the issues that when you surface this data and start to use it, come up with your practice team.

Obviously everyone here is very familiar with clinical quality. We are asked to deliver excellent HEDIS STAR performance and for preventive and chronic care. So practices like ours strive for and often achieve 4.5+ stars HEDIS performance on the metrics that you all know well.

And then thirdly, we look at obviously population total cost of care in clinical utilization. So we will look at trends, set polls, or ranges around things like avoidable hospitalizations, ER visits, and readmissions because those are major utilization factors that contribute to total cost of care and that we know we can improve with a strong, comprehensive, and continuous dose of comprehensive primary care. And then lastly, just like in fee-for-service, there's some notion of productivity, in our world it's often engaged panel size. That is the basis by which we think about moving the needle on population outcomes.

So just to summarize this slide, this is an example of how a balanced scorecard is used in a total cost of care-oriented primary care practice under full risk. Patient experience is one component and very important and equally weighted, but it is not the only one because we can only give people so much to absorb and act on.

And then secondly, I just note that groups like ours often create a bonus program around scorecards like this with the additional bonus of somewhere between 10 or 15 percent of

the clinicians' fee salary, up to 20 or 25 percent. And I'd say anecdotally, that is the size of incentive needed to get the attention, alignment, and teamwork that is needed to really change what's happening for patients.

If we could go to the next slide. So I hinted at this, but you can't talk about patient and caregiver experience without talking about customer service. It is the same thing in many ways to patients. So as other service industries sort of advance and build much higher customer service orientation, they've developed online access, real-time feedback that's publicly visible, personalized communication, and the operational wherewithal to create closed feedback loops so that you know that your need has been served and sometimes even how long it's going to take and who's going to deliver on it. Think about Door Dash versus what we do in health care right now.

So I give you three examples here of how many groups I've worked with use what's out there to learn what patients or customers are actually saying. So let's start with the left, which is Google reviews. If you have a practice site listed on Google, you want it to be on

Google Maps, and you get these reviews whether you want them or not. So the question is what we do with them. And you see that sophisticated customer-oriented, patient experience-oriented groups. Make sure that there's comprehensive orientation about the practice online, what's the right phone number, what are the open hours? Is there virtual care access? Is the website updated? Is the location right?

And then they actually curate and monitor and respond to individual patient feedback. And so either through the clinic manager or for large groups like ours, sometimes whole-scale service response teams, we look at these on a regular basis to learn, to act, to repair, and to become better.

In the middle category, I mentioned net promoter score previously, we partner with groups -- groups like ours partner with third party platforms and tooling systems like NRC Health or [unclear]to conduct the kind of net promoter score service I mentioned. We look at this very intensely. We look at trends. We look at how we vary clinic to clinic. We compare ourselves to benchmarks available through these platforms from other like groups because they're

very heavily utilized.

We also deliver to our clinicians on a monthly basis, their personal scorecard and patient comments, most of which is very positive. As they're often clinicians that see these kind of comments, they're very good about them. But I'll tell you, when you have a negative or unreasonable comment, it will really stick with clinicians because they feel like they're trying to do their best. And sometimes the things that come up are outside of their control. These comments and rating systems often populate our own internal practice provider directories that we publish on our website so that when people are seeking care, they can see the comments and feedback for each individual clinician. And many times, patients look at those, and they look for something that stands out to them, that allows them to feel a personal connection when selecting the PCP that they want to see for their ongoing care.

And then lastly, every organization I've been a part of that's very customer patient focused, listens to and monitors the quality of calls. When people aren't getting what they need, they call. They call the practice, and

they hope someone will help. So the more advanced you are, the more you look at your -- not just your call responsiveness, the length of time of the call, you know, did you complete the call? How did they rate you afterwards from the call?

But you actually build deeper analytics to understand what types of issues are coming up with what frequency and volume. And you can imagine the kind of calls that came to practices as COVID hit. And if groups are monitoring that, they knew -- they knew that there was an unusual respiratory illness causing serious issues and lots of things happening in the health care ecosystems that were not well understood. So if you want to find a patient experienced focused medical group, look for what they're doing with calls and what patients tell them when they call.

Go to the next slide. So I'll pivot a little bit to CAHPS, not to explain CAHPS obviously to this group. We all live within the world of CAHPS surveys. Obviously the surveys required for all Medicare Advantage contracts. There's a different survey that's very similar for future service beneficiaries. There are

three main issues with CAHPS from my perspective.

First, the questions are spread out and combined across health plan and practice or medical group areas of responsibility. It's a combined effect, and there are different things that obviously each party does, but it's an overall survey that covers both.

Second, the survey results are months delayed, not real time such as the customer service insights I noted in the prior slide. This disallows or disables the practice from taking real-time or near real-time action, iterating and solving issues as they emerge.

Third, the surveys are required in some places like Medicare Advantage, but not all. And there is not a national uniform required medical group-oriented CAHPS like survey or tool that would allow us to look at how we're trending around patient service and experience factors, care coordination, all the factors here as a practice over time across all of our patient populations.

So ultimately, CAHPS delivers crucial information, but it is not timely or specific enough from the medical group perspective to drive the type of action that I talked about on

the prior slide.

Let's go to the next slide. Obviously there's a lot of ongoing work and innovation as Dr. Safran and Krishna mentioned. I've been personally thrilled as a physician who's had to rank teams around quality and population health outcomes to see a push for the universal foundation and quality framework from CMS. There have been too many metrics, too much variation, too much selectivity, and obviously the fragmentation that Dana and others mentioned.

However, I would say while there's an adult and pediatric version of the universal foundation proposed, there's not a senior-specific one proposed yet that I've heard about. Seniors need a primary care home that delivers Barbara Starfield's four C's of primary care. First contact, comprehensiveness, continuity, and coordination. In this framework, the CAHPS survey could be substituted by something like the person-centered primary care measure, which is a simple validated eleven-question survey advocated for by the AAFPand others that really assesses someone's relationship to their primary care clinician and primary care practice. And their sense of whether they're -- whether they're

getting the responsiveness that they need.

In addition, a universal foundation around quality that's senior-specific could incorporate the five M's of geriatric care over areas such as medication complexity, mind, mobility such as fall risk, altered complexity, and crucially what matters most. Because as health issues stack up, dysfunctional issues stack up. You have to pick what's most important. They cannot all be fixed. And so we need frameworks like the five M's to help orient around what's most important for patients to drive the experience and help outcomes that they're looking for.

Additionally, CMMI has advocated for incorporation of patient-reported outcome measures. I would just say I hope we learn from the lessons to date, and we don't allow too much selectivity across different payment model and pilot programs, that we keep moving towards national practice area-specific metrics and balanced scorecard type approaches.

So if we go to the next slide. I won't say all this. It's a lot of text. I've covered a lot of it already. But again just to summarize, it's a -- we had a tremendous

opportunity to create national reporting alignment around patient and caregiver experience. And to deliver it at the union of operations that actually matters, which is the practice. And to allow medical groups and practices to learn from those insights that can be as real-time as possible. And to drive intervention, process changes, and programmatic changes, they need to deliver on the modern expectations of patients.

We should take a balanced scorecard approach, including consideration of a senior-specific universal foundation for the reasons that I mentioned before. And by moving to this approach, we can equip that the data we collect is not garbage as Mark Twain warned us. It is useful. It is well placed. It creates real action and uniform movement towards the experience all of our patients deserve. Thank you.

CO-CHAIR HARDIN: Thank you so much, Vivek. I know, another really interesting presentation. Committee members, please be capturing your questions so that we can dive in as soon as we're finished with this next presentation. I'd like to welcome Dr. Sai Ma who

is the Director of Enterprise Clinical Quality at Elevance Health. Please go ahead, Dr. Ma.

DR. MA: Thanks for inviting me today to provide some thought about selecting health equity measures for population-based total cost of care models. During my previous experience at the CMS, CMMI, NQF, and in the private sectors, I would like to provide some technical considerations concerning metric selections for health equity.

So here's a summary of some key points that I'm going to touch on today. Stratification is a first step to identify disparities, but it does not identify root causes. It's a great start. And I will touch on briefly about how do you stratify has implications on preventing unintended consequences.

And the second point I want to make today is health care equity contributes to health equity, but they are not interchangeable. Terminology is important, and I would love to provide some thought about -- to distinguish between health care equity and health equity.

And finally, I will touch on providing a roadmap to identify root causes and how do you take action and provide -- maybe provide some

insight to inform your budget allocations.

All right, so we can move on to the next step. Health equity has become a fundamental priority for policy makers and for the entire industry leaders. To date, most efforts have been focused on stratifying existing measures. And I would say stratification is the first step to the right direction because to improve health equity, we first need to call out where the disparities are, and stratification is a great way to do that. For example, NCQA has implemented a race/ethnicity stratification for several HEDIS measures. CMS is implementing the health equity index, HEI, for Medicare Advantage programs.

I want to point out -- maybe it's too basic, but methodology is really important. There's several critical methodological considerations and choices for stratification. And depending on the choices you make, you might get to the different conclusions, and it will inform your program design differently.

Given the time limitation today, I would only focus on two really important considerations. The first one is risk factors can be interactive. Right now, a lot of the

stratifications only concern one single category at a time, whether it's race, ethnicity, rural versus urban, for example. But one risk factor looking at that at one time can misguide us because the risk factors could be interacted. Meaning that the impact of one factor could be magnified or mitigated by another factor.

If you'll look at the figure on the right, if you only look at difference between race, ethnicity, or different racial groups, you might conclude that the Black individuals need the most help. But when we further stratify the population by dual eligibility for Medicare and Medicaid, which often is used as a proxy for social economic factors, you would conclude that, that the white dual members are just in as much need as Black dual members.

The second technical consideration I would call out for attention is within versus between disparities. Very often when we talk about disparities, we're comparing two groups, whether it's racial groups or again, urban versus rural or other groups. We're really just looking at the average difference between two groups. However, I would say within each group, we also have high-performers and lower-performers. If

you're not looking at within group, you're missing out a lot of population and members in need.

So for example, on the right side of this figure, we look at within group disparities and again, white dual members, as well as Black dual members have a lot of members in the lower end, and they need attention. And how you look at the data again, informs how you design your programs and where you are allocating your resources.

And on the next slide, I would want to talk a little bit about the difference about health care equity versus health equity. So as I mentioned before that both health care equity and the societal structure equity contribute to equitable health outcomes. And I think for today's discussion, I think it's probably in a lot of people's mind that I'm just one health care organization or one health plan. I have limited funding to improve health equity. Where do I start?

The question I often heard is we don't want to boil the ocean. Where do we start at, and how do we allocate our limited resources? This roadmap framework is aimed to provide that

kind of distinction between health care versus health equity. I think for this audience, we probably are very familiar with what health equity is. Health equity means that everyone has a fair and a just opportunity to attain their highest level of health. However, I would mention that equitable health is a result of a broad spectrum of individual, as well as societal factors that are experienced over one's lifetime.

Often used interchangeably with health equity, health care equity more narrowly describes equity in the experience of accessing and interacting with the health care system and the organizations. Health care equity more directly examines whether a patient has equitable access, receives equitable care, and has equitable experience along the care journey.

And we provide you three criteria for you to consider when a measure has fallen into the health care organizations purview. Is this measure -- equity measurable an individual level, whether is at patient level or provider level. And whether or not this inequity is proximate to health care outcomes. And then finally, if it's actionable.

If you apply those criteria in equity, and it falls in -- you know, checks all the boxes, I would say it definitely falls into the health care equity – health care organization's purview and that you should be doing something about it to improve the equity. And if it falls outside of one organization's purview, for example, a lot of the organizations have spent resources improving community health, community resources. For example, tackling food desert. That's a great admirable activity, but do you want to use that to set a goal to measure a VBC, value-based care arrangement, probably not -- it's probably not the best measure to use.

If we go to the next slide just to take the message home. Again, the way to use this roadmap is identify an outcome you wanted to advance equitable outcome on the right side. Tie that to payment. And then walk it back along the care journey to think about along the way, how do you -- how you can improve this outcome, whether it's in the prevention access area, is it transition health care? Is it to improve quality health care? Or maybe there's something you can do in the post-discharge phase. You can use this roadmap to help diagnose root causes along this

care journey. And looking at your KPI[43]'s operational measures internally or looking at published research to help you identify where the disparities are along the way. And help those to improve your process along the way, but we would not advise using those process measures to tie to payment. To Dana's point earlier, we wanted to tie payment to the big dot measures for person's outcome, not being too prescriptive, how do you provide that along the way?

So to close out my portion of presentation about Elevance Health, we have developed the Whole Health Index measure to understand the individual needs better to support and improve an individual's health. The Whole Health Index is a comprehensive measure to encompass all the measured drivers of health. We're currently testing to see if we could use that measure to evaluate our health care organization’s ability to address all measure drivers. We will be happy to share the results as when they come in for progress.

That is it for my portion. Thank you.

CO-CHAIR HARDIN: Thank you so much, Dr. Ma. That was again another really

43 Key performance indicator

interesting presentation. So Committee members, please have your questions ready. I'll kick us off with one, and then we'll dive into comments and questions from the Committee.

So this is a question for everyone in the group. What are the major challenges providers and health care systems experience with implementing performance measures in population-based total cost of care matters? Who would like to start?

DR. GARG: I'm happy to offer two quick thoughts related to the balance scorecard framework I shared earlier. The first is clinicians want to look at their metrics across all their patients. So creating alignment and uniformity across different peer models or programs allows them to think about patients in the way they think about them, which is what is their clinical need? What's their context? What are their goals? So that is a challenge obviously, and one of the reasons groups like ours built massive data infrastructure to immigrate the data as much as possible to present one uniform group.

And that relates to my second point, which is explainability. Every metric I shared I

have to explain to my clinical team. And they, with the significant waiting on their bonus, which creates aligned incentives about the population management focus come, how accurate is this data? Which is logged, and which isn't from different payers or partners like Great Plains and send back information? Is it accurate or not? So at the end of the day, our clinic teams become very savvy at understanding where the data feels off or not. And they recognize that behind it is a lot of data interoperability that they wish that didn't have to exist.

And then they also need to understand these metrics. So actually in our onboarding in my current group for new primary care physicians, part of our onboarding is about explaining this type of balanced scorecard. Many doctors who join us have never practiced in a value-based care environment. They have not had much data or experience looking at the cost and utilization trends for their population or drilling into things like specialist referrals from a different vantage point. So explainability and defensibility and data integrity and real-time data all matter for them.

DR. SAFRAN: I'll build on -- I'll

build on those perspectives from Vivek. And I draw here from my experience over the 12 years of Blue Cross Mass overseeing implementation. So in addition to the really important points that Vivek has named, I would name a couple additional ones. One is the opportunity to actually plan for improvement on the measure set that you're accountable for really requires that you have enough time to -- before the measures are going to change or the benchmarks are going to change. And I think that's a critical piece. And in fact, something that I worked hard for my seat at MedPAC to advise. And that, you know, I think MedPAC put forward as recommendations that in multi-year contracts including, you know, multi-year models of CMMI would put forward, but CMS's other programs, private payer programs, multi-year contracts should allow the measure set to be fixed and the performance targets to be fixed so that those who are accountable for that can really plan their improvement journey and strategy.

And in addition to that -- and you saw this on one of my slides -- having those performance targets be set in absolute terms, not relative terms means it's very motivating because

your success is not impeded by somebody else's success. And therefore, it's very motivating and in fact, promotes best practice sharing because your success will not impede my success.

A second point I would make about the key challenges for providers is knowing who can drive the improvement internally. And that might be different. So let's say we have it in a measure where the accountability is at the organizational level. How do you know internally who can actually drive success on that? Is it primary care, within primary care? Is it the role of our pharmacists, our social workers, our nurse practitioners, our physicians? How do we actually have a framework for that and create the internal incentive structure and measurements that support the external accountability for measures and targets and improvement?

A third is, you know, is it worth it? Right? And so many of the value-based payment programs today put very, very little money on quality. There is the shared savings opportunity and whether that's two-sided risk or one-sided risk. The quality measures are very often just a gate to the accessing of shared savings. And my own hypothesis as, you know, a recovering social

scientist in 20 years of my life is that, that's one of the reasons that the Blue Cross Alternative Quality Contract saw very, very significant gains in quality and outcomes documented in a series of articles in Health Affairs and New England Journey of Medicine and others, and others where most initiatives find, you know, impacts, if any on the cost side. Very little on the quality side when the AQC offered very significant payouts for quality performance. And that, I think was differentiated and is something we have to think about because we know that if the juice isn't worth the squeeze, that you know, all the effort with especially the cacophony of measures will stand in the way.

And then the last piece, I would just underscore something that Vivek said, which is from my experience, we really had to help our provider network with data to understand where might there be waste that would help them identify opportunities for shared savings? The quality measures, assuming they were motivated to improve them by the sums of money and a view of fairness, et cetera, they pretty much knew how to work on those. But you know, mostly they had not previously been in a contract that made them

accountable for total cost of care. In fact, quite the opposite, as one hospital CFO said to me in a negotiation. You're changing the game. Like the way I used to win was do more as complex as possible, that's how we make money. Now you're turning that on its head. You have to tell me: how can I possibly do that? You know, think of it as I'm a kid that doesn't know how to swim. Tell me how I, you know, hold my breath, flap my arms, kick my legs. So I think that support around how to find those opportunities for savings is really important. Thanks.

MR. RAMACHANDRAN: Great perspective. I guess what I would add, and I think there's definitely a plus-one to many of the comments there, lots of alignment there. I guess from my perspective, I think most providers I've seen are using a balanced scorecard approach like what Vivek was talking. Mostly where -- to get to the quintuple aim, we have to. There's so many dimensions to balance. And so there is always a higher volume of measures built in. And so where we can really create alignment to reduce that. So it's still a balanced scorecard, but it's a manageable balanced scorecard. Because obviously if you had a scorecard with 200 measures, it's

not very balanced. It's sort of like a death by paper cuts. And so how do you, you know, create some alignment, I think is one. And I think we've touched on that topic in the course of our comments as well.

And then Dana's comment on the actionable insight. The way, particularly the cost of care I think is resonant as well because many of our providers in my past life and other payers would hey, we signed an agreement. We don't know how to bend the cost care. Like teach us how. Serve us up the insight, serve us up the methods to do it in a way that -- in a timely, meaningful, accurate. And so that philosophy suddenly, you know, in quality, I think it's the easier one to get their arms around and certainly be cost, which is trickier as well. So those are two perspectives from my perspective.

DR. MA: Yeah. I would add really quickly that the scorecard is a great approach. And from our experience because we have our line of business would have Medicare, Medicaid, commercial, exchange, and some other -- some more line of businesses -- what we have seen is not oh, I would have too many measures. The measure

specifications are required by different regulators, very different. So even though the measure concept might be the same about blood sugar control, for example, some states might be requiring different cutoff from Medicare, from Medicaid, or they use poor control versus good control. So the measurement alignment itself, I think cannot be understated how important it is, you know, in addition to reducing the number of measures.

CO-CHAIR HARDIN: So helpful. I'm going to turn it to the Committee for questions. Jim.

DR. WALTON: Thank you, very nice. Thank you, each of you for coming this afternoon and helping us out and sharing your thoughts. I had a question for Vivek. I'm particularly interested in the topic of primary care clinician burnout. I'm curious about what you think and your experience has been -- and other members of the group too, but you mentioned the net promoter score and particularly, measuring the outcomes from patients. But I'm curious about whether or not you've considered in the past or you consider for the future, asking your providers to give you a net promoter score for your system as a proxy

or an indirect measure of maybe how they might be struggling with the system. And the system's support for them and their patients that then would lead to lower net promoter scores for their particular patients. Do you follow my logic there? Okay. And so I'm just going to leave it there and see what you have to say.

DR. GARG: Well, I'll tell you no issue is clear to us or a group like us when your patients and your doctors are saying the same things in their different feedback mechanisms, and you know you have to focus on it. And so we do have an annual team member survey that's more general. And actually in our current group, we're actively assessing options out there that are much more clinician-specific to assess things like how easy is it for you to trigger the next step in care within the team or outside of the team? How well does your practice handle different service and operational issues like referrals or calls? Do you feel like, you know, you can be sustained in your practice? You know, the burnout survey questions or things like that.

And so many groups like ours obviously do implement tools like that. Our group just happens to be a process for assessing them to go

from a general annual employer-associate experience survey to one that's much more clinician-specific for the reasons you mentioned. And through actually partner organizations like Press Ganey or NRC or other platforms like that, they can provide both sides of the equation, in addition to benchmarking from geographic groups, and you're seeing geography or groups in your area of practice – you're a gastroenterology practice, you can look at other gastroenterology practices. That's a really crucial point.

DR. SAFRAN: If I could just comment on that, Jim, one additional thought. I don't know whether by your question, you were considering a kind of provider NPS[44] as an accountability measure from the payer. There I would be concerned because I think the providers would feel quite a lot of pressure to help their system look good on the measure. And I don't have data on specifically NPS alignment between patients and providers, but it sounds like Vivek might. And if you want an accountability measure, I think the patient NPS will probably tell you quite a lot about the provider NPS and is much less gameable. So just a few thoughts to

44 Net Promoter Score

add in there.

CO-CHAIR HARDIN: Let's go to Larry next.

DR. KOSINSKI: As someone who has sat on specialty boards for years and currently sits on the American Gastroenterological Association Governing Board, we spend an enormous amount of money developing guidelines and measures. And it's very frustrating when we try to get them into action through the NQF process and then get them into the EMRs[45]. It's very frustrating. I mean I think we spent last year in 2023, spent a half a million dollars on developing four guidelines. I was really impressed by both Krishna and Dana commenting on how we need harmonization of these measures. And I was really impressed by Dana's Slide No. 6, Aligned Innovation. Those are all the players that need to be put together to move this thing forward. But you only have four medical societies. We have to figure out a way to get more of the medical societies on board and harness the strength of all of those societies together so that we're pushing out a harmonized set of measures that then can be implemented. I'd love

45 Electronic medical records

to hear your comments.

DR. SAFRAN: Yeah, thank you. Thank you so much, Larry. And, I couldn't agree more. I should have made it more clear that the four that you saw on that slide are explicitly for this first cycle of work where we're focused on behavioral health measures and maternal health measures.

But, for every cycle of work, as we focus on other clinical areas, we have the appropriate specialty society partners.

So, that's an absolutely critical part of this work. Is making sure that the profession feels that the measures will have value, will be fair, will be feasible.

CO-CHAIR HARDIN: Committee members, any other comments? Questions? Jen.

DR. WILER: I want to thank each of you for your presentations. It's been a wonderful discussion.

My question is going to be for Dana and Dr. Ma. We talked a lot today about, and you've already addressed it, but I want to just go a little bit deeper, around the administrative burden and feasibility.

So, for the NQF process, you talked

about how, including the EHR vendors as one important stakeholder in the proactive measure development space is one way to tackle that.

But, what I'm thinking about is, can you talk more, not just around reporting of measures, but when we hear from our other panelists, how critically important analytics is to driving change. How are you thinking about that aspect?

Because we heard some information in the previous session around, you know, one practice's costs related just to software solutions, again, to collect data. And, that analytics has a separate, you know, fiscal note.

And, my follow-up question is then going to be, then how does this cascade from a feasibility and cost perspective, into this complicated space that has yet to be fully developed around defining what equity looks like?

And, what is the cost burden going to be, for not just reporting, but then analytics related to that space?

And, I'd say PROMS are in that other undeveloped space.

DR. SAFRAN: Thanks for your question, Jen. I'll answer this from two perspectives.

The first perspective is what I'll call the analytic tools that we need to inform clinical decision-making and clinical practice.

And then, there's the population level analytics. So, let's take those in pieces, right?

So, I think that the analytics needed to inform the individual clinical decision-making really are, they ought to be ideally part of the requirement of the EHR vendor. But, increasingly, we do see other solutions that have to then be married in and used in that way.

I'll share the example with Aligned Innovation. The behavioral health measures that we're developing that I talked about outcomes for depression/anxiety with children, adolescents, and adults, are going to be patient-reported outcome measures.

So, a PRO-PM[46] is being developed for each of those three age groups. And, we know that PROMs implementation has been one of the greatest pain points for practices.

And that, you know, slowly, slowly, the EHR vendors are starting to incorporate it. It would happen much faster if payers

46 Patient-Reported Outcome-Based Performance Measure

increasingly started to demand the use of PROMs, because then there would be the business case for the provider of why they need the EHR vendor to enable those capabilities.

But, so what we did in the meantime was to hire one of a number of solution vendors that are out there that are facilitating not only making it easier to collect the PROMs and get the resulting data into the clinical record, to trigger the longitudinal follow-up that needs to happen with PROMs at the right moment so you don't need, you know, some human being in the practice remembering, oh, it's time for, you know, for us to send Krishna his survey.

And so, all of that is happening. But, one of the things that's really powerful and gets to the first part of my answer to your question, is they are also sort of having analytics that create a data display of those PROMs for the patient over time, with benchmarks about other patients like this patient. And, even indications of how that score changed when you, as a clinician, changed the dose of medicine or did this other intervention.

And, that's -- think about how powerful that is as a tool. And, how motivating

that is for clinicians in terms of the use of PROMs.

Because suddenly, you know, the barrier to PROMs adoption that has been about, I don't know what these numbers mean or what I can do about them, starts to be addressed.

So, that's answer -- the first part of my answer is, we need analytics that are at the individual patient level and that kind of enable clinical decision-making.

And, I think those are happening through the EHRs. But, they're also happening through solution vendors and, you know, I'm foreseeing them all to compete to see who can create the solutions that providers want the most.

On the population level analytics, I think some of our conversation today highlighted one of the biggest challenges, is, when we have that misalignment across payers, then you need different analytics for the data sets from every provider. Right? From every payer, rather.

So, I could tell you about the fantastic analytics that my team at Blue Cross did for our providers in the AQC, and they did.

But, we know that what providers want,

and I think it was Vivek who said it, but it might have been Krishna, is, to see their entire population of patients that they serve on these measures. And then, be able to parse it by payer, et cetera.

And for that, there's some efforts underway to create what we're calling measure model alignment. Which is, not just alignment on the measures used, but alignment on sort of the data that's being collected, the compiling of the data, the analytics, and so forth.

So, I think, experimenting in certain markets where, for example, in Krishna's market where you already have multi-payer alignment and purchaser alignment with their providers and doing the same measures used in the same ways, getting the trial of multi-measure model alignment around analytics, is going to really help show us the value of that.

So, I know that was a long answer. I apologize. I hope it was a useful one.

CO-CHAIR HARDIN: Any other comments from our presenters on that one?

All right. Committee members, any other questions or comments?

I'll add one then, so, Dr. Ma, you

went very deep into really interesting information about health equity and equity-related measures.

There's a lot of interest nationally in, what are essential measures that should be considered for equity?

And also, what measures are you seeing that are having a larger impact on improvement in health equity that you would make recommendations to consider?

And, I'd like to hear from each of the panelists on that question.

DR. MA: Yeah. I can start. I should mention that, you know, most effort to date is stratifying existing quality and outcome measures.

But, there are some direct measures that are in place to directly measure the root causes, whether it's health literacy, or food insecurity, or transportation barriers.

So, one of those measures that is a little bit further along than others, is the social driver screening tools that NCQA and CMS are pushing forward for providers and the payers to collect those information, health-related social needs.

So, I think, for -- at the minimum, it's a greater way to break into understanding numbers of social drivers. And, that there are other very specific health equity direct measures, whether it's for access to care, or patient engagement, or culturally competent care.

I think one opportunity I would point out is, like what NQF has been doing for measuring the evaluating and endorsing quality measures. We need a parallel process of evaluating those health equity measures.

And, I'm not aware there is a process evaluation endorsement process in place now. And, I would call for the industry and government to regulators alike to think about what kind of process can be put in place quickly.

Because, you know, for those measures, we still need valid tools. So, we need some endorsement process in place.

And lastly, one of your questions is about best practices. I would tie back to the point that everybody made earlier, that workers' outcome measures pay for outcome measures.

The reason being, I was looking at a hypertension control, for example, if you look at which members or individuals were recommended for

lifestyle modifications and a medication treatment, the racial disparity is not huge. It's only about four percentage points between white and Black individuals.

However, if you look at for those members who get a similar recommendation, what their uncontrolled rate looks like, the racial difference becomes 11 percentage points difference.

So, I think, you know, if we are going to tie payments to quality outcomes, let's pay for what matters for members the most and not, you know, process measures. Let the providers figure out how to input outcomes.

DR. GARG: I'm happy to add a few quick thoughts. First, I would just note the universal foundations, inclusion of universal screening for health-related social needs for patients is really an example of a great step forward.

In some of the organizations I've worked in, when we've done surveys, and Humana's published through its Bold Goal and SDOH[47] initiatives, analyses that show that the burden of health-related social needs is very high

47 Social determinants of health

across Medicare and Medicaid populations. They may differ in which is most prevalent, which factors are the biggest gaps.

But, it is 40 to 50 percent of seniors are low-income folks on Medicaid. And, it is a very high number as we all know. And so, the more we look, the more we will find.

And then, the question is, what is the impact on outcomes? That's the first next question.

There are a lot of operational challenges to appropriately stratifying by race and ethnicity. And, I'm sure Dr. Ma's team spends a lot of time to ensure that we're accurately capturing people's racial and ethnic backgrounds. And, there are many structural barriers to that that single organization teams have to work through.

When you look at outcomes stratified by race and ethnicity and income, the differences have been known for decades.

And, then the question becomes, so you can shine a light on it. And then the question for a group like ours is, what can you do about it?

And so, obviously there are things

that are within a medical group's purview to do within our capability set. There can also be a lot of sense of futility within clinicians. Especially in primary care about what else can we do?

And, we have a model where we have social workers, you know, community health workers, connections to community-based service organizations. We use in Aunt Bertha.

We use all the tooling and resourcing we can find. We invest in it. But, there's still a limit to what you can do alone.

And so, then I would say, what can we do at the community level through the broader constructs, whether it's payment or how we cover different populations, to maybe adopt a similar approach to galvanize resource and attention across lines of business, across payment programs, to solve the structural issues that create these health-related social needs that impact outcomes based on your background and context that a medical group can't solve alone.

DR. SAFRAN: If I could add into that, just three thoughts. So, one is, you know, I really love Vivek's point about universal foundation and the inclusion of the collection of

social drivers of health data.

And, one of the challenges that we know that provider organizations face is, well, how do I know to use those data to actually make patient's care, and more importantly their health outcomes, better?

And so, that really has to be part of our purview, is to really help to identify how you take those data and connect to the community-based organizations, for example, that can help address those health-related social needs.

And, I'll share with the team that coordinated with us as speakers, the final report recently released from NQF leadership consortium, 30-some odd organizations, including CMS and others who participated in this very question of, okay, we're all collecting SDOH data. Now, what do we do with it?

And, so, I think it's a very helpful and valuable report, probably important to the question you're asking, Lauran.

The second point I wanted to make was, I think we have to face the both/and. That we want to have health equity indices to tell us at sort of the organizational level how we're doing.

But, we know that when you bundle all

the different aspects of disparities across different clinical areas into an index, you're obscuring the information needed to drive improvements.

So, we need the both/and of the index but also the granular information, condition by condition, population by population, around what the results are, so we know how to improve.

And then, the final point I would make is one I think I made two years ago when I met with this group. But, it is still pertinent and maybe even more so.

Which is, we have to confront this issue of whether as we understand there are differences in social risk in populations, do we adjust the measure performance, or do we adjust the financial payment?

When I was on MedPAC, a MedPAC commissioner colleague and I wrote a paper in Health Affairs about that we can have our cake and eat it too, if we adjust the money side. There's so much controversy around adjusting on the performance measure side.

Those who say doing so obscures disparities that need to be addressed, not obscured. Those who say, if we don't adjust

that, you know, we're treating providers unfairly who take care of higher social risks and risking access.

We can have our cake and eat it too, by adjusting on the financial side. Advantaging those financially who take care of populations that have higher risks, by giving them up-front money that acknowledges it might take something more different to care for this population.

And, by rewarding a given level of performance more if you're taking care of a population where that's viewed to be more difficult.

So, I just wanted to make those additional points in addition to the points that Sai and Vivek shared. Thank you.

MR. RAMACHANDRA: Thank you all. Great perspective. I guess how we look at it, one, I think, as the payer, where can we align incentives to sort of move the ethical conversation forward as one.

Two is, you know, just coverage type opportunities where we can just, you know, lean in, and just cover for services.

Like, I think we did some work with the doula coverage as a pilot, which is, we

actually worked with our employers to cover it and to expand the pilot.

And now, the State of California has made it a requirement in 2025, which is fantastic. That's a way by which we can use sort of the coverage lever as well.

The third, I'd say is just like, where can we just add more providers? I mean, California is a very diverse and big state with a lot of variations.

And, how can we reflect our provider network to reflect our membership, is another angle that's taken. So, those are like, three sort of levers we pulled at.

On the incentives piece, I think Vivek, your comment, I mean, we are clearly still collecting, there's holes in the data to even start to stratify that Sai was talking about.

And so, where we can work with our purchasers and, you know, obviously large players like Cover California, or MediCal. One clearly collects some of this data and some, you know, don't.

And so, how can we create a consistent way of collecting the data? And then, of course, using ways to sort of stratify measures and even

understand the disparities to bridge.

I think it's a balance of, how do you create -- so, a consistency in how we collect it. But, then, flexibility in how you solve for it. And, there's obviously regional variations, provider variations.

So, we don't want to have a super rigid approach as well, where Dana, your point on we are, by doing so, having one score, we are actually creating disparities or actually sweeping over disparities in the process. And, how do you not do that?

But, I think, Dana, you have to have the consistencies. So, that's the balancing act we're trying to do in using our, you know, value-based care models to help us on that journey as well.

CO-CHAIR HARDIN: It's a wonderful way to take us to the next session. We want to thank you each so much for taking the time to be part of this session.

You've informed our perspectives. And, will inform the report very deeply. And, we really appreciate everything that you've shared today.

Next, we're going to be heading into a

10-minute break. We want to invite you to stay for the end of the session, where the Committee will be coming together and discussing insights from today in preparation for our all-day meeting tomorrow.

So, until the end of the break, we'll return at 4:20. Thank you so much.

(Whereupon, the above-entitled matter went off the record at 4:08 p.m. and resumed at 4:21 p.m.)

*** Committee Discussion**

CO-CHAIR SINOPOLI: Welcome back. As you know, PTAC will issue a report to the Secretary of Health and Human Services that will describe our key findings from this public meeting.

We now have time for the Committee to reflect on what we've learned and heard today from our sessions. We'll hear from more experts tomorrow.

I wanted to take some time this afternoon to gather our thoughts before adjourning for the day.

Committee members, please find the potential topics for deliberation documents stuck in the left pocket of your binder. To indicate

that you have a comment, please flip your name tent up, or Josh that's here on Zoom, to raise your hand.

I want to start out with a couple of comments that I hope will do nothing but stimulate the PTAC members to have some more discussion.

So, I think it was a robust day today with a lot of, a lot of great subject matter experts. A lot of information ranging from very high-level concepts down to very granular things that we need to think about.

As I was listening, I started jotting down just little notes of things that I heard. Mostly at a very high level. These are, this is an undeveloped list of topics that is clearly incomplete.

And, each one of these needs to be unpacked and developed. But, I thought these were just things that I wanted to be able to get on the table.

So, the first thing that I heard, is that from a health care standpoint, that we have had limited transition to becoming a high-performing industry for multiple reasons.

And, I think that kind of sets the

stage for all the other discussions in terms of how we perform and how we measure ourselves.

We heard about making sure we had a clear purpose for measures. And, we heard John Bulger talk about the various buckets that he thought about when he thought about the purposes for these measurements.

We heard discussions about developing a portfolio of measurements. But, with an intent to move towards outcomes with no fixed reason to have measures in each bucket.

Using process measures only to test theories about whether certain processes contributed to outcomes. Or, if it had a clear link to an outcome.

We talked a lot about person-centered outcomes and patient-reported outcomes and a need to develop those.

We talked about developing CMS level measures that were -- that could cascade to an entity level. And then, very specific measures that could also then cascade to individual physicians, depending on their particular specialty.

We heard about the expense of all of these measures, both in the development, the

implementation, the measurement, and how expensive it was to do that.

But, at the same time, we heard discussions about how many more measures we needed, particularly in the specialist area. And, so, that was a little bit of a contrarian discussion there, the expense, but needing more of them.

We heard the need of developing measures for social determinants of health and equity. And, that our equity was persistent and/or worsening. And, that we needed to include some form of risk stratification as we look at those measures.

We also heard about defining what populations we were talking about in total cost of care. And, making sure we understood how we were defining those populations.

We heard a need for being more comfortable with thinking about these outcomes from a long-term planning standpoint and not short-term.

Moving away from claims, we heard some discussion about shifting to big dot measures, away from micro-measures. And, we continue to hear their call for needing an all-payer model to

help with those efficiencies and alignments of the dots.

So, I'm going to stop there and look to my PTAC members for comments and discussion further.

DR. KOSINSKI: I've had a big mouth all day. I may as well keep going.

CO-CHAIR SINOPOLI: I love it.

DR. KOSINSKI: What did I hear? A lot of what you said, Angelo. I think I heard we need conversations and collaborations so we can have harmonizations.

And, we can't keep, I mean, so many people are working so hard in their little spaces. And, we heard champions who work really, really hard and spent years of their lives working in this process.

But, they're working on this silo, and the next one is working in that silo. And, we need multi-payer solutions.

We need to harmonize all this work some way. That was probably my biggest takeaway today.

Secondly, we need investment. We need investment. I think Dana had a great little slide there where she had a square that said, the

incentives have to be more than what the doctor is making from their fee-for-service.

So again, like we've heard so many times, we need to make fee-for-service less appealing. And, we need to invest into this.

And then, the other thing that I heard over and over again today, was that it's the entity that bears the risk. It's the entity that creates the measures.

And, the providers are not at financial risk. They are incentivized to meet those measures.

So, those are my big three takeaways.

CO-CHAIR SINOPOLI: Great. Thank you for those comments. Jen, you're always good at summarizing things. I'm looking at you as you're flipping through your notes.

So, I'll put you on the spot.

DR. WILER: I'm not quite to 10 yet. I need to get better organized. A couple of the same comments, not well organized. But, I thought we had some fabulous speakers.

That it was interesting those, the diversity of topics that we touched. And yet, the same things that kept coming up, despite the various focus that we asked our panels to

diversify on.

Which I think is reassuring that we know the challenges. And yet, is disheartening to hear that for over a decade we've been focusing in this space and have made some improvement, but not the improvements that we want.

What I heard was that the downward pressure of financial risk has actually eroded outcomes and trust. And, exacerbated inequities.

And, I think we all know that to be true. And, it's unfortunate. And, I can't think of any other reason why we need to be more focused in this space and have a louder cry for change than that. Because that's the exact unintended consequence of what we were trying to alleviate.

And then, I heard a potential solution that said, the total cost of care should be laser focused on equity. And yet, we heard, you know, challenges around methodology and how to do that.

But, I think it might even be valuable for this group to think about future sessions that are completely dedicated to getting in the weeds around definitions of equity, methodology, risk adjustment, what different subpopulations

look like.

And, we keep bumping up against this challenge around who's responsible for care. And, what systems can better coordinate?

Who again, are all focused on an outcome of improving health. But, this discrimination between health and health care, I thought, was such an important one. Obvious, but yet important in that space.

I also heard, and it's interesting, because again, in my day job we talk a lot about this around basements and balconies. So, the basement being around safety, eliminating avoidable harm.

And, the call out from our first panel around focusing more on safety measures and what are those increments of care that if not done we know will result in harm.

And again, I'll give an example that just recently came up, because as we were talking about behavior health, again, in my day job, when we talk to our psychiatrist and ask them, what do you think you should be evaluated on?

They said, we order these medications that we know patients are supposed to have annual lab checks to make sure that there is not an

impact on liver function for instance. We try to do it. We don't know if we're doing a good job. We probably aren't doing a good job.

That's just one example of, again, without getting into micro-details. But, there are many examples of safety metrics. And, maybe rather than just thinking about improvement work, thinking about how safety folds in.

And that leads me then to, I thought Dr. Bulger's comments were a good rubric for thinking about what types of measures do we need?

What he threw out were measures for improvement, measures for accountability, which could include safety, and could include appropriateness, and could include reporting, and measures for payment.

And, that maybe they could all be different and should be different. And, I thought that was compelling.

And then last, you know, we gave our panelists an opportunity to talk about what they thought was necessary for success. I use the word mandatory to prompt, you know, their thoughts.

But, we keep hearing about multi-payer alignment. We keep hearing about, I'll put it in

soft quotes, mandatory participation in programs that has a deliberate glide path with an appropriate timeline for engagement, evaluation of current performance, and then, to do the work of improving performance, which is a long time.

In addition to components that to do that, care coordination is important. And again, that focus on equity is important.

CO-CHAIR SINOPOLI: Great. Thank you. I knew you'd do a good summary. Jim?

DR. WALTON: Yes, thanks. I was reflecting, when Tom Sequist was talking, that I knew him 20 years ago when I went up to Mass General for one of my early fellowships in equity.

And, I was telling Jen at the break that when Baylor Healthcare System decided it was going to consolidate with Scott and White, they disbanded the equity department that I ran, because after their -- after our second annual disparity report.

Not because we resolved the disparities, but because it was not -- there was not a financial incentive.

And, it appears that we're still in the same kind of circumstances today that there's

not actual maybe alignment with equity reimburse -- reimbursement for improving health equity at a level that would make a significant move of integrated delivery networks move toward the equity door to try to figure this out.

It is shocking, honestly, to listen to Dr. Ma, is it Ma, Ma? Dr. Ma, speak about equity research at the level she was speaking around.

And, she had advanced, they had advanced the ball in 20 years a little. And, that is how we think about health equity and health disparities.

So, it's discouraging. You know, I think channeling a little bit about Larry. And, we see this in kind of 20-year blocks of time.

We now -- and I think one of the comments that came up was that, now I forgot the doctor's name, from the University of Chicago, was powerful. To me it was, we need to redouble our investment, because this is a long journey. And, we are stewards, right?

We are just stewarding at this time. And so, we should advocate for more funding for research budgets, for the next generation of clinical scholars, but also for the health equity deep diving that's still yet to be done.

I thought -- I took away, something that really kind of struck me was that multiple speakers talked a little bit about gaming the system.

I was a little bit struck by that. Like that was resonating. Like people kept hitting the bell. It was as if they were listening to the other person and said hey, don't forget that people are gaming the system.

So, I thought that was -- I thought that was very interesting. I also thought that the points around structure process to outcomes, you know, was a fascinating reminder from Tom.

And so, in pulling it all together, I thought that it was Dr. Schneider that really kind of rang my bell around this notion of providers and patients losing trust.

And so, I talked to him offline, and I said, well, would you think there would be a possibility that we should try to figure out how to create a trustworthiness metric for systems and providers rather than implying that there's something wrong with the patient?

The patient's only responding to a system that they perceive as either trustworthy or not trustworthy. And, just as easily as they

could believe it's not trustworthy, they can just as easily believe it was trustworthy, depending on the features of that system.

And, I think there are lots of systems, I think Tom is like illustrating that at Mass General Brigham, they're trying to, they're trying to accomplish that and trying to focus on that.

So, I think that this notion of system trustworthiness that protects the public and advocates for both health equity at the individual and at the community level, because I do believe that there's an interplay.

And, I think that we might just have -- we may not be able to influence the community level metrics, but we can advocate for them. Because that's our charge as providers, is to stand in the gap for the community and represent the community's health care needs.

So, excellent provider -- speakers. And so, that's kind of what I wanted to contribute today.

CO-CHAIR SINOPOLI: Great. Thank you. Great comments. Lee?

DR. MILLS: I think I'm going to go with what Jen said last, which for me is the

catch phrase of the day, is glide path.

And, we heard multiple people talk about, there's just a prevailing confusion in many areas around the complexity of the metrics, around the trouble to implement.

And, the data problems around who the providers of a given service, and metrics that are defined for a given provider but yet in a different community, there are different providers then who the measure is designed for around the purpose of the data.

And, we are drowning in data that doesn't have much insight or wisdom to be able to bring to it.

And, I heard multiple speakers in multiple types of discussions plead essentially for a clear, multi-year roadmap, because it's a journey.

So many incentive programs are built, you know, it's a one-year metric. You can't even get a dashboard built in a big system in a year.

You just have to know where you're going to be able to even, even if it's not external investments, it's internal investment and time and expertise and leadership focus and attention.

So, if there's a role that, you know, CMMI or CMS can bring to this, I think we heard a pretty clear call, a clarion call for a clear roadmap pointing at least directionality, if not exact stations in the train journey.

I appreciated that multiple speakers brought up just managing, managing the work life and always keeping that focus of the quality and the aspect of the caregivers. Which in many specialties has gotten pretty poor.

And, I appreciated Dr. Gaylis' specific example about, you know, sending $220 thousand building a single analytics package and dashboard for a single measure for a small single specialty group.

And so, there is very significant investment in getting this stuff done. And, that certainly resonates with my professional experience as well.

I heard multiple people speak about equity. And, that certainly was a theme that carried through most of the conversations.

But, I was struck that we simultaneously need essentially equity at a large scale. We need even standardized measures like the ADI to apply to populations.

Yet, if that's all you have, you still need to do the nitty gritty work, patient by patient by patient to know what you can impact in your community. And that was pretty evocative.

And lastly, I really appreciated responses to this question about what's the -- the question was, what's the mixture of quality outcome, patient experience, process, utilization measures for measuring system transformation?

And, I heard the structure of the answers were slightly different. And, I thought it was interesting.

And, the categories that people spoke to was a portfolio of measures, first of all, will not be the same. Because every locality has, you know, different culture, different streaks, different weaknesses, different blend of specialties, et cetera.

But, a portfolio would include, above all, outcome measures. And next, decreasing influence of process measures, this idea that they seemed to reduce and lock in inefficient practice. Right?

That's -- unless they're tied closely to outcomes. And then, emphasizing equity. Then emphasizing appropriateness of care. Both

reducing low-value care and increasing high-value care.

And then ideas of access to care. A great evocative example of, you know, getting a specialty referral and all the specialists in your community are scheduling out one year. I think that happens all over the country all the time. I know it's true in my community.

And then, some measures of churn. And, that was interesting to me that spoke to that, that idea of percent of a provider or a specialty, or group's population that churns gets at cherry picking, gets at satisfaction, and gets at culture of trust between patient and clinician all kind of simultaneously in one measure.

And, that was sort of interesting to me.

CO-CHAIR SINOPOLI: Great. Thank you for all that, Lee. Walter?

DR. LIN: Yeah. This is a great day. A very informative and rich discussion. I'm just going to pick up on some of the themes that Lee and Jen just mentioned.

This whole idea of having a balanced portfolio of measures, I think, was thought-provoking. You know, I think all of our experts

agreed that kind of, kind of measures total cost of care in a total cost of care system, which makes sense.

But, kind of the kind of balancing measures of what was mentioned, when asked that question, were very intuitive answers, like access, care integration, like how do you measure integrated care?

Which I thought was quite relevant, especially given our total cost of care meeting last year.

Safety, and then this whole idea of churn, which I thought was really an insightful concept to me that I hadn't thought much about before.

But, you know, I was trying to fit what the first session panelist mentioned on the balance full of measures. And, the HCPLAN's framework of measures, the big dot framework that Dana mentioned.

You know, I think, you know, that the big dots were like lower cost, better care, and better health. Right?

And, you know, one of the clear themes that ran through pretty much every conversation we had this morning was, how overwhelming the

amount of measures out there are. The measure of cacophony and just the extreme burden.

And, I think there is a lot of wisdom to -- at least at this level, the CMS level, focus on the big dots. Right?

And, I think the big dots were some of the balance portfolio measures that I just mentioned.

The other thing that I kind of took away was applying the big dots to different populations might actually result in very different measures. For instance, even in the same program, let's just take the MSSP[48] ACO for example.

If the population of patients in MSSP ACO is kind of community-dwelling, relatively young, relatively healthy, that -- the big dots might remain the same.

But, the level two and level three quality measures might look very different in another MSSP ACO that focused just on nursing home patients like the one I belong to.

And so, kind of thinking through, at what level do we recommend, make recommendations about the measures?

48 Medicare Shared Savings Program

I think it's probably at the big dot level. But, when applied to different populations, the level two and level three sub-dots might look very different even in the same risk-bearing value-based program.

CO-CHAIR SINOPOLI: Perfect. Thank you. Um-hum?

DR. KOSINSKI: PROMs, we need to include PROMs in whatever report we're generating out of this. Because we heard that over and over and over again.

The complexity in capturing them. They're important. How they're related to equity. I think PROMs have to be part of our focus as well.

CO-CHAIR SINOPOLI: And, noted their expense, yes.

CO-CHAIR HARDIN: I'll just add one other layer. So, the digital component, I was really struck by Eric's comment that 20 years ago, he was working on the digital future measurement.

But, he called out some really interesting trends that are, things that have moved that are available now that are important

to consider, like AI and NOP[49] and FHIR. And, really getting an electronic health record.

CO-CHAIR SINOPOLI: Yes.

CO-CHAIR HARDIN: -- Vendors to collaborate and come together. And, to really think about the other theme that came forward is dashboards, visualizations, things that really help providers and systems to understand the data that we do have and be motivated by it rather than punished.

And then also, the opportunity to capture data from publicly available sources to help drive change, like Google. I thought that was really interesting to integrate with. Accessible and easy data.

So, that's the only other comment I would make.

CO-CHAIR SINOPOLI: Lindsay?

DR. BOTSFORD: Yeah. I'll build, I think a lot of -- a lot of good things have been shared already.

I think building on what Lauran called out and picking up a little bit on what Vivek shared. It sounds like the current claims-based measures won't suffice. We need more.

49 Notification Oriented Paradigm

We need to decrease the cost of reporting, decrease the cost of development. And, rely on digital quality measures or the like to help with some of it.

It's not necessarily going to just come automatically that clinicians know how to succeed in these measures. And, there's some degree of education that would need to be provided as we think about going down this path.

So, I think I would just build that as we need to, as we think about the, all the new measures that would be needed here, there's going to be a whole layering of education needed for clinicians to understand these measures as well.

The last point I wrote down that hadn't been said yet already, is just, I think, this surface in our special, specialty integration conversation is how many gaps there are in measures still in the specialty care space. And specifically in measures that could link specialties back to primary care as opposed to being stand-alone measures.

So, it seems that that remains an opportunity as we think about total cost of care measures.

CO-CHAIR SINOPOLI: Great comments.

So, Audrey, anything else that we need to cover? Anything you want to comment?

MS. McDOWELL: I'm not sure if Josh is online? He's not. Okay.

*** Closing Remarks**

CO-CHAIR SINOPOLI: Okay. Good. All right. Well good. I want to thank everybody for participating today, our expert presenters, the panelists, my PTAC colleagues and those listening in.

We'll be back tomorrow morning at 9:00 a.m. Eastern time. Our two-day agenda will feature, our day two agenda will feature a roundtable panel discussion with experts on stakeholders' perspectives on best practices for measuring spending and quality outcomes and total cost of care models.

A special panel discussion with CMS staff tomorrow. A listening session on linking performance measures with payment and financial incentives, as well as time for public comments, in person or via telephone.

*** Adjourn**

We hope that everybody will be able to join us then. Thank you. And, for this day, the meeting is adjourned.

(Whereupon, the above-entitled matter went off the record at 4:49 p.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Public Meeting

Before: PTAC

Date: 03-25-24

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate complete record of the proceedings.

Neal R Gross

Court Reporter