PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

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PUBLIC MEETING

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Room 800
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

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Monday, September 14, 2026

PTAC MEMBERS PRESENT

TERRY L. MILLS, JR., MD, MMM, Co-Chair
SOUJANYA R. PULLURU, MD, Co-Chair
LINDSAY K. BOTSFORD, MD, MBA
LAURAN HARDIN, MSN, FAAN
WALTER LIN, MD, MBA
KRISHNA RAMACHANDRAN, MBA, MS

PTAC MEMBERS IN PARTIAL ATTENDANCE

JOSHUA M. LIAO, MD, MSc*
DAVID C. TYSON, MA*

PTAC MEMBERS NOT PRESENT

HENISH BHANSALI, MD, FACP
LAWRENCE R. KOSINSKI, MD, MBA

STAFF PRESENT

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

* Via Zoom

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

9:31 a.m.

* CO-CHAIR PULLURU: Good morning, and welcome to this meeting of the Physician-Focused Payment Model Technical Advisory Committee, also known as PTAC. My name is Dr. Chinni Pulluru, and I'm one of the Co-Chairs of PTAC along with Dr. Lee Mills. 2026 marks 10 full years of PTAC operations.

The Committee felt that this was the right time to reflect on all of the evidence regarding Alternative Payment Models, and value-based care that's been presented to PTAC through the stakeholder-submitted physician-focused payment models and theme-based discussions over the years.

Based on all of the information and evidence presented, the Committee believes that the efforts of the CMS[1] Innovation Center, the Center for Medicare through the Medicare Shared Savings Programs, and other payers have made important progress in moving this nation towards value-based care.

PTAC has drafted a white paper titled,

1 Centers for Medicare & Medicaid Services

Transforming Health Care Delivery Through Value-Based Payment Models and Care: A Roadmap.

The paper articulates a roadmap for building on current learning and successes to further advance the development and implementation of APMs[2] that support the transformation of the U.S. health care system towards a high-value, patient-centered care.

In the paper, PTAC offers recommendations that focus on total cost of care, TCOC models, and strategies to accelerate the adoption of value-based care.

PTAC's recommendations are based on information that's been discussed and shared at PTAC's prior public meetings.

At this public meeting, we've brought together various experts to provide their input and feedback on PTAC's draft white paper.

Before our first session of the day, we are very honored to have opening remarks from Mr. Abe Sutton, the director of CMS Innovation Center and Deputy Administrator of -- at CMS.

Mr. Sutton, prior to assuming his current roles at CMS in January of 2025, served as a

2 Alternative Payment Models

principal at Rubicon Founders, where he co-founded two health service companies: Honest Health, which focuses on enabling primary care physicians, and Evergreen Nephrology, which focuses on enabling nephrologists.

From 2017 to 2019, he's also served at the National Economic Council, Domestic Policy Council, and the Department of Health and Human Services.

In these roles, he coordinated health policy across the federal government with the focus on value-based care and increasing choice and competition in health care markets, as well as updating the federal government's approach to kidney care. Welcome, Abe.

*** Abe Sutton, JD - Director, Center for Medicare and Medicaid Innovation (CMS Innovation Center), and Deputy Administrator, Centers for Medicare & Medicaid Services (CMS) Remarks**

MR. SUTTON: Thank you, Dr. Pulluru, Dr. Mills, and thank you to the entire members of the Physician-Focused Payment Model Technical Advisory Committee for the invitation to join you this morning.

It's a privilege to be here with you, both those in person and those joining online. Thank you for having me back.

Now, the last time that I joined the PTAC for a conversation was in June when we discussed patient safety and how it connects with CMMI[3]'s models and our strategy. Today's conversation is different in scope, but it builds directly on that history.

We're here to talk about the Committee's draft white paper, a document that pulls together nearly a decade of PTAC's work into a single vision for where value-based care should go next.

We can all agree that this question of where we go next matters more than ever, because the status quo is not sustainable.

Health care is on a track to consume roughly $1 out of every five in our economy while outcomes remain elusive.

PTAC and the Innovation Center have different roles, but a shared task, bring forward promising ideas, test them rigorously, move ahead only when they improve care and protect the federal taxpayer.

3 Center for Medicare and Medicaid Innovation

That's the spirit within which I want to engage in today's conversation with the paper, highlighting the broad areas of overlap and also a few places where our thinking diverges to explain why.

Before I get into the paper self, I think it's worth naming how we got here. Over the last 10 years, across 36 physician-focused payment proposals, recommendations on 28 of them, and more than 250 expert presentations before this body, PTAC has built a rich body of evidence and independent judgment that few institutions in this country can match.

In September of 2025, this Committee focused in patient empowerment. In February of this year, it shifted focus to multi-payer alignment. In June, we talked about patient safety, as I mentioned earlier.

These are all threads that run through every Innovation Center model. This white paper effectively draws these threads together.

When I respond to it today, I do someone who has been on this journey with you, who has watched these ideas develop meeting by meeting and is a partner in the same long-term project that we

share, to move Medicare from paying for value to paying better health, better outcomes, and better value.

When we think about the future of the Medicaid program and the implications of this paper for them, that's the spirit in which I engage today.

So to start, there are broad areas where we are in agreement, which is not surprising. It's really most of the paper.

We agree with the call for continued commitment to value-based care. And to us, that means continuing to iterate, testing, learning, revising models, rather than treating any one model as finished prior to certification.

We also agree that stable, predictable benchmarks matter. Organizations need confidence that the ground won't shift under them year by year.

In order to invest in prevention, we have worked closely with our colleagues in the Office of the Actuary at CMS in the design phase, to try and produce stable benchmarks that won't need to be updated year over year and won't need to see large changes, building and learnings from past

models and working to not build in features like retroactive trend adjustments that left participants feeling like a rug was being pulled out from under them.

We see real promise in nested episode-based accountability, the kind of design that is reflected in the CMS-administered risk arrangements, building specialty-level accountability into a broader total cost of care model.

The transformation cannot only be about organizational level total cost of care; complementary physician-focused models can test outcome-aligned payments, coordination with primary care, and bring more clinicians into accountable arrangements.

ACCESS[4] is one example of that. It pays for measurable outcomes in technology-supported chronic care, creates a co-management pathway with referring connections and complements ACOs[5] and other risk-bearing arrangements.

We also agree that accountable care must work for people with the most complex needs. LEAD, our Long-term Enhanced ACO Design Model, is

4 Advancing Chronic Care with Effective, Scalable Solutions

designed to integrate high-need patients across ACOs, including people who are dually-eligible or homebound.

Kidney care is another area where tailored accountability, earlier intervention, and coordination across settings remains essential.

We support the paper's call for entity-level balanced portfolio approaches to measure performance with a clear and transparent link to payment.

We also recognize the rural providers need a distinct path. AHEAD[6] pairs state or substate regional accountability with perspective hospital global budgets and primary care investment.

The Rural Health Transformation Program run by CMS supplies state-level investment in workforce, technology, and infrastructure.

One is not a substitute for the other. Capacity investment can create the on-ramp, but payment reform has to make that capacity sustainable for the long run.

The Committee's recommendation to empower ACOs, the way Medicare Advantage plans are

5 Accountable Care Organizations

empowered, resonated with us.

The parking premium buydown feature in the LEAD Model is a concrete step in that direction, and we see room to build in this direction further together.

We've already taken action to revise a MAHA[7]-specific, HCIA[8]-style award through MAHA ELEVATE[9], which is designed to accomplish the very goals referenced in the paper for a HCIA-style award.

And we see it as meeting the moment inspired by the vision and clarity that Secretary Kennedy has brought to how we should all be engaged in preventive health efforts.

And we also agree that real-time usable health data is essential to shared decision-making, purpose-limited to improving a patient's health, and that model design must anticipate rapidly evolving technology landscape.

The goal is not more data or newer tools for their own sake. It's information that helps clinicians act earlier, patients make informed choices, and payment follow outcomes.

6 Achieving Healthcare Efficiency through Accountable Design
7 Make America Healthy Again
8 Health Care Innovation Award

There are two principal areas I want to call out where we think about things slightly differently than the approach laid out in the draft paper.

First, how to expand participation and move providers into meaningful downside risk.

And second, where to place accountability while preserving rigorous evaluation. I welcome dialogue on whether we are getting these aspects right and where the Committee thinks about them differently.

On the call for new on-ramps around upside only and mandatory ACO participation, we think we're already addressing the same underlying goal, but through a different pathway.

The LEAD Model is designed specifically for organizations that risk-based models historically haven't worked for, without crowding into lower-risk ACO space that the Medicare Shared Savings Program and the alternative -- the APCM[10] codes already serve.

In 2025, the Innovation Center undertook a review of our model portfolio and concluded that

9 Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence
10 Advanced Primary Care Management

our primary care portfolio was too crowded and confused potential participants about which model to join.

By operating fewer models in this space and designing them intentionally around the needs of distinct populations and practices, we aim to simplify the entryway into risk.

On the mandatory ACO suggestion, I want to offer an alternative solution to this problem. Geo AHEAD or Geographic AHEAD, is designed to move us towards the goal of having all of Medicare beneficiaries in an accountable relationship without requiring a mandate to get there.

Geo is an acknowledgment of where many primary care physicians are, an attempt to pave a pathway to get to full accountable relationships without destroying the fee-for-service option as a way to practice.

I understand the goal of a mandatory ACO model, and I understand what it's trying to solve, but I think there are other options that we should test before moving in that direction.

In terms of the recommendations to place accountability at the organizational level, with some flexibility in how care is delivered, I also

understand the logic there, and it is reflected in many of the models that we design.

We sometimes choose to place accountability at an individual level and constrain delivery flexibility because doing so protects our ability to evaluate a model rigorously.

That's a deliberate operational trade-off, and I won't pretend it always sits comfortably alongside competing priorities within the program around model design, but it's one that we make with a valuability design in mind.

This evaluation versus participation operations trade-off is one that I'm fairly confident if you sat down with any of my predecessors, they would talk about and how that was a significant factor in model design.

This type of trade-off needs to be made in the design of practically every single model that we have produced at the Center, and it's one of the hardest decisions that we have to make.

I raise these similarities in two areas of differences to highlight the high degree of natural alignment between the Committee's vision and the active work underway at the Innovation

Center today, and also to identify the places where I think further conversation help enrich our thinking.

This alignment was already evident to us from prior meetings, such as the Committee's findings on patient empowerment last year and how the multiplayer alignment findings from February are visible in models such as AHEAD.

So as we spend today in discussion around the paper and going into detail on it, I want to leave you with this.

We are aligned with the Committee on the fundamentals, that there is an urgent imperative to find a better path for American health care, and value-based care is essential to that path, that stability and predictability matter as much as ambition, and that patients deserve real ownership over their data and their care.

Thank you for the work that you have been doing, for the work that went into this paper, and thank you for the opportunity to respond to it today. I look forward to the discussion and today's panels.

* **Welcome and Co-Chair Update - PTAC Recommendations for Transforming Health**

Care Delivery Through Value-Based Care

Day 1

CO-CHAIR PULLURU: Thank you for sharing those remarks, Abe. We appreciate your support and engagement, and we look forward to continuing to collaborate with the CMS Innovation Center.

For this public meeting's agenda, we will have four sessions focused on obtaining expert input on PTAC's recommendations on value-based care that are laid out in the Committee's draft white paper.

We are very excited to welcome diverse experts from academia, organized medicine, provider and payer organizations, and other industry sectors to share those perspectives.

PTAC's draft white paper and other materials related to this public meeting can be found on the public meeting registration site and on the meetings page of the ASPE PTAC website.

I also want to mention that tomorrow morning will include a public comment period. 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 PTAC, ptacregistration@norc.org. Following this public meeting, PTAC will prepare a final version of its white paper to submit in a report to the Secretary of HHS[11].

As a Federal Advisory Committee, PTAC will base its final white paper and recommendations on information that's been shared or discussed at the public meetings.

PTAC's final white paper will be posted on the ASPE PTAC website. I would also like to note that as always, the Committee is ready to receive proposals on possible innovative approaches and solutions related to care delivery, payment, and other policy issues from the public on a rolling basis.

We offer two potential submission tracks for submitters, allowing flexibility depending on the level of detail of their payment methodology.

You can find information about submitting a proposal on the ASPE PTAC website.

* **PTAC Member Introductions**

At this time, I would like to invite my fellow PTAC members to please introduce

11 Health and Human Services

themselves. Please share your name and organization. If you would like, feel free to share any opening thoughts regarding the two-day public meeting.

I'll start. I'm Chinni Pulluru. I'm the founding Chief Medical Officer of Agentic Healthcare Incorporated, which is committed to building a unified patient record, as well as enabling and empowering patients with agents and agentic architecture.

It brings trustworthy information and interpretation, as well as professional assistance to enable the health care consumer to use agents for engagement and navigation and empowerment when navigating the health care system.

I also work with Stellar Health, which is a value-based care aggregator, and have prior history with the largest independent multispecialty group in the country, as well as Walmart. Next, let's go to Dr. Lee Mills.

CO-CHAIR MILLS: Good morning. I'm Lee Mills. I'm a family physician. I currently serve as Chief Medical Officer of Aetna Better Health of Oklahoma, one of the state's three managed care Medicaid plans.

I started my career coming through operational primary care and health system leadership, where I had the privilege to operate and lead five or six different CMMI pilots over the years.

Now, I spent 10 years on the health plan space, deeply involved in value-based contracting and models and currently leading the way through a state -- a state mandate under statute to increase primary care spend from 4 percent to 11 percent of total -- of total dollars spent, mainly through value-based contracting and APMs.

CO-CHAIR PULLURU: Walter?

DR. LIN: Good morning. My name is Walter Lin. I am an internist and Founder of Generation Clinical Partners. We are a medical practice focused on the care of the seriously ill and chronically complex living in senior living, primarily nursing homes and assisted living facilities.

We have a long history of value-based participation. I currently serve as the Chief Clinical Strategy Officer of LTCACO, and also a medical director of a PACE[12] program. I'm also

12 Program for All-Inclusive Care for the Elderly

part of the board of the Post Acute and Long-Term Care Medical Association.

CO-CHAIR PULLURU: Lindsay?

DR. BOTSFORD: Good morning. I'm Lindsay Botsford. I am a family physician in Houston, Texas, where I continue to care for patients and serve as their Regional Medical Director for the Midwest in Texas for Amazon One Medical.

In that capacity, I've served as the Chair of the governing body of the One Medical Care Network and ACO REACH participant for the last five years, which has generated consistent savings each year.

I also wear the hat as the Chair of the board of the Texas Academy of Family Physicians where I'm the immediate Past President.

CO-CHAIR PULLURU: Krishna?

MR. RAMACHANDRAN: Good morning. Krishna Ramachandran, Chief Information Officer for UnitedHealthcare's Operations and Experience division.

I've been in health care for 24 years serving in executive roles in payer, provider, and technology organizations, 15 years of which has been in furthering value-based care from the

incentive model creation, the incentive alignment work from the payer side, and from the care delivery side, actually embedding value-based care principles and furthering it, as well as in technology, aligning incentives, and surfacing up actionable insights as well. So good to be here.

CO-CHAIR PULLURU: Now, we'll go to our virtual member, Josh.

MS. HARDIN: Good morning.

DR. LIAO: Good morning everyone --

(Simultaneous speaking.)

CO-CHAIR PULLURU: Sorry, Lauran.

MS. HARDIN: Sorry to -- I'm Lauran Hardin. I'm a nurse by training and Chief Integration Officer for HC^2 Strategies. As a former Co-Chair of PTAC and a long-term member, I'm really excited for our meeting today.

It's a collection of a lot of insights and valuable evaluation and reflection on what's working in this space. My background includes innovation in hospice, children's hospice and palliative care, and serious illness.

I developed a complex care model in the Trinity Health system that scaled across six states, really focused on reducing risk and

increasing quality delivery.

Was part of the team that started the National Center for Complex Health and Social Needs at the Camden Coalition and worked for eight years with states, payers, communities, providers, designing models and approaches for complex populations.

And now with HC^2 Strategies, partner with states on innovation and value-based payment at the state level, Medicaid 1115, and Medicaid innovation and delivery.

And many, many different cross-sector approaches bringing communities together to solve for complex needs.

Thank you.

CO-CHAIR PULLURU: Thank you, Lauran. I'm sorry again. Now to Josh.

DR. LIAO: Morning everyone. Joshua Liao, internal medicine physician and National Associate Vice President for Clinical Transformation at Ascension, where I oversee enterprise remote patient monitoring, patient-reported outcomes and engagement campaigns, including those that encompass the care of Medicare, Medicaid, and other value-based care

populations.

I spent, you know, 10/15 years doing a number of different things in the value-based care space, including generating what I hope has been foundational evidence to inform bundle payments and how they interact with ACOs and lead to population outcomes.

I currently also serve as a Commissioner on the Medicare Payment Advisory Commission and -- and like other Committee members, I'm excited about the conversation that's going to unfold over the next few days.

CO-CHAIR PULLURU: Thank you all. Three of our Committee members, Dr. Larry Kosinski, Dr. Henish Bhansali, and David Tyson, were unable to join us for the September meeting, but we want to acknowledge their great work on this Committee. Now to Lee.

*** PTAC Presentation: PTAC Recommendations for Transforming Health Care Delivery Through Value-Based Care**

CO-CHAIR MILLS: Okay. Now, let's move to our introductory presentation. PTAC members, you will have an opportunity to share any additional comments after the presentation.

The Committee has collaborated closely with staff to prepare for this meeting, and I will share some background information regarding PTAC's 10 years of operations and provide an overview of PTAC's draft white paper and recommendations to set the stage today. Okay.

So first, operational background and experience. The PTAC was established to review stakeholder-submitted physician-focused payment models, PFPMs[13], against specific criteria established by the Secretary of HHS.

Within this context, PTAC also reflects on pertinent theme-based topics regarding effective payment model innovation and PFPMs and Alternative Payment Models.

PTAC holds public meetings to review PFPMs and associated topics, and PTAC subsequently prepares and submits its comments and recommendations from these public meetings to the Secretary of HHS.

PTAC was, as you know, created by Medicare Access and CHIP[14] Reauthorization Act of 2015. The PTAC is comprised of 11 active members who serve terms typically three years in length

13 Physician-focused payment models

with some variation.

PTAC has comprised 27 individual national experts over its 10 years of operations. The PTAC typically holds quarterly public meetings with its first public meeting held in February of 2016.

PTAC produces a report to the Secretary of HHS with recommendations related to each PFPM proposal or theme-based topic, and all such reports are posted on the ASPE PTAC website.

To best inform its review of PFPMs and theme-based discussion topics, PTAC does a variety of things.

First, it does an in-depth background research and environmental scan to set the context. It conducts supplemental analysis as needed out of the Medicare data set.

It requests expert input even -- either through presentations at the public meeting or written and oral feedback options.

All materials produced by PTAC are posted on the ASPE PTAC website, including PFPM proposals, the environmental scans, supplemental analyses, written public comments, the expert presentations we've received, reports to the

Secretary, and the public minutes of meetings, transcripts, and videos.

Over its 10 years of operations, starting in 2016, PTAC has held 32 public meetings. We've received 37 PFPM proposals and debated -- and deliberated and voted on 28 of those.

Of the remainder, eight were withdrawn by the presenter, and one is under preliminary review now. We've had 16 theme-based discussions, topics explored, and 238 experts providing input at PTAC's meetings.

Some characteristics of the stakeholder-submitted PFPMs: They are submitted by a wide variation of stakeholders, including national provider associations or specialty societies, regional or local single-specialty physician practices, academic institutions, and other interested stakeholders.

They've focused on specific health conditions, provider types, or settings, or some with broad applicability.

The main approach to payment for care delivery in these PFPMs has been per-beneficiary-per-month payments, and shared risk or episode-based shared risk or additional payment

structures.

The theme-based discussion topics have been related to value-based care, and issues in previously submitted PFPM proposals have covered a wide variety of topics, including telehealth and virtual care, care coordination, social determinants of health and health equity, background and components of population-based total cost of care, best practices and care delivery models, payment model features, specialty integration, care transition management across sites of care, rural participation, performance measures, patients with complex conditions or serious illness, pathways to maximize participation, as well as methods to reduce barriers to participation in patient total cost of care models, data and patient empowerment, multi-payer alignment, and most recently, patient safety.

Now, moving to the white paper with recommendations for value-based care. PTAC is truly uniquely positioned to provide recommendations about APMs and delivery system transformation.

PTAC has considered all the evidence,

both qualitative and quantitative, presented to it over the last 10 years of operations and produced concrete recommendations related to value-based care.

Realize that as a Federal Advisory Committee, PTAC's recommendations must reflect topics that have been discussed at open public PTAC meetings.

PTAC's recommendations pertaining to stakeholder-submitted PFPMs and theme-based discussion topics have been submitted in individual reports to the Secretary of HHS.

And finally, PTAC has summarized its recommendations related to the specific payment models in the form of Issue Briefs that have also been posted on the ASPE PTAC website.

So PTAC has summarized and consolidated all of its experiences and testimony heard in a draft white paper titled, *Transforming Health Care Delivery Through Value-Based Payment Models and Care Roadmap.*

And the purpose is to articulate a specific set of recommendations or roadmap for policy that further incentivizes and supports the transformation of the U.S. health care system to

one that produces high-value, patient-centered care.

The assumption is that PTAC believes it is most prudent to use what has been learned to date as working and to evolve and refine efforts to implement these value-based payment models, indeed, to accelerate and lean into these efforts to scale value-based payment and care across the delivery system.

PTAC is today seeking input on its draft white paper at this public meeting as it continues to refine its recommendations.

The final white paper will be published later this year on the ASPE PTAC website. PTAC presents 22 recommendations across nine discrete topic areas, including looking back and moving forward.

Three recommendations about total cost of care as a vision for patient care and population-based models; three recommendations on a payment approach; maximizing participation in total cost of care models, two recommendations; performance measurements, three recommendations; enablers and flexibilities in total cost of care models, three; total cost of care models in rural areas, two

recommendations.

Two recommendations about technology enabled care, AI[15], and patient empowerment; and then three final recommendations involved in patient safety.

Let's get into those. First, looking back and moving forward, PTAC holds that Accountable Care Organizations, the principle TCOC model in the country today, are achieving savings that are growing over time.

Stakeholder presentations to PTAC suggest a broad acceptance and willingness among stakeholders to adopt accountable care as the model for moving into the future.

Recommendation number 1, policymakers should continually reinforce a sense of urgency around and commitment to value-based payment and care as the principal policy tool for transforming the health care delivery system.

Next, total cost of care as the vision for patient care and population-based models. Recommendation number 2, shared vision of high-value, patient-centered care should be the foundation for policies intended to transform the

15 Artificial intelligence

delivery system.

Success factors are multiple and include team-based care, patient-centered care, care coordination and well-coordinated care, patient empowerment, risk mitigation, disparity reduction, and connection to resources for health-related social needs.

Payment methods and performance measures should continually evolve to reinforce the standard vision of care.

Recommendation 3, organizations should have accountability in total cost of care models, but they should also have the flexibility to design incentives down to the provider level.

Recommendation 4, accountable entities should have flexibility in how they manage and organize care. Now, we'll pivot to recommendations about payment approach.

The PTAC holds that financial incentives and APMs should reinforce the care delivery model. Meaningful payment amounts are critical, particularly for primary care providers treating high-needs patients.

That leads to Recommendation 5. CMS should continue to make progress in establishing

benchmarks that create long-term predictability for payers, health plans, and accountable entities.

Recommendation 6, some portion of payments should be made prospectively to provide financial predictability and enable investments and infrastructure needed for the transformation to value-based care.

Recommendation 7, for clinicians and organizations new to value-based payment, a clear, predictable, simple multiyear glide path should be implemented to enable capacity building and ensure the vision is well understood leaning forward.

Now, we'll pivot to maximizing participation in total cost-of-care models. The PTAC holds that maximum provider participation in total cost of care models is essential for effective delivery system transformation, and payment models should promote transition to value-based care while also ensuring financial stability for stakeholders.

That leads to Recommendation number 8. New pathways are needed to encourage greater participation in total cost of care models among independent practices, rural providers, and

integrated delivery systems.

Recommendation number 9, CMS should develop models to incentivize the integration of high-value specialty care with advanced primary care.

Now, recommendations related to performance measurement. PTAC holds that current measures do not adequately capture the desired performance characteristics for total cost of care models and that high-value measures are needed; patient-oriented measures are especially important for high-needs patients.

This leads to Recommendation number 10. Performance should be measured at the level of the accountable entity in total cost-of-care models.

Recommendation 11, measures used in total cost care models should be a balanced portfolio that reflects domains such as clinical quality, population health outcomes, patient experience, and others.

In Recommendation 12, performance measures should be linked using transparent methods to payment at the level of the accountable entity in total cost of care models.

Now, pivoting to enablers and

flexibilities for total cost of care models. PTAC holds that to enable, encourage, and maximize participation in value-based care, CMS should: Recommendation 13, continue efforts to provide real-time patient-level claims data to accountable entities in total cost of care models.

Recommendation 14: Use its leadership position to help public and private payers align both their commitments to value-based care and payment and their methods for implementing these strategies, including risk adjustment and performance measures.

Recommendation 15: Provide accountable entities with Medicare-directed waivers and flexibilities similar to those in Medicare Advantage to ensure the accountable entities can achieve the vision for care under total cost of care models.

Now, moving to total cost care models in rural areas, PTAC holds that increasing the adoption of value-based care in rural care areas is critical, and that rural areas face truly unique economic, social, and environmental challenges that can adversely affect participation in APMs.

Recommendation 16: Multiple strategies are needed to encourage rural participation in total cost of care models such as providing up-front payments yield -- payments to yield the capital to support adoption of health IT and other infrastructures and establishing longer glide paths for taking on risk.

Recommendation 17: Rural providers should be encouraged to collaborate with other providers in their area to aggregate the volume of patients under value-based payment models.

Now, moving to technology-enabled care, AI, and patient empowerment in total cost of care models. Recommendation 18: Patients and their clinicians need access to real-time usable patient health data to promote patient engagement.

Digital tools should be used to help promote data collection, sharing, and integration, and AI and other new technologies should be used to synthesize data in order to produce actionable insights, support provider clinician decision-making, identify changes in patient health prospectively, and to personalize care.

Recommendation 19: Through both payment methods and performance measures, APMs should

strengthen incentives for providers to use the vast amounts of usable data to generate actual insights and empower patients through shared decision-making at the point of care, and that models should also incentivize patients to participate in shared decision-making and engage in health promotion activities.

And our final domain of patient safety, PTAC finds that despite improvements to date, medical errors remain a very significant problem in health care.

Leading to Recommendation 20, significantly increased incentives to improve patient safety should be emphasized in new and current APMs and strengthened through new performance measurement and payment methods.

Recommendation 21, CMS should consider developing a patient-safety-specific model that includes incentives for new methods of reducing patient harm, such as investing in new information systems, changing system-level culture, and introducing greater transparency.

And Recommendation 22, CMS could or should initiate a new version of the Health Care Innovation Awards for ground-level development

and implementation of patient safety model.

Conclusion. So the data on published ACO outcomes to date have not quantified the impact beyond simple economic results, expressed as cost savings.

We understand that very significant changes in care delivery and innovation of care have resulted from these models, have really not been fully quantified yet.

There should be a shared vision for value-based care that's widely expressed and understood. Total cost of care models need to move beyond the current ACO model payment structure and be the primary vehicle for value-based care.

The focus on total cost of care models should be on providing value to members, the patients receiving care and incentivizing and maximizing participation of the organizations that are well equipped to provide value-based care but continue to find fee-for-service more attractive, and that providers that need financial and other assistance to make investments in value-based care.

So next steps. At today's public

meeting, PTAC has invited multiple esteemed experts to share their thoughts on PTAC's draft white paper, including overall assessment of the paper and its value for policymakers, the range of topics and recommendations we've covered, the wording and tone of the recommendations for a broad audience, whether any recommendations should be strengthened or sharpened or alternatively made less prescriptive, whether any relevant recommendations should be included, and whether any other pertinent information should be included.

Realize and understand that the PTAC's recommendations are based on topics that have been publicly discussed at PTAC public meetings, and additional items shared today may become topics for future PTAC meetings and or lead to recommendations in the report to the Secretary.

So, PTAC members, great set of recommendations, a great founding for today's discussion. Any follow-up comments the Committee would like to share, and if so, indicate your -- with your tag flipped up, and we have adequate time for broad discussion.

Any comments? Okay. If none at this

time, we will have a break until a planned 10:40 Eastern Time. Please join us then as we welcome our first group of experts for our first session to discuss PTAC recommendations to white papers. Thank you and brief break.

(Whereupon, the above-entitled matter went off the record at 10:12 a.m. and resumed at 10:40 a.m.)

*** Session 1: Expert Input on PTAC's Recommendations on Value-Based Care: Part 1**

DR. BOTSFORD: All right, well, welcome back everyone. I'm Lindsay Botsford, one of the PTAC members, and I get the pleasure of facilitating this next session. Thank you to Lee for setting the stage for the public meeting and summarizing the recommendations from our white paper.

So I now get to welcome four esteemed experts to share their perspectives on PTAC's draft white paper, and recommendations on value-based care.

You can find our expert's full biographies and slides posted on the ASPE PTAC website and the public meeting registration site.

So welcome to our four experts today, including our two in-person session participants and for our remote participants, please go ahead and turn your cameras on. There we go.

After all experts have presented, the Committee will have plenty of time to ask questions and engage in what we hope will be a robust conversation. So first to our online participants, we are pleased to welcome back Dr. Mike Chernew, Professor of Health Care Policy in the Department of Health Care Policy, and Director of the Healthcare Markets and Regulation Lab at Harvard Medical School. Mike, please go ahead.

DR. CHERNEW: Thank you so much everybody. It's wonderful to be here. I will try. You've done a ton of work. I have a (audio interference) of time, so let's jump in and go with the next slide.

So my view of APMs in general is that they're about risk transfer and giving providers the flexibility in production. So I'm not sure I'm really good at all these graphics, so I apologize, but my view is that the biggest problem with the fee-for-service system is that it creates all these barriers to get what we want.

So that's supposed to be the mouse and the maze on the -- in the upper right corner. And it puts into the clinical decision-making process a bunch of financial considerations that become problematic and prevent the delivery system from really being flexible and finding efficiencies.

And so the bottom right, the running mouse, whatever's running, is meant to be, we should get rid of those barriers and kind of go quickly.

I understand the notion of incentives and using incentives, that's the upper left. I do believe incentives matter in general, but I think it's really surprising in many cases how limited their impact is in sort of the broad quality space.

And I think that a lot of the work that's done, and you see this in the white paper some, that uses the term value-based payment. I actually think the word value is broadly the sugar that helps the medicine go down, and it's really about trying to create a system that gives providers the flexibility to find efficiencies and making sure that when they do so, they maintain or even improve the quality of care.

Can we go to the next slide? So in general, and I will focus a little bit more on the money, I think it's actually what's driving a lot of policy. There's waste in the American health care system. APMs create a system where that waste becomes an asset.

If you can get rid of the waste, you can keep some of the money. And what really matters in this whole system of APMs is how the waste is assigned and then the incentives to save and to participate.

I'm supportive of the MedPAC[16] recommendation, which is basically APM should be synergistic, default to population-based models, and add synergistic episodes or other models, you know, when it can support the entire system. And that gets to something I've spoken to you all about before, about just sort of the simplicity of the system. So can we go to the next slide?

So there's this policy tension on the left. It's sort of a thousand ideas. I could have done a thousand flowers blooming. It just depends what I happen to find in clip art.

But anyhow, I think if you do that, you

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end up with the picture on the upper right, which is just a cluttered mass of programs that tend to bump into each other and confuse people.

And I think what we really want is a cleaner, more synergistic kind of set of programs, more like the bottom right.

I think that's going to be the theme of the comments I make about the recommendation. So I think the next slide is going to have to do with my comments.

Well, actually probably the one after, but I'll keep on this one. So my comments on the report, I think it's important to remember a few broad things.

Alternative Payment Models are a tool; they're not an end. So the goal is not. Success isn't everybody's an APM. Success is lower cost, better quality.

I think in this point is probably the most important one, that APMs should minimize the degree of micromanagement. As I said in the beginning, I think it's really about giving the delivery system flexibility to achieve those broad goals about spending and outcomes, and it's really not about how we get there in a range of ways.

In fact, in general, and many of you I know work in delivery systems, the context of those delivery systems matter a lot. What you do, the decisions you make, the programs you put in place, how you engage different types of providers will all vary, and the patients you serve will all vary.

And so I think it's hard to know how to structure particular programs and I'll say as an aside, even if you were to decide the right way to do it, it tends to be hard to monitor whether an organization is following the outline or the principles that you like.

So for example, I would take the case of medical homes. We may be very supportive of medical homes, but once you move it into sort of an administrative system, then you have to figure out how do we know if someone's really being a medical home as opposed to advocating for the principle of it.

It becomes something that gets measured, and that's often problematic. So the third point I'll make here is, as I was saying before, I think it's really important to avoid doing too much.

Just keep the APM system simple, and

avoid the clutter from my previous slide. Okay, next slide.

So I'm going to give you my thoughts on the recommendations. There's obviously a lot of recommendations. I'm not going to go through all of them. I've been in a lot of organizations where you make recommendations and, you know, it's just not useful to go through and wordsmith.

So I'm going to talk more thematically. So I think urgency is fine, but doing too much may backfire. So I think it's fine to kind of push people forward, but I think going at a more deliberate pace with a better sense of a North Star is probably how I would think through this.

And sometimes it's hard to see exactly what the North Star is. For me, the North Star is a lot of flexibility. And so for example, if you look at some of the recommendations, so I'll pick Recommendation 2, for example, there's a lot of specificity in that that I'm a little uncertain about.

There's other Recommendations, 3, 4, 15, that might fit more closely to my preference for broad flexibility. I think the model should be coordinated.

So Recommendation 9, for example, talks about that a lot. I won't go through some of the others. I sort of tried to list where I thought all the recommendations were on these points.

I do agree completely that the design is crucial. There's a number of recommendations with that -- related to that and the benchmarks and performance.

I think those are the two most important parts of the design, is that you get the benchmarks right. There's actually a lot of stuff on the benchmark, the predictability stuff, maybe some of the prospective payment stuff that I think is actually really important principles for designing benchmarks.

And then of course data is important, and you have some recommendations on that. So broadly speaking, I think there's a lot there.

There’re probably more thumbs up than not. If I was having this conversation before all the recommendations, we could go through recommendation by recommendation, have a discussion.

Maybe we'll do that later. We're not going to do it now or at least not until you start

asking questions. So let's go to the last slide. Pretty sure this is the last slide.

So a few other supporting policies that I think are really important. I really think the biggest challenge to APMs going forward is going to be Medicare Advantage because Medicare Advantage will just swamp all the APMs in terms of just the scale and the number of people in them, and I think it's going to be hard.

The second thing is I think how you think about incenting participation becomes really important. Obviously, mandatory helps. It's hard to make things mandatory.

My personal view is you don't have to go quite as far as mandatory. You might be able to incent people to come in with a carrot or a stick.

The stick part would be removing things like unrelated carrots. So we pay above the empirical amount for graduate medic education. Maybe if you're not in a model, you don't -- you get the empirical amount we pay.

You're allowed to reclass what wage category you're in, your wage index. And maybe we say if you're not in an APM, you can't get reclass for your wages.

There's a bunch of things like that that I would consider having CMS explore, not even so much, you know, to give them an APM bonus, although I am supportive of a redesigned APM bonus system, but just to acknowledge there's a bunch of other reforms that are needed, and maybe we can use reform of those things to encourage APM participation.

And then of course my last point, which has been my theme, I think every time I've spoken to y'all is we just need to harmonize and simplify the models.

The pictures that I have here might actually have been pictures from a previous PTAC presentation. So those are my main views, and I look forward to the other presenters and in particular to your questions afterwards. I think that's the -- yep. There we go.

DR. BOTSFORD: All right. That was rapid fire. Thank you. So we are going to save all questions from the Committee until the end of the presentations. So with that, next we are excited to welcome Dr. John Whyte, who is the Chief Executive Officer and Executive Vice President of the American Medical Association. Welcome, John.

DR. WHYTE: Well, thank you. Thank you for having me. I'm sorry I couldn't be with you in person, but I really do want to, thanks for the opportunity to review this paper and provide the AMA's[17] perspective.

We appreciate the commitment of the Committee's work, and we share the goal of making value-based care work better for physicians and patients.

Now, let me be clear, we strongly support the transition to value-based care, but for the transition to succeed, physicians need models that are sustainable, that are flexible and designed around the realities of patient care.

And that's what we think is missing here. So I want to highlight a few areas where I think we can make that promise a reality. So if we can go to the next slide and then even the next slide.

And the first is we have to invest in patients. So too many Alternative Payment Models have been built around a very short-term definition of success, and that's did we lower spending this year?

And that misses the point of value-based

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care. And that's why we have this tension because better care often requires investment up front.

So we need to help physicians manage chronic conditions earlier and prevent complications that lead to hospitalization and other costly care. And those investments can improve outcomes and lower costs, but let's be realistic.

They take time to pay off. And we shouldn't judge a model as a failure because it didn't produce savings in year one or even year two or three. We need to figure out what's the longer view.

Now, we're encouraged to see CMS moving in that direction, and the new 10-year LEAD ACO model is one example, and the AMA does support that longer-term approach, but we also support the growing use of prospect payments, which can give physicians greater flexibility to invest in the care that they feel patients need.

Let's move to the next slide. We also need to recognize that Medicare APMs are still built on a fee-for-service foundation, and Mike commented on that. You know, benchmarks and target prices ultimately depend on Medicare

physician payment.

So if we want more physicians participating in APMs, we have to strengthen the foundation. And Medicare payment has fallen 33 percent since 2001 when adjusted for inflation or in practice costs.

So that makes it especially difficult for independent practices to invest in value-based care. That's why we support the Bipartisan Patient First Act, which would strengthen Medicare physician payment, reform budget neutrality and MIPS[18], and make important improvements to APM.

Let's move to the fourth slide, which is an area where we disagree in including some of the previous comments about this issue of mandatory. And we don't support mandatory models.

We don't support requiring a physician to participate in APMs because often this is a mechanism to force the physicians to accept further Medicare reimbursement rates under the guise of financial risk.

So if we do what we are talking about today, design models around patients, we give physicians the resources they need, then we create

18 Merit-based Incentive Payment System

a real opportunity to improve care, and physicians will want to participate.

Let's move to the next slide. And -- the patient -- the paper, and I congratulated, also recognizes that smaller independent and rural practices face different challenges and may need additional flexibility.

We agree with that, but more broadly we should think differently about how we define success in these models. MACRA[19] allows APMs to improve quality while holding spending steady, yet most models have focused primarily on reducing costs.

Saving matter, but they should not be our only measure of success. So what if we're able to expand access without increasing spending or drastically improve quality of care while improving spend -- keeping spending steady?

These ideas warrant exploring too. And this is a slide now I think we're on because I think off a few slides, but not every physician practice starts from the same place.

Again, small independent practices, rural practices, those serving underserved communities

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often lack the resources, technology, and infrastructure to participate in APMs.

And practicing medicine in a rural setting comes with very different challenges. It's not a one-size-fits-all. So we're pleased to see rural practices and patients receive significant attention in the paper.

So congratulations on that. And that helps explain why these types of practices have failed behind in adoption. So if we want broader participation in value-based care, we need to meet these practices where they are, and make sure they have a real opportunity to succeed.

We also need more opportunity for specialists to participate in APMs. Most models have focused on primary care and population-based care, but for many specialists, there simply is not a model that they can participate even if they want to, and that needs to change.

So we have consistently called for greater specialist participation in APMs. Now, we also need to ask which patients are being left out of APMs. Patients in underserved and lower-income communities have made the most to gain from these models because APMs can address barriers.

The traditional fee-for-service care often cannot. Now, sometimes better care is as simple as arranging transportation. So a patient makes a follow-up appointment. We all know that removing cost sharing for an important service.

Those may sound like small interventions, but they can make a real difference in whether patients get the care they need. So let's move to slide five, where we have to make technology work for us.

And we also have an enormous opportunity to make APMs much less burdensome for patients. Too much time is still spent collecting and reporting performance data, and wherever possible, CMS should automatically pull quality and cost measures from existing sources, including claims and EHRs[20].

We're beginning to see more use of claim-based measures, and that's encouraging. We also need to make better use of technology at the point of care.

Real-time medication checks can prevent complications and help physicians get prescriptions the first time. Better referral

20 Electronic health records

tools can connect patients with specialty care before they leave the office.

And clinical decision support can provide another layer of safety by helping physicians keep pace with evolving best practices.

And I also want to point out technology can also help us expand access and encourage patients more directly in their own care.

And that's one reason that AMA is supporting models like ACCESS from CMMI that make greater use of technology to connect patients with care. Now, the bottom line is that technology has to be designed and built the right way, with physician feedback incorporated through development and implementation because more data is not always better.

What matters is getting physicians the right information at the right time because technology should help filter information so the most relevant data rises to the top.

But let's be clear, the information has to be accurate and up-to-date. Real-time specialty referrals are of no use if the specialist is not accepting Medicare patients, for example.

As we use more technology in care, we also need the right safeguards. So for instance, wearables can give us valuable information, but more data is not automatically better care.

Patients need appropriate context, and physicians need to be able to interpret that information and determine what it means for patient care.

And that we also need to recognize that practices within the same ACO or APM entity may use very different technology needs and abilities, including different EHR systems.

That can make something as basic as collecting quality data much more difficult. So federal requirements need to be more flexible rather than overly prescriptive while we continue pushing for interoperability.

So we are pleased that CMS recently backed rolling, rolling back some burdensome requirements for ACOs following concerns raised by the AMA and others.

Now, one important point that was not addressed in the paper is the need for better data feedback, not just in APMs, but in MIPS as well.

It's important to point out physicians

need timely, useful information to understand what's working and improve patient care.

And that feedback can also help build the experience and confidence they need with information performance tracking to eventually move into an APM.

Let's move on to slide six where we talk about, let physicians focus on patient care, because one of the promises of APM is simple, focus more on outcomes and less on paperwork.

But as this paper rightly points out, we haven't fully delivered on that promise. Physicians and APMs are still spending too much time on burdensome quality reporting.

And if we're holding physicians accountable for cost and quality, reporting should be as simple and as flexible as possible. That means measuring at the ACO or accountable entity level where appropriate and aligning measures across programs and payers, including traditional Medicare and Medicare Advantage.

We should be measuring what matters, not asking physicians to report the same information in different ways.

We also need greater clarity around

regulatory waivers, and that's something that's been confusing because even when waivers are available, practices may not understand exactly what's permitted.

You know, one major source of burden that deserves more attention is prior auth. AMA research shows that 95 percent of physicians report prior authorization delays in patient care, and more than a quarter say it's attributed to serious event.

So we're hopeful that the move towards electronic prior authorization will begin to reduce that burden. But there is a larger point for APMs.

If physicians are already accountable for cost, quality, and patient outcomes, they should have much greater freedom from prior auth.

Otherwise, we're asking physicians to take responsibility for the results without giving them the flexibility to deliver the care.

And physicians do know what it takes to make these models work in the real world, but too often they're brought in after major decisions have already been made.

And the AMA has consistently urged CMS to

encourage physicians early in the development of new CMMI models, not after they're ready to launch.

So I'll close with one specific ask of the Committee, and really appreciate the opportunity again to present. PTAC has recommended promising physician-focused payment models that have yet to be tested.

We encourage you to say clearly in this paper that CMS should move these models forward, including testing them within broader ACO models where appropriate.

Now the AMA will continue to advocate for these models, but PTAC should as well. These are models that this Committee has carefully reviewed and recommended, and we hope you'll make the case for giving them a chance to work. Thank you.

DR. BOTSFORD: Thank you, John. So next we are happy to welcome in person Mr. Shawn Martin, who is the Executive Vice President and Chief Executive Officer of the American Academy of Family Physicians. Shawn, go ahead.

MR. MARTIN: Thank you so much. Thank you for the opportunity to be here. I want to start by just saying I am thrilled that you guys

exist, as a human that was involved in language and contributed to the language that ultimately led to the formation of PTAC in MACRA.

It is great to see that this Committee continues to do its work and contribute. I also think I have the unique perspective. I think I was the first person to present a model to the PTAC when it first convened at the AAFP[21].

We brought forward a model, so it's a full circle moment to be back here. I want to echo appreciation and congratulations on the report.

I think it's a very thoughtful perspective on the work that you have been asked to do. I think it's a roadmap. I think we would offer you kind of some high-level feedback that the paper gets the fundamentals right.

Fee-for-service, especially for primary care, is really incongruent with the work that we're asking primary care to do in the practice setting.

As has been noted, it continues to create barriers and siloing of care, incentivizing the wrong things and disincentivizing the right

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things.

We think moving away from fee-for-service continues to be the most sustainable approach to improving primary care. You get the foundation right.

We're big fans of primary care at the AAFP, that's not going to be a surprise to you. So we were thrilled with the emphasis that you continue to place on that foundation of the health care system.

I think your approach of team-based primary care is appropriate. Primary care is a -- a difficult proposition to take to every American, and I think it's going to take a lot of people contributing to that.

We think the model is well-grounded, and we think you did a really nice job of identifying a lot of the conditions that make the work that you have been charged to do more challenging moving forward.

So similar to the previous speakers, I'm going to tell you the things we really agree with, a couple of things that we would recommend, and a couple of things that we would urge caution around.

So first, we think high-quality primary care -- not high-cost, high-quality primary care is foundational to a better health care system. We think you get this right in the report. I think the report hints at, but we would encourage you to really think about the concept of continuity or usual source of care.

I think there's a lot of data from around the world and certainly within the United States that having a usual source of care is identified and causal with better health outcomes and lower costs.

So we would encourage emphasis there. The perspective payment piece, we applaud you for continuing to emphasize this. I think it is work that I have personally done since the early 2000s in the medical home, which Mike talked about.

We have not perfected that, but prospective payment is really important to advance primary care, not just from a financial perspective, but as has been noted because it allows for the flexibility and creativity that physicians need and practices need to do the work that's being asked of them.

Data and interoperability are critical at

primary care, but it's even more important inside of APMs and advanced primary care functions.

They need data from across the health care system, not just from other physicians, but they need hospital data, pharmacy data, and more and more, they need that consumer-driven or consumer-reported data that's going to become more important.

And like the AMA, we continue to see the promise of the ACCESS Model and position -- consumer patient-reported data as being a really important component of primary care moving forward.

Meaningful measurement. Meaningful measurement for me personally, not my organization, is usual source of care and total cost of care.

That's probably unrealistic at this point in our maturation around measurement. So we know there will be other measures, but I think really being thoughtful about what we're measuring is important, and making sure that that measurement set is as frictionless as possible for practices, and we're not just asking them to report data.

We're asking them to report data that

actually stands to improve the work they're being asked to do and contributes to the betterment of health or reduced spending overall.

It's been noted in your paper, and it's been noted here this morning, that rural and particularly small independent practices face a very unique set of challenges that is different than others.

Thank you for calling out rural practices and those challenges in your paper. I would encourage you to go further, and I'll do that in a little bit.

I think there is just more that needs to be done, particularly in the rural setting. It is difficult to put it into a paper, even though you guys did a really nice job, the impacts of isolation and just how isolated rural physicians are from everything.

And they need additional resources just to be able to navigate that isolation that they experience.

And then patient engagement, like others, we see an opportunity for patients to be more engaged in their health care moving forward, and we think they're taking up that opportunity at

pretty robust rates, whether that be as simple as AI or whether that be digital health and AI health platforms, we see patients being more engaged in their health care moving forward, and that's going to put different pressures on primary care to both receive and harness and interpret that information as they work in partnership with their patients.

So some places we would encourage you to think about strengthening, prospective payment. We still see an opportunity to really build out this concept of prospective payment.

There has been a lot of efforts to do this. I think the point that John just made that PTAC could put a fine point on is, it's not just about saving money. It's about saving money and better health in the overall construct of what we're trying to achieve, but we're not asking everybody within the system, nor should we ask everybody or every function within the system to save money.

I would say that more investment in primary care would position us to save money more broadly in the system.

So I think really focusing on this concept of prospective payment, even in the fee-

for-service system on things like the advanced primary care management codes, there's opportunities to really build out a good population-based prospective payment in the Medicare program, whether that be in an APM or in fee-for-service.

Real-time data sharing, I want to elaborate on this. It's been spoken about a couple of times this morning, but it's really important.

And my members both on this Committee and everywhere else would want me to say this, a 75-page PDF with a bunch of data in it is not real-time data sharing.

That is impractical and unusable at the point of care. Data sharing needs to be practical and applicable and implementation able at the point of care.

And I think that's really important for me to say. And then of course multi-payer alignment. There's a lot of activity in the APM or advanced primary care space, both in Medicare Advantage and other, you know, innovators that are out in the marketplace.

I think PTAC, we would urge you to lean

into this alignment across payers, creating maybe a roadmap or some rules of the road for everybody to live by.

Where we would urge some caution like others on mandatory participation, I think philosophically, yes, we would probably align with really pushing everybody into a non-fee-for-service-based practice model, but the reality is that a lot of practices aren't ready for them.

A lot of practices are resistant to that. And we would urge some caution from a workforce perspective. You don't want to take physicians that may have four to seven years in practice remaining and really push them out of providing care to their communities or their patients because they just don't want to go through a transformation that is being suggested to them.

So I would think about the impacts on workforce. I would also really encourage you to think about when you think about mandatory and voluntary participation, how that drives merger and acquisition activity or consolidation in certain markets.

It does push people to seek help or alignment in ways that can create consolidation.

And then we would urge you to do more in the rural and small practice support.

Your paper centers this work. Thank you for that. It's still a very unique practice setting that needs additional help. I will be so bold as to say they just need money that is geography-based.

You're not asking them to do anything. They just need more investment to overcome the isolation that they have from other resources that people in suburban and urban practices benefit from.

We would add a couple of things. We are heavily engaged in this concept of primary care investment along with our collaborators at the National Association of Community Health Centers.

We've launched a campaign called the Triple Double. One of those three elements is increased investment in primary care. The other two are growing the primary care workforce, and the third one is increasing the number of Americans with the usual source of primary care.

We think all of that starts with the increased investment in incentivizing people to have robust primary care practices. The workforce

follows usual source of care because capacity opens up when you do that.

Like Dr. Whyte, I would encourage you to expand the technology discussion. This is going to be forced upon us, so we would encourage you to be thoughtful on how you think about technology inside APMs. Is it a tool? Is it a partner?

Is it both? I think, you know, this really needs to be, you know, thought out, particularly when you think about population-based payments. Are those services incorporated into the population-based payment, or are they separate to et cetera?

And then again, clear expectations around this concept of alignment across all payers. So in closing, I would just say thank you for the emphasis on primary care.

We think the report emphasizes the right things. Prospective payment, interoperability, meaningful measures. I think the one word that I would encourage you to think about as you continue this work is creating APM similar to what John said is removing friction.

And I still think there's a lot of friction in the APM world. It's still really

difficult to get into. It's really difficult to navigate. I think making APMs, particularly primary care APMs, as frictionless as possible, both for the physicians and care teams, but also for patients would be a really important closing comment for me to make.

So thank you for the opportunity to be here and to share those thoughts.

DR. BOTSFORD: Don't worry. We'll come back for more comments shortly. Thank you, John. So next we're delighted to welcome also in person, Ms. Jennifer Podulka, who is Senior Vice President of Federal Policy at America's Physician Groups. Welcome, Jennifer.

MS. PODULKA: Good morning, and thank you to all of the members of the Committee and staff for the opportunity to speak with you today. I'm very pleased to share our reaction to PTAC's draft white paper. But before I get into our comments, a quick word on who we represent.

APG or America's Physician Groups, is a national membership organization of more than 300 physician groups all committed to value-based care.

Together, our members include roughly

260,000 physicians and other clinicians caring for nearly 90 million patients.

That represents about one in four Americans or one in three people enrolled in Medicare Advantage. Our groups operate across nearly every Alternative Payment Model that exists.

The Medicare Shared Savings Program, multiple models within the CMS Innovation Center, managed Medicaid, commercial accountable care arrangements, and two-sided risk contracts within Medicare Advantage.

And that last item particularly matters, so I'll be coming back to it. Our overall assessment is straightforward. This is a very valuable roadmap grounded in real evidence, and it deserves to be sharpened rather than softened.

We commend PTAC for the work behind it, 10 years of operation, more than 250 expert presentations, and real participation data. That's a serious evidentiary base, and it shows in the final product.

The paper's core conclusion to evolve and expand value-based care rather than retreat from the progress made to date matches the position APG

laid out in our own report from last year, *Medicare Done Right: Prescriptions for Success*.

We also strongly agree with its emphasis on population-based total cost-of-care models as the primary vehicle going forward. That's exactly what APG's physician-led members have already demonstrated.

These models are cost-efficient and produce better outcomes for patients. One caution, the paper will be most persuasive where it offers clear, actionable recommendations such as fixing ACO benchmarks and including prospective payments with defined glide path.

Where it states only high-level principles, it risks reading as aspirational rather than providing an actual roadmap. And I'll flag a few places where more specificity would help.

So the white paper's focus areas, payment, participation, performance measurement, enablers, rural access, technology and patient safety, all genuinely give policymakers a complete picture of what it takes to scale accountable care within traditional Medicare.

That part is comprehensive and incredibly

well done. But here's our biggest structural concern. The paper is framed as a roadmap for value-based payment models and care broadly, yet every recommendation addresses only traditional Medicare or original Medicare's ACOs and Alternative Payment Models.

There is nothing here about Medicare Advantage, which is a significant gap given that 55 percent of all Medicare beneficiaries eligible for Parts A and B are now enrolled in MA[22], and that share is continuing to grow.

Let me take a moment to step aside and talk about a study that our organization commissioned that demonstrates why this particularly matters.

Berkeley Research Group released this analysis last year called *Sticker Shock: Personal Financial Features – Factors Leading New Medicare Beneficiaries to Choose MA over Traditional Medicare.*

It modeled actual real-world choices a new beneficiary faces: either stay in traditional Medicare and later on a Medigap supplemental plan plus a standalone Part D drug plan, or enroll in

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often zero-premium MA plans with drug coverage built-in.

The study modeled three types of beneficiaries: those who are healthy, those who require episodic care, and those with chronic care needs.

And we looked across five major markets in the U.S. On average, the healthy beneficiaries saved more than $3,200 a year by choosing MA over Medigap, and the episodic care beneficiary saved almost $1,500.

Even the chronic care needs beneficiary came out about $300 ahead under Medigap in a typical single year, but this beneficiary still fared better banking MA savings rate against the risk of a catastrophic year when looking across the two enrollment options longitudinally.

Across all 15 scenarios that we modeled, Medicare Advantage was the better financial choice in 11 of them.

Now this isn't a marketing story for MA, but it's a rational, dollars-and-cents decision-making by people on fixed incomes.

And we have direct evidence published in

JAMA[23] *Network Open* and the *American Journal of Managed Care*, along with our affiliated researchers, that physician groups in two-sided MA risk arrangements produce superior outcomes, including for dually eligible and socially vulnerable populations.

These results even offer positive spillover into traditional Medicare itself. So a roadmap silent on MA leaves out the part of the program where most beneficiaries already are, and actually where physician-led accountable care is furthest along at this point.

So let's turn now to the paper-specific recommendations. There are six that APG supports without reservation. First, flexibility for accountable cand -- entities to manage and organize care included in Recommendation 4.

We find this essential to solving the downsides risk inherent to fee-for-service. Second, fixing the benchmark ratchet effect included in Recommendations 5 and 6.

This is the issue that APG has raised most consistently about total cost of care models with CMS, since long-term, predictable benchmarks

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are foundational to sustaining participation.

Third, prospective up-front payment, also included in Recommendation 6, matches APG's call for advanced investment payments for smaller and safety net practices to enable them to build risk-bearing infrastructure.

Fourth, a simple glide path to two-sided risk included in Recommendation 7, the realistic on-ramp new entrance need and one APG has specifically asked CMS to formalize.

Fifth, encouraging specialist engagement by nesting accountability within total cost of care models included in Recommendation 9. And sixth, trimming and aligning performance measures included in Recommendations 10 and 11.

As noted, our members live this burden directly. There are more than 600 measures across 24 different Medicare programs. Many of our members participate in more than one, and many of these measures are used nowhere else in the system.

We'd also like to point out six places in the papers where the paper's direction is right, but we think that the language needs some sharpening.

First, protect patient – physician-led accountability included in Recommendations three and eight. The paper itself notes physician-led accountable care organizations drive savings, while integrated delivery systems often lack the incentive to participate.

New pathways bringing those systems in should not come at the cost of standards physician-led organizations already meet. Second, Recommendation 5 names long-term predictability in benchmarks. It doesn't say how to get there.

We find this to be directionally correct, but policymakers really need specific published methodology to act on, not just a principle. Third, calibrate any move towards mandatory participation.

The paper raises mandates as a remedy for selection bias. We agree incentives should scale with size and readiness, but small and independent practices need funded on-ramps before a requirement and not after.

Four, Recommendation 8 should link its enablers more clearly to an actual participation pathway.

Five, Recommendation 11 should

acknowledge that not every electronic health record system can actually collect and report quality measures the way that the recommendation might assume.

And finally, the patient safety earn back model mentioned in Recommendation 20 -- 21 reads as hospital-centric, and we believe it should cover ambulatory physician-led entities as well.

Beyond sharpening what's here, APG would suggest three additions drawing on our own *Medicare Done Right* recommendations.

First, address Medicare Advantage risk arrangements explicitly. CMS should actively encourage more two-sided risk between MA plans and providers, not just traditional Medicare ACOs.

Second, align risk adjustment and performance data across MA, the Medicare Shared Savings Program, and other total cost of care models so accountable entities operating in both arms of the program have one consistent credible source of truth on patient risk and outcomes.

And third, redesign the advanced APM bonus as a flat dollar amount per attributed beneficiary rather than as a percentage of fees.

The current design skews investment away

from primary care and even rewards specialists unevenly, favoring the better paid ones over those doing the more coordinated work.

So in sum, APG's message to this Committee is sharpen, don't soften. Keep the paper's core direction, evolving and expanding population-based total cost of care models rather than retreating from value-based care.

Pair its strongest principles. There are benchmarks, prospective payments, and sensible glide paths with specific actionable recommendations and a defined methodology.

Protect the physician-led accountability that the evidence this paper itself cites, shows as driving savings today, and extend the roadmap to Medicare Advantage, where beneficiaries are now enrolled and where much of the health care's risk-bearing innovation is already taking place.

So thank you again for the opportunity to speak today. APG looks forward to continuing to work with PTAC to strengthen this roadmap for policymakers, and I look forward to questions and discussions.

DR. BOTSFORD: Thank you, Jennifer. And thank you to all of our panelists for the

presentations so far. So we'll get to move to the discussion portion of this panel.

We'll have the next 40 minutes for discussion between the panelists. So at this time, PTAC members, please feel free to flip your name card up or for our virtual Committee member, please raise your hand on Zoom if you have questions.

We welcome our experts as you've heard the other presentations to comment on the other presentations if you have any reactions. All right.

So in the interest of ensuring balance across different perspectives, we encourage you to keep your responses to a few minutes. All right. We've got a couple questions off-hand, so I'm going to start first with Krishna.

MR. RAMACHANDRAN: Thanks, Lindsay. Fantastic perspectives, fantastic presentation. So thank you all for the time and insights there. Maybe two questions. One for Dr. Chernew. You had spoken about reforming MA, so I would love to maybe if you can pull the thread on what that means, I think would be helpful. And the second one is for Shawn. Particularly, you spoke about

patient engagement. Love to get some perspectives on like what would it mean from a benefit design perspective?

Are there incentives we should include? Much of the payment model conversation has been on really the payment models between physicians and payers, and so love to see how we can engage members and patients as well there. Those are the two questions.

DR. CHERNEW: So in the instance of brevity, I will be quick on what I think about reforming MA. You could read a lot of my views in the MedPAC work, but in any case, broadly speaking, lower payment, I would get rid of the STARS program.

We can talk about why. I would make some changes to how risk adjustment is working. I personally would standardize benefits if you were asking me, but I think the core point that was -- I think it was Jennifer said this same thing, MA is where a ton of the action is.

So thinking about what's going to happen in American health care system, certainly in the Medicare portion of the American health care system, really has to think about what's going on

in MA.

And if MA is paid the way MA is paid now, a lot of this is going to shrink. The one thing I will emphasize is, I am much more ambivalent than I think Jennifer was about encouraging MA to change the way they pay.

I actually think they will be more apt to move towards value-based models if they're sort of paid better, because I think there's a lot of value in those models.

I think it's very tricky to try and reward them for their use of different types of models because you never know if what they're doing is -- it's just really hard to know if what they're doing, is really what you wanted them to do because they're doing it because of some administrative requirement as opposed to doing it because they realize it's a better way to get value.

And I could see a world, particularly as MA plans engage more with the delivery system, that they may want to do things that might not fit some pre-described notion of exactly how they should contract with those providers.

So I'm not a huge fan of trying to tell

MA what to do, but I do think we need to figure out what to do with the MA program because I think if we don't, we're going to have a really hard time maintaining a vibrant fee-for-service system, which I think is important, and I think that payment models should make that as efficient as possible. Jennifer may have some responses to that actually.

DR. BOTSFORD: I think let's stick on the MA topic here, maybe with some responses, and then Shawn will get to Krishna's second question. So I think, Jennifer, you've been given the floor.

MS. PODULKA: Great. Mike, you raise a really great point about MA sort of dwarfing everything else going on. I think given the particular audience for this draft set of recommendations, I think it's time and then some for CMMI to weigh in to better understand, like you said, we don't know what we should know about the payment mechanisms between MA plans and their contracted provider groups.

It's a really exciting opportunity for testing, but the testing only works if we have a view into what's going on. Now, we understand that CMMI is planning perhaps multiple models

looking at Medicare Advantage.

I think this is a ripe opportunity to get our arms around what payment mechanisms and incentives really do work when you tie accountable care to Medicare Advantage.

DR. CHERNEW: I think -- I'm sorry for jumping. I just want to say one last thing and then I will promise to be quiet for at least 15 seconds. I think the challenge is what works and doesn't work often depends on the context.

And so it's very hard when regulation gets put in place, which tends to work on average to make sure that it's right in different areas.

I think it's important to allow the plans and for that matter, the provider groups to have the flexibility within their context to behave the way they think is both clinically and economically the most advantageous.

DR. BOTSFORD: Other comments around MA? Okay. Let me actually just take a point of privilege there to see any questions for John Whyte. Looks like he'll be dropping in a minute. So we'll interrupt Shawn's second question here. All right. Jenny, let's go to you.

MS. PODULKA: John, my question for you,

you pointed out waivers and how we can make them clear. I wanted you to sort of maybe go into more detail there because waivers have been long held as a possible preexisting chassis for us to make changes without reforming the whole system. So I'd love to hear from you.

DR. WHYTE: Yeah. I'm always appreciative of Shawn Martin for providing some time, but I think it goes to the broader point because we don't have time to discuss all the specifics of flexibility, right?

That's what we're trying to determine here. And in waivers, you're able to demonstrate some of those areas of flexibility. So we actually can test as other people have tested and have said what is working and what is not.

And that's the whole point where I've talked about. Sometimes in clinical practice, what we are thinking about in terms of models doesn't actually work. So this could give additional flexibility.

DR. BOTSFORD: Lee?

CO-CHAIR MILLS: Yeah. Before we lose you, John, multiple people have commented about, and we've talked long about needing additional

models that will pull high-quality specialists into value-based care.

I guess I'd love to hear your comments and hear the rest of the panel's comments about what -- so what other specialties are right for that, and what would that model look like?

So of course we've had models for oncology, for orthopedics and for nephrology. Those are kind of obvious bits -- I can see an episode model around cardiology, maybe an episode model around, you know, certain hospital conditions linking in post-acute care. What other types of specialties and models would come to your mind that you might queue up?

DR. WHYTE: Yeah. And, you know, full disclosure, I'm an internal medicine physician by training and up until recently I still saw patients here in the DMV[24].

But you hit right on it in terms of cardiology, I think is one of those places that fits many of these models where we're trying to think about the continuum of care, we're trying to focus on prevention, seeing people earlier.

Cardiology is definitely one of those

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areas. I think there's a lot in the surgical areas as well, not just in orthopedics, but in general surgery where there's a little bit of a resurgence.

I think there's areas where it could be in anesthesia as well. It's to your point that the perception is by many people that value-based care is a primary care function. And I think we want to move away from that perception.

So I think there needs to be a process where we can include all specialists who are willing to participate under the structure that allows them to succeed and not be viewing it as something that isn't for them or doesn't work for them because I think that creates a difficult system.

CO-CHAIR MILLS: Other panelists, what other specialties would you suggest that we invite to the party?

MR. MARTIN: Well, I would like to pick up on something John just said. I think primary care is well-positioned because it's a community-based discipline. The most encounters take place at primary care, the most pathology takes place at primary care.

But I do think we have to be cautious, and I think, I don't want to put words in John's mouth, so give him a chance to respond. The burden of total cost of care can't solely reside on the primary care workforce.

I think it needs to be expanded where there are participants in other disciplines of medicine contributing to that. Primary care can do a lot, but it can't do it all.

So I think it's a really important point to think about how you design models that allow both procedural-based and non-procedural-based specialties to engage in, you know, this umbrella issue of value-based care.

DR. BOTSFORD: To Mike?

DR. CHERNEW: I want to make sure that John has got to respond or people have got all their questions to John before I jump in. I do have a lot of reactions to this part of the conversation, but I don't want to interrupt if John has any reactions to some of that or others because I will say my piece in a minute.

DR. WHYTE: I'm going to stay an extra minute so I can hear your piece.

DR. CHERNEW: Okay. Oh wow. So here's

what I would say. Back to my slide on waste as an asset. The problem with a lot of episodes. So, first let me acknowledge. Specialists are in many ways central.

They provide much of the care, much of the important care. I -- you know, my appendix burst. I was really grateful for the specialists. Like I really cannot emphasize enough how important specialists are.

That said, the challenge with building a lot of payment models in an episode orientation where you're thinking about cardiology and neurology and endocrinology, and I don't even know all the "ologies" is, you end up having this question of having to attribute the portion of waste that's getting eliminated by whomever to whoever's eliminating that waste.

And that becomes very complicated because these patients have multiple conditions. You often have to figure out what's going to be attributed to the hospital or not.

So if you avoid, for example, a post-acute stay, does that go to the cardiologist? Does it go to the primary care doctor? Does it go -- who does that go to? That's the decision that you

have to make when you have all these models.

In that episode orientation, it's very focused on particularly specialty groups, often leads to the clutter that I was kind of talking about in my talk. So it's not that I'm opposed to having episode-based APMs, it's just you have to be really careful about how they interact with the other types of providers and the other types of episodes and the total cost of care models.

And I think you need to be really, really, really, really, really deliberate in how you build those out because if you begin to give all the savings from reduced imaging or reduced post-acute stays or reduced whatever it happens to be to the specialist, it's just harder and harder for those primary care quarterbacking folks that are making referral decisions and doing other things to realize where that waste is.

So if the conversation in generalities is often different than I think the conversation and specifics are when you go into real, like what is the waste? How do you want to get rid of it, and who should keep it?

When the specialist is getting rid of the waste, the primary care docs never could do, it

should go to the specialist, no doubt. It's when multiple groups claim that they can get rid of the waste that you run into this problem with complicated patients with multiple conditions, that becomes very hard to operationalize.

DR. BOTSFORD: All right. Let's switch back. I think Shawn has a comment here.

MR. MARTIN: Okay. On the patient engagement question. So I would answer it in kind of three ways. I think with respect to patient engagement with the attributed population-based payment at the primary care level, I think the first goal is twofold.

One, it's reducing barriers for the patients to engage, and the other one is increasing the incentives for the practice to engage.

So one of the recommendations we've put forward for a number of years is elimination of cost-sharing requirements for patients that are self-attributed or otherwise allocated to a designated primary care physician or team.

We think this is a really important policy transformation that would create greater connectivity, incentivize usual source of care,

prevent leakage, like a lot of the things that have hindered a lot of APMs of value-based payments previously.

So the best attribution model, even all the way back to my early medical homework in the 01, 02 range, is when a patient raises their hand and says, "This is my primary care physician or team." I think we should reward that by eliminating cost sharing.

I just -- Mike may disagree with this, and that's fine. I think it's a robust, you know, policy discussion, but I think that one's really important. The second one is incentivizing the practices to engage.

So I think there's ways to do that either through encounter data or, you know, measurement, making sure that the practices are actually engaging with the patients prospectively, particularly around the areas of primary prevention, cancer screenings, checkups, MedRec[25], all the types of things, many of which technology may be able to do.

My second point would be, you know, incorporating technology into the

25 Medication Reconciliation

comprehensiveness of the primary care team instead of technology being bolted on or sitting out to the side.

I think we're at an inflection point of is technology going to be outside the care team, or is technology going to sit inside the care team, particularly in primary care?

I think this is -- there is a fork in the road. I think, you know, you start to see value-based care and primary care go one or two directions depending upon what happens in that particular space.

I think another thing that drives patient engagement is creating models that are agnostic to modality. And we still, even though, you know, we think we're doing that, there still are payment incentives, reporting incentives, documentation, disincentives around whether that visit is in person or telehealth or digital or a phone call or a home visit.

I think we really need to move towards being, you know, a modality being determined by what's best for the patient and really getting away from some of the rules about what can be incorporated, particularly into a longitudinal

primary care -- primary care model.

DR. BOTSFORD: One maybe fast follow, Sean, for you. When you talk about de-elimination of cost sharing as a strategy in primary care, do you think about it confined within a patient's usual source of continuity care or all primary care where you would anticipate those costs being reduced?

MR. MARTIN: I think you start with the usual source of care. So I think where the patient has identified their primary care physician or primary care team, I don't know that it always is a physician in the modern day and age.

You know, it could be practicing A. But I think as long as the benefit -- and the Committee knows this, the benefit of having a longitudinal relationship with the usual source of primary care is no.

So I think whatever you can do to incentivize that. I think the other thing where we see this working really well is just elimination of barriers prevents that leakage to higher costs, you know, moderate effectiveness care settings.

And if you keep people connected to primary care, you start to see better health outcomes, and you do start to see reduction in leakage to higher-cost care settings.

It is a pure financial incentive, right? If I don't have to pay 20 percent copay to go see primary care, in theory you can go to primary care every day, and that's impractical but not a bad idea, right?

I mean, especially if you're sick or you have high need, you want them to go to primary care as much as they need to, to manage their health.

DR. BOTSFORD: All right. We'll go to Lee and then Chinni.

CO-CHAIR MILLS: Okay. I want to peel a few more layers on the onion on this idea that everybody spoke to, and then we've heard lots of testimony over the last 10 years about to -- the simple, predictable glide path towards APMs, right?

Our purpose here is to change the care in the country, not just simply to gen up new models to pilot for the rest of our lives, right? And so that predicts that there is some number that is

not 30 years from now and yet more than two years from now, that somehow we must get a vision around this is the path the country is going to go.

So I'd ask you to comment on that specifically, what's different from urban and rural, what's different from maybe primary care versus specialty and be pretty -- if you had infinite power, what would be your simple clear glide path that we should put out that gives those who have to do this investment enough time to say we see the future, the future is coming and we're going to adapt? What does that look like?

MR. MARTIN: So I'm going to quote Kobe Bryant in response to this, and, you know, Kobe Bryant instantly said like, you know, when he was asked to reflect on his career, like, you know, what made him one of the best players in the world, and he said when I was young, every day I try to be a better version of myself and ultimately I became Kobe Bryant, you know, that the world knows.

So I think the message there is really important. I think we need to help, particularly the more rural practices we need to help them. We need to create policies that help them be the best

version of themselves every day, and ultimately they build skills that allow them to incorporate into other models that we think are important.

I am a big, big, big, big fan of building out the advanced primary care management code and fee-for-service. I think it is a gift that CMS has put into regulations that can be expanded into a population-based payment that allows these practices to start reframing from an episodic-based fee-for-service mindset into a population-based payment, build some skills, incorporate data, build out teams in a different way.

I would love to see that expanded as kind of that on-ramp where people start to get used to population-based workflows, patient engagement in a different way.

I think that is then a nice transition into particularly MSSP[26], and that population-based payment can follow them into that. I think the more rural you are, you have to build out the comprehensiveness, Lee, about what skills you're really asking them to incorporate, because now you're talking about the ability to use technology to connect with other physicians and other

26 Medicare Shared Savings Program

disciplines in a way that in our urban setting or suburban setting, you probably just send them down the hall.

They don't have it down the hall, so they have to learn to use technology. I've said this to some of you in private, this is why I think rural practices particularly just need a check that is solely geographically dependent.

We're not asking them to do anything with it. I think they just need money to be able to break down the barriers of geographic isolation that allows them to do things.

And you guys all know rural physicians, they don't have time to think about this. I mean, you know, they're just trying to get through their day.

And I think you have to create financial incentives to allow them to build the support structures to begin to get on that glide path without forcing them out of practice.

I think this is really important. You can't push them out of practice. So I would pause there, but those are two recommendations.

DR. BOTSFORD: Jennifer, then Mike.

MS. PODULKA: So this is actually

reminding me of my first stint as a staffer on MedPAC. And there was discussion back then that generated the term Accountable Care Organizations, which really stemmed from a research idea called extended hospital medical staff.

And researchers were noting that in the U.S., we really didn't have the system-ness that other countries have in their health care, but they created this idea of extended hospital medical staffs with physicians with admitting privileges plus other physicians and providers in that catchment area as a proxy to say we could measure treatment patterns and other characteristics within these groups and perhaps even then encourage system-ness.

And unfortunately, many, many years later, we're still in a position where I think the crux of the issue for encouraging these pathways is thinking about this lack of system-ness.

Think about what are the specific obstacles for different types of providers? So for rural and other under resourced providers, it's most likely the first one is investment.

They really can't interact more broadly with their system without investment, either of

their own, but frankly I think it really needs to come from CMS as well to ensure that they're connected with others.

For other types of physicians such as certain procedure-based specialists, the obstacle is very different. It's really that the inherent carrots in prospective payment and fee-for-service are too sweet and juicy to give up on those carrots and switch over.

So that's really the obstacle to system-ness there. So I think we need to think about. We're still not at a system. Even with ACOs existing, we really don't have the system-ness we were hoping for.

We need to think about what are the specific obstacles for different groups and address those in the glide paths to ensure that frankly there's more communication and that we're not pushing to other groups these efficiencies that Mike was talking about earlier.

MR. MARTIN: Mike?

DR. CHERNEW: So I agree with a lot of that. I'll say a few things. I think we sometimes conflate ruralness with urbaneness, versus independent versus system-based, versus

small versus large. And there's a lot of heterogeneity.

A rural doc that's part of the Mayo system is different than a rural doc that's, you know, in rural Arkansas. An independent doc that's part of Atrius where my provider is, is different than one that is not.

If you're part of Oak Street, that's different then if you're not part of Oak Street. Like these are very, very different places which makes it very hard to develop the regulations.

I think the question about how to ensure good access to care and techno -- technology and a bunch of things in rural areas is a really, really first order question, and I think it transcends whatever you do with payment models.

I am less enthused about putting an advanced care coordination code in fee-for-service because of a bunch of operational reasons, but to the core point that we need to get payment right and money to providers in certain places that have a hard time, you know, staying in business and providing that care.

I think that is actually a really important issue that one needs to think through

beyond whether it's an additional code and fee-for-service versus an APM model tailored to them or some other mechanism or how we think about the overall integration of those providers with hospitals.

I think the challenge is, and Jennifer mentioned this kind of briefly, and I think we did some of this work, the independent groups actually do better than integrated delivery system groups.

My joke is if you want to keep people out of the hospital, it's harder if you're a hospital. That doesn't mean we couldn't design models to give hospitals better incentives, which is kind of my preference.

I do think hospitals and hospital-based systems can provide a ton of value. I just think our models haven't been great at forcing that. So my North Star -- and I think actually this is not that far away from the report's North Star, and if I misread the report, I apologize, is really to have some version of total cost of care accountability, if you will, that puts a lot of weight on primary care because of that population centrality of it, and then tries to find ways to leverage the specialist where or you can do so

synergistically.

And then once you get past that sort of North Star view, then I think you're left with a bunch of other technical details that we probably best discuss in a different setting.

How do we do risk adjustment? How do you do attribution? How do you set the benchmarks? How do you ensure that quality is not being stinted upon?

How do you divide up the savings amongst the different organizations in the group? A whole bunch of questions like that. But for a North Star question, which I think was the original question, I think having some level of accountability at a person level to a group that is fundamentally working through their primary care relationship, and built in a way that meets some of the principles that was in the white paper is sort of where my North Star would be.

DR. BOTSFORD: Chinni and then Walter.

CO-CHAIR PULLURU: Some of my questions I guess were sort of brought up by Michael, but what I wanted to ask and particularly to Shawn, but also Jennifer and Michael is, as you think about the model of primary care, and I know, you know,

watching sort of the growth of direct primary care within the, sort of the realm of primary care that's also being compensated for by employers and like, and the success of it in establishing a patient relationship that's longitudinal, as you think about taking that model and putting it into alternative payment structures such as ACOs, there's obviously prospective payment involved.

How do you think about executing on things that would be accountability in that situation, as well as modelling how that payment would be paid out, I guess would be my question.

And how do you take what direct primary care is bringing into the environment that's positive and embedded into these alternative payment mechanisms?

MR. MARTIN: What a great question. So I think, I would answer it by what direct primary care is not. So direct primary care, you know, in its purest form has just stripped away everything that isn't in theory directly related to the two people in the exam room, and it has created a payment model, you know, through a subscription or otherwise that finances that relationship.

There's no quality reporting. You know -

- they just get rid of all the noise and friction that comes between the physician and care team and the patient.

So I think one of the things to answer your question, Chinni, would be, how much can we take away in the other models? How much of the reporting, how much of the documentation, how much of that can we start to eliminate so that the population-based payment, however it comes up, and I do want to say, I think Mike's comments about my comments on the advanced primary care management code are really, really fair.

I think it's a debate that should take place, but I do think those are fair. But let's just say you create a population-based payment, how do you get rid of all the noise so that that population-based payment is really driving engagement between the two parties in the exam room, and then add back in the things you need to drive usual source of care, encounter data so that it's not just that the practices are engaging with the patient and supporting the broader health care system through some type of data reporting.

I think the other thing that's really fascinating to me about direct primary care is if

you talk to any DPC[27] physician in the country, they will say their quality measure takes place every 30 or 31 days, that the ultimate quality measure takes place at the first of every month when the subscription gets paid.

And I think it's just a different mindset about patient engagement and involvement, and we can't do that in Medicare. I mean, that's not the Medicare promise or the safety net of the program, but I think the mindset about, you know, my obligation to that patient or my panel of patients is affirmed or not affirmed on a continuous basis based upon whether they remain engaged with my practice.

And I think it's a different -- it's a really different engagement criteria of how they think about their engagement with their patients.

DR. CHERNEW: So, I'm -- I actually think Shawn and I are completely aligned on aspects of this, which is, I'm not an expert on direct primary care and I won't claim to be, but I think one of the things that has happened as we've gone down this path is there's been an incredible tendency to want to put in more requirements, more

27 Direct primary care

quality measurement, more complexity that just makes it really hard for all physicians, primary care or otherwise.

So you may know I'm on a kick now to get rid of many of the quality measurement programs. I think they just don't work, and they drive everybody freaking crazy.

I think we should refocus them to make sure there's not really substandard care. I think a ton of the other types of regulatory overview work has just become an impediment, all well-meaning.

And I think we really need to simplify aspects of the system that is outside of an APM construct by the way.

But I do think in -- for example, MIPS is -- I think really problematic. I do think when we build whatever APM models we build, we have to understand that the burdens of what we're asking people to do are real.

And that at the end of the day, for the vast majority of physicians, we're probably just better off letting them practice medicine. And we need to have a payment system that lets them practice medicine.

I call that flexibility by the way, in my presentation where I do think subscription model primary care payments completely reasonable.

The tension is always around what you have to do for that subscription fee and when you're referring people out, how much risk they take, how do you risk adjust the fee, a whole bunch of other stuff.

We could go back -- people that are seeing multiple primary care doctors in different ways.

How do you deal with people that are integrated to big groups and stuff? There's a lot of complexities about the operation of that, but I think we should avoid trying to take a model that we think is working in one context and assume it would work in other contexts and then try and build our system around making everyone look like direct primary care or indirect primary care or primary care the next generation or deep space primary care or whatever it happens to be.

I think it's so tempting to see something that's working and try and figure out how to leverage it in other places when in fact it doesn't leverage that well in other places.

We should just give the organizations the flexibility to practice medicine with incentives to try and stay out of the way and have the public system try and make sure that people aren't getting really crappy care.

MR. MARTIN: Walter?

DR. LIN: I wanted to just follow up on the quality measure discussion that we've been having. Great discussion and I love, Shawn, how you said the DPC doctor's ultimate quality metric is renewal of their subscription, the first of every month.

Because it really does seem to me that the way we measure quality in value-based care models is very disconnected from the total cost of care.

They seem to be kind of on two separate planets and, you know, it's just -- looking at the CMS Universal Foundation for example, arguably the only quality metric that really directly affects total cost of care is the All-Cause Hospital Readmissions Model.

My question is around Shawn, what you said about meaningful measurements, and what would that look like in a more connected total cost of

care model?

What kind of quality measurements or maybe at a broader level performance measurements should we include and like really hone in on to better connect the quality measurements to the total cost of care?

MR. MARTIN: Yeah, it's a good question. I think two things. I think there's the primary care measure set that I know this Committee and CMS and others have been working on for a while to get down to, you know, let's say three to six really impactful measures.

One of them is kind of a continuity measure. I think measures that drive primary prevention activities are really important. I mean I think just as a system, we want to make sure we're doing cancer screenings and other types of things that we know can prevent both illness and disease but also prevent other spending as a result of neglect or lack of receiving services.

I think I have really shifted on quality over the course of my career. I -- you know, when we came out of kind of the, you know, ACA[28] time, I thought it was really important because I thought

28 Affordable Care Act

it would solidify the value of primary care.

I think I was wrong about that. I think it created an auditing system that actually allowed a lot of payers to not pay my members for the services they're providing. So my transformation has really happened.

One, all of this quality reporting was really upsetting physicians and care teams, and it didn't, to my knowledge, show any promise of really improving the overall health of the nation or reduce spending.

Disease was going up, spending was going up, my physicians were burnout and quitting. It just seemed to be pulling all the wrong levers. So I think we've invested heavily in getting back to some manageable set of measures that are really driving better health.

And I -- and I think that's evolving a little bit. I mean this idea of a physician reporting quality measures in 2026/2027 is almost laughable. I mean, you know, it's going to be extracted from, you know, the clinical notes or from the medical record.

Like this is going to become an automated thing in real time, you know, I mean, it is

already happening where you as a physician might do something and your EHR[29] might say the AAFP guidelines suggest X.

And, you know, so you're kind of getting into this real-time engagement, which I think is just much better at the point of care because we really want physicians and patients to make the right choices to drive health.

And I don't know that we need to measure that at the end of the year or on a two-year cycle. I think we really want to incentivize it at the point of care. And I think that's where, you know, I think where we need to go.

I don't know what that looks like, but I don't think it's unreasonable to think we could get there.

DR. BOTSFORD: Mike?

DR. CHERNEW: I'm 100 percent where Shawn is and then some. I was probably never as optimistic and now I'm probably more pessimistic than he is. So we both shifted. I started more pessimistic.

I think we've created a big auditing system, a huge burden, and I think quality

29 Electronic health record

measurement is aspirationally wonderful, but in practice it ends up being a huge burden, and I just think we need a lot of humility on what we can measure and how we can incent it.

And for example, just to pick -- let's take cancer screening. So I'm a big fan of cancer screening. Do I think it is good to create quality measurement programs for primary care doctors based on the colonoscopy rates of all their patients or their mammography rates of all their patients?

I am much more on the fence about that. Sure, I wish they would do that. I'd like them to be active in doing that. I do believe that's a good thing.

I believe the evidence on some of those screening services are really quite high, but if you give them populations that don't want to get screened or are facing a lot of out-of-pocket costs to get screened or have to travel very far to get screened or some other things, you're going to end up dinging those providers as providing bad care when really it has to do with what the patients want to do.

So I think if I would take any of those

things, I would stop, like -- I would stop asking the question, how do we create a quality measurement system for anybody to improve cancer screening, and I would ask the question, how do we improve cancer screening? If the answer turns out to be give primary care doctors or specialist doctors or hospitals or insurers an incentive to do that, I could live with that answer.

But the question needs to start with how do we improve the quality gap we're trying to fill, not how do we come up with measures for particular types of providers on things that we know are good because often we create a ton of burden.

They end up having to hire consultants to do outreach and make sure they're getting the medical record documented because the person actually got screened at the hospital, and it didn't actually get back to them, and it's like an information problem.

You know, I just find that the burden of forcing particularly small practices to do X, Y, or Z is a lot worse than the aspiration of getting them to do that when honestly, I might rather them in a visit deal with a person's real proxy -- say

a person has a really bad behavioral health problem.

There's a lot of things I want you to deal with. Maybe getting a colonoscopy isn't top of my list, and you end up with a very checklist box of things that drives people maybe away from other aspects of quality.

So I wish I was there so I could see Shawn. Right now Shawn is like this tiny little box in my screen, but I am just very skeptical of the fundamental questions of starting with how do we create quality measures instead of the question, we're worried that people's blood pressure's out of control, how do we make people's blood pressure better? And the answer might not be a quality program for rural primary care doctors.

DR. LIN: So Mike, maybe just a quick follow-up there. Under a total cost of care model then, what are the quality guardrails in your mind to make that total cost of care model not just focused on the --

DR. CHERNEW: I'm spending a lot of my time to figure out what those guardrails are. So the first thing I'll note is, whatever the guardrails are, they're guardrails that are going

to focus on the bottom end that you're not getting very good primary care.

They're not going to be guardrails that give you, you know, you have to be a four or five star, right? So I guess what I would say, and again, now Shawn is even not on my damn screen.

What I would say is I would ask you all that are clinical, what would you do to try and understand where is the really substandard primary care? Is it the -- maybe it is the monthly subscription fee in that model.

Maybe it is some measure that you're -- it, you know, you are way out of that. You are in the bottom 10th of your providers, are your patients getting some set of chronic care measures?

I'm not sure we need necessarily. It might be that we think about this at a higher level. So, Jennifer has been uncharacteristically quiet. It might be that you don't deal with this in these very small practices.

You think about this in a broader organizational kind of convening way. And certainly I think you would do something different if you're Atrius -- you're judging Atrius versus

if you're judging Dr. Zhivago in rural Kansas.

So I wish I knew the answer. Now, you just got me the rambling part of my presentation.

DR. BOTSFORD: All right. We are nearing our end here. I have a question that I wanted to touch on because all of you called out the mandatory piece in some fashion, whether it was calibrate, you know, it helps, but there's caution, and I think John mentioned it too, especially when we do this on the back of fee-for-service where payment is inadequate to begin with.

I think we've heard tension in the past between making it increasingly painful to stay in fee-for-service as a strategy to getting to primary care.

I think the reality is a lot of the current Alternative Payment Models though have this glide path that we've identified as important that really is built on this fee-for-service chassis.

So I guess from the perspective of what you do in the interim with fee-for-service to avoid it becoming too comfortable, but allowing the ability to get the money to primary care or other places, how do you balance those tensions

between making fee-for-service comfortable to stay in versus getting on that glide path to value-based care?

MS. PODULKA: Okay. Well, I'll jump in since I've been told I'm being quiet. I think there's a lot of physicians right now that would dispute that fee-for-service is incredibly comfortable, but of course we know that it is more comfortable than the alternative for some of them.

APG actually does support mandates in situations like this. At this point we could have educated an entire human being from preschool up through 12th grade with the time that the Innovation Center has been testing models.

It makes sense now that those who were going to raise their hands and step forward and volunteer have pretty much done so. Mandates make sense in many situations.

The areas where we urge caution is groups that don't have the resources necessarily, but that's not the ones who are necessarily finding fee-for-service, such a tempting carrot. They're unable to step away from it.

MR. MARTIN: So now to get a little spicy. So a reaction there, but I think a

perspective is important. So I think the macro construct, at least based upon what we knew in 2014 and 2015, was right.

I think it was this gradual discomfort in fee-for-service as we built models and moved people into APMs, particularly in the primary care space, but others.

I think it's important not to overlook how disruptive COVID was to that progression because then, you know, we went through this time period where practices had to be sustained, and the only way to really sustain the majority of practices in the country was to incentivize through fee-for-service.

So, you know, a roadmap that was being executed was largely disrupted by a pandemic. And when we came out of the pandemic, we just pretended like we went back to 2014, we didn't go back to 2019.

All right. We didn't pick up the progression of moving people towards APMs other than those that were already on the path. I said in my comments that philosophically, I think I really want to be where Jennifer is, right?

I mean, we need to move people,

particularly family medicine and primary care. Like fee-for-service is really, you know, inconsistent with what we want them to do and what patients want from them.

I worry a lot about the workforce. My resistance to mandatory models, particularly for family medicine, is more around the workforce because I think you would either push people independent practices into consolidated or M&A[30] engagements, or you would make people leave practice altogether.

They would just, particularly those at the later years of their career, and I think you could compound workforce problems in a lot of communities.

DR. BOTSFORD: All right. We'll go to Mike, and then we'll do one final call for the panelists for your closing thoughts before we have to end here, Mike. You're on mute.

DR. CHERNEW: I think it's important to think about the different organizations when we talk about mandatory versus not. How I feel about MGH[31] versus a small physician practice is very different.

30 Merger and acquisition

One thing that wasn't said is, there's a really important role for conveners and other organizations to help support small practices that want to be part of this and managing the associated information.

And I think when we build our models, we can -- we can sort of rely on that. I guess my general sense is -- for big organizations, I'm much more in favor of the type of sticks that I mentioned in my presentation.

For smaller organizations, I'm not a big fan of them. I would start with how we think about reforming the APM bonus, the 0.05, 0.75 fee updates, I think is going to be unsustainable. I think we need to translate that to a per person type of payment.

That's probably consistent with where Shawn would be, maybe where Jennifer is, I'm not sure. And I think if we do that, we can try and get people into this sort of broader population-based focus and use that APM bonus, whatever you call it, as kind of that portion of the subscription.

And then we have to deal with the rest of

the, I think it was you, Jennifer, that said ratchet was the big deal. It may have been, I just don't know. But I 100 percent agree.

Whoever said that, I could not agree more. If you have a ratchet in your system, it's a system towards failure. And so if you just solve some of the design things, I think you can get away with avoiding actually mandating a bunch of stuff.

And I think we are blessed with having a lot of organizations that can provide value if we set up models that enable them to really succeed.

DR. BOTSFORD: All right. Thank you all. So we are at time, but I -- we always like to close with a final if you have anything you haven't gotten out that you need to get out before we close. Anything for our panelists?

MR. MARTIN: So I have one and just -- and as we talked, it came to mind. We train residents, particularly resident family physicians and primary care physicians in this country, on a fee-for-service model.

They don't leave their training programs with knowledge and skill and experience in value-based models. And that feels like a real gap to

me. I don't know how you add it to your paper, but that -- I mean, just as we talked just here this morning, the four of us with the Committee, that is just something that jumped out to me.

DR. CHERNEW: My comments would be wherever possible, simplify, avoid the tendency to try and micromanage or figure out what model you think is actually best.

Allow the system to have that level of flexibility and understand there's a lot of unintended consequences with measurement and a whole bunch of other things.

So be very cautious of the administrative burden and the complexity that organizations face in deciding what to do. I think with some relatively modest changes, we can do a lot better, and I would try and keep it at sort of at that level.

DR. BOTSFORD: Jennifer?

MS. PODULKA: I would again --

DR. CHERNEW: The other thing I wanted to say is. I'm sorry.

AI is going to change a lot of how physicians practice in ways that we don't understand. So we need some flexibility to allow

those new models and leveraging a technology in ways that will not get into. I think Farzad tweeted something out about, you know, AI is going to be bad in a fee-for-service world and good in a value-based world. And I agree with that completely.

MS. PODULKA: I would just repeat the sharpen, don't soften. Value-based care has a lot to evolve, still going forward. But we're definitely at the point when you look at the trajectory of the Innovation Center models, if not value-based care, then what?

Has to be the real question at this point. And then one little tidbit that popped into my head as we were talking, from the direct primary care and other models, ACOs and other total cost of care models, too often patients don't even know that they're aligned.

So most Medicare beneficiaries when they sign up for an MA plan know that they're Aetna, United, whatever. Many have no awareness. They know who their physician is, but they don't know that they're aligned to the Shared Savings Program or REACH or the Kidney Care Choices model.

And I think building more awareness and

engagement would help answer this question. If not this, then what?

DR. BOTSFORD: All right. Well, a big thank you to all of our experts for joining today. We covered a lot of ground in this session. You are welcome to stay and listen for as much as you like. But at this time, we will be on break until 1:10 Eastern Time. Please join us then. We have another set of experts which continues the discussion of the drafts of our white paper and recommendations on value-based care.

(Whereupon, the above-entitled matter went off the record at 12:16 p.m. and resumed at 1:09 p.m.)

*** Session 2: Expert Input on PTAC's Recommendations on Value-Based Care: Part 2**

MS. HARDIN: Welcome back. I'm Lauran Hardin, former Co-Chair of PTAC and one of the PTAC members. We're very excited this afternoon to have a very remarkable group of experts for our second session, focusing on PTAC's draft white paper, and recommendations on value-based care. You can find our experts' full biographies and slides posted on the ASPE PTAC website and the

public meeting registration site. Welcome to our session. Participants, please go ahead and turn on your video if you haven't done so already. After all three experts have presented, the Committee will have plenty of time to ask questions. First up, we're very glad to welcome Dr. Hoangmai Pham, who is President and Chief Executive Officer at the Institute for Exceptional Care. Mai, please go ahead.

DR. PHAM: Thanks very much. Can you go to the next slide? I am founder and current CEO of IEC, which is a nonprofit focused on making health care better and safer for people with intellectual and/or developmental disabilities. But I was formerly the First Chief Innovation Officer at the Center for Medicare and Medicaid Innovation, and I was there at the beginning, setting up the ACO and primary care models. After CMS, I also led Elevance's value-based care initiatives, nationally at enterprise level across different insurance lines.

For background, I'm a general internist and primary care safety net physician, by DNA[32]. Next slide. So, first of all, I wanted to

32 Deoxyribonucleic acid

congratulate PTAC on a very fulsome report and set of recommendations. As secretary, I wanted to just offer some additional nuances around some of those recommendations, and then offer PTAC some additional factors to consider as you move forward.

It is certainly true, everything that the report says, about the demonstrated value of value-based payment initiatives. I think what it has generated in the marketplace is more important than the percentage of models that pass the expansion threshold. Research and development goes like that. That said, I do think that it's important that decision-makers understand what the counterfactual would look like, if there were not value-based payment initiatives. And as we can all imagine, there would be this tremendous ongoing chronic undertow of volume incentives that would drive a certain kind of behavior. And while those incentives still exist, they are at least blunted by value-based payment, and I think that that's really important to emphasize. While people are debating the exact quantifiable benefits of given models, there's this broader market impact that is significant.

PTAC's Recommendation 2, I just wanted to emphasize that there is the potential for value-based payment to really encourage patient empowerment and engagement, not just through obvious design elements such as voluntary beneficiary attribution, but also in frankly how the models are designed. We tend to take -- and I was guilty of this too, when I was at CMS, of taking a very paternalistic approach to beneficiaries. You know, we the technicians, the technocrats, and the provider experts will design the models, thank you very much, and then we'll tell you what we think you need to about them, when in fact, beneficiaries could have a lot of very insightful contributions to make to the design of models, such as indicating what types of quality outcomes are actually important to them, as opposed to ones that make providers comfortable or that are easy for payers to execute.

They might have made voluntary alignment more effective, by telling us how they wanted to be communicated to, and what the right language would have been to help them get to that decision. So, just a couple of examples there. And also, empowering beneficiaries and reducing health

disparities, and addressing their social needs. That is, you know, something that certainly agency and value-based payment providers have tried to focus on. We have a lot farther to go. Right now, these service sectors really do exist in silos. And while there may be referrals and consultations back and forth, they don't share the same data systems. There are just many, many barriers that make this challenging, but it does not mean that it's not worth continuing to pursue.

PTAC's Recommendation 8, just wanted to emphasize the importance of encouraging greater participation among integrated health systems. Physician-led ACOs do tend to perform better, and we want more of them in the program, but they are not the ones causing the most harm in the system currently. And if we think of value-based payment as a brake, however carefully pumped, on that volume incentive motivation, then we really need to think about what provider organizations need that brake pumped more.

And then, lastly, on Recommendation 11, I would just strongly encourage PTAC and CMS to think about a collection of measures that is really balanced across those that reflect

technical clinical quality, population outcomes, and patient experience, or more precisely, patient-reported outcomes. This goes back to my strong belief that we need to be measuring what matters to patients. When in our own work with the disability community, we spent three years working through with them and with clinical leaders and payers, what's most important to measure for people with neurodevelopmental disabilities? Not a single person mentioned hemoglobin A1C. What they wanted to find out was whether their problems were being solved, and whether they were respected, and whether clinicians working around them were actually talking to one another, and helping them navigate the services in a dignified way. So, we don't see a lot of those types of outcomes reflected in current VBP[33] measures sets, and there really does need to be more balance. While, we believe, it being entirely feasible to reduce the overall number of measures.

Next slide. So, then moving on to other factors that I would encourage PTAC to consider as it engages with CMS, and as you think about your future recommendations to the Secretary. Next

33 Value-based payment

slide. A really, really key thesis here is that value-based payment, while it has become commonplace in the land, is not universally adopted. And when it is limited in participation, it limits the gains to the system, and it undermines overall healthiness of health care markets. We largely are living with voluntary models now. At least, the total of cost of care models are all voluntary. And that means that we have a gross underrepresentation of high-cost, high-growth providers, what I would call the must-have providers. The ones that have so much market, either market leverage or market share, by virtue of their patient volume, their service mix, or their brand recognition, that no payer in their market can afford to cut them out of their network. That is a must-have provider.

Only one-third of hospitals participate in VBP models in Medicare now, and I haven't looked at the crosswalk, but I guarantee you that they are not proportionately including high-cost, high-growth, must-have providers. The lack of these providers in the models limits gains for both Medicare and Medicaid, because your highest spend generators are not in the program trying to

reduce growth in spending. But it also limits the potential gains for high-performing value-based payment participants, because it skews how the Office of the Actuaries estimates the potential for the model to generate savings, and hence, it constrains the kinds of financial arrangements, sharing percentages, and other incentives that the program can offer participants. And at the same time, it does little to counter the growth of these must-have providers in the marketplace.

Now, this paradoxically leads to an even bigger job for value-based payment. Why? Because when must-have providers can command higher and higher private sector unit prices, they then turn to policymakers at the federal level and say see, look at the difference. Look at the differential between Medicare prices or Medicaid prices and our private prices. There must be cost shifting here. When in fact, it was their own negotiating leverage that generated that differential. If they can, however, convince policymakers that there is cost shifting going on, that adds to the political pressure to raise public sector prices, thereby undoing some of the gains that we hope to achieve through value-based payment. Next slide.

Now, there are a couple of ways to increase broad value-based payment participation. I am a strong proponent of mandatory total cost of care models, because I think that is the shortest path to seeing the value of VBP optimized, as well as trying to rebalance dynamics in the marketplace. However, you can also, and this is not either/or, you can have mandatory models, and you can make those mandatory models more -- I wouldn't say palatable, but more reasonable looking, by removing arbitrage opportunities in the current system. And we'll talk about -- I'll talk a little bit more about this in detail, but some of those arbitrage opportunities include pricing distortions in the underlying prices that Medicare currently pays through its fee schedules, risk adjustment, which I know that many of PTAC's members and the agency is very aware of in both the value-based payment models and Medicare Advantage and facility fees. Next slide.

So, the second thesis is, we forget that the Medicare Physician Fee Schedule can also be a value-based payment model. We think of it as the enemy to value-based payment, when in fact it

provides the chassis for all of the pricing in current value-based payment models. It's not going away, and so we should try to optimize it as best we can in the direction of value. That means addressing all the ways it can influence the outcomes of value-based payment models, right? So, well-documented distortions in the relative prices of different services over time has led to gross overvaluation of some services, and undervaluation of other services. Overvaluation of certain types of procedures, and undervaluation of primarily cognitive services, and some procedures.

Unfortunately, those distortions run directly counter to the goals of value-based payment programs, because what they generate are gross motivation to invest in infrastructure and capital fixed costs at the level of a facility or a provider organization. And then once you have that investment, you're going to feel compelled to leverage it and generate volume, right? To recoup the investment, and to get higher margin as a result. So, there is a reason that oncology hospitals keep building. There's a reason that we had in the early 2000s, the huge nationwide trend

of investments in specialty hospitals. It is really impossible for any individual value-based payment program, and certainly for any single value-based payment organization, to counter those distortions, because they can't change just their corner of the clinical labor market, right? If just one payer in one market reduced what it was willing to pay for orthopedic procedures, those orthopedic surgeons would just go to another market. And no single program can counter the market competition for those high-margin services.

You also have facility fees, which drive, you know, the perverse incentive to offer services where you can bill for a facility fee, versus a less expensive site of care. You also have unbundled services that would make sense to bundle together. And not least, you have multiple codes and pricing for very, very closely related procedures. Now, I don't believe any of us really think that the world needs 9,000 CPT[34] codes, especially when so many of those codes are for closely related procedures, and really, it just generates arbitrage opportunities for a provider to pick the highest reimbursed code. And then, of

34 Current Procedural Terminology

course, there's upcoding in this sort of continual chase around risk adjustment scores.

How you can address this, through PTAC and value-based payment models, is to think of this as being a really key part of R&D[35] for value-based payment, right? If value-based payment models currently are fighting the Physician Fee Schedule, then fix the Physician Fee Schedule to give them a better chance at generating the results we want. That means, for example, that the Innovation Center, as well as the Center for Medicare, and other CMS components can collaborate and experiment with the fee schedule. For example, as was requested for information by the agency itself in the most recent proposed rule on the fee schedule, what are some alternative data sources that CMS could use to get more accurate pricing for different services? Both up and down. How can they simplify and redesign the payment codes to reduce arbitrage opportunities?

Let's leave the CPT system aside for a minute. Even if you have to live with 9,000 CPT codes, there's nothing to stop the agency, save will and a lot of political will and some

35 Research and development

operational funding, to reduce those 9,000 codes into a much smaller, say several hundred, payment families, right? That then you can reimburse by smoothing out the prices for the codes within that family. And then, once you have one or more alternative fee schedules, you can think about how to test that, which you can do certainly through rulemaking, and/or under CMMI authority. I'm not going to get into the weeds about, you know, whether it's wise or even possible to do a randomized trial around a different fee schedule, but CMS has taken other, much more dramatic payment changes in the past, such as introducing DRGs[36]. And there should be opportunity to consider such an approach for an alternative, much more balanced fee schedule. Next slide. And that's the end, and I really look forward to the conversation. Thank you very much for the opportunity to comment.

MS. HARDIN: Thank you so much, Mai. This was so interesting. We are saving all questions from the Committee until the end of the presentations. Next, we are pleased to welcome Dr. Paul Krakovitz, who is Chief Executive Officer

36 Diagnosis Related Groups

at Cone Health. Paul, welcome. Please go ahead.

DR. KRAKOVITZ: Thank you, and thank you for including Cone Health in the public remarks, and for all the work that PTAC's done over the last decade. It's -- from our standpoint, this paper is very, very well done. It shows a lot of thought, and I'll highlight some of those pieces, and then some parts where we think that there could be some improvement, or at least some changes to be considered. Next slide.

As I said, my name is Paul Krakovitz. I'm the CEO of Cone Health. I grew up mostly in large health systems, both in fee-for-service models and in integrated value-based care, and then I've also been outside of health systems, but always remaining within health care. I'm not a primary care physician. I'm actually a pediatric otolaryngologist by background, and this probably brings a little different perspective, that I come from clinically, but not from the business side. Next slide, please.

So, a little bit about Cone Health. We are a not-for-profit system that lives right in central North Carolina, and as a not-for-profit system, our shareholder is the community, and we

take this accountability and responsibility very, very seriously. We're multi-payer, multi-provider. We're set up that way on purpose, so that we can provide the community as best as possible, and to make sure that the clinicians are able to practice in the way that they want to practice. We do have an ACO, the Triad HealthCare Network, been around for quite some time. We also have a small Medicare Advantage health plan that's called Health Team Advantage. We've been doing value-based care for about 10 years, and in December, we became part of Risant Health.

Next slide, please. This is the area we are in. As I said, we're in the middle of North Carolina. Our environment is mostly rural, but we do have urban and suburban areas that are mixed within, and our system, from a geographic standpoint, is pretty similar to other systems that are within North Carolina. Next slide, please.

So, the recommendations. The first one that we thought was really, really strong and right on is Recommendation number 14. We are not Kaiser Permanente. We are not a single payer or provider. We are in a multi-payer, multi-provider

system, and with that comes challenges of dealing with both provider-side physicians, and the payers. So, for when -- each value-based care contract that we're in, and multiple payers, it's essentially like being in our own value-based care organization. The more complexity we add by adding more and more payers into our ecosystem makes it very, very complex, and it starts to really weigh us down with administrative burden. We are working with the payers in 2027 to try and work on quality metrics, but this recommendation is very important for us as a health care system that is working to do as much as possible in the value-based care environment. Please go to the next slide.

Primary care as the foundation, Recommendation number 2. I know this has been hit on before. This is very important that we bring this up again. Primary care has to be at the center of what we do. This is critical for us being able to do team-based care, and for the heart of population health management to really be and run through primary care. Next slide, please.

Some of the opportunities where we see some, for recommendations, really goes back to,

how do we incentivize? And part of the incentivization is not money, but it's actually just the natural competition that exists between clinicians that want to do as well as they possibly can for their community, for their patients, but they also want to make sure that they're being compensated. One of our big challenges is often around data. We work really hard to provide data real-time to our clinicians and to those within our networks, but that's not always so easy to do. The reality is, is that we have a shortage of physicians, we have a shortage of all providers, and the more that we can incentivize them and get them the appropriate data so that they feel like they're winning, and so that our patients can get the best care as possible, is a true alignment piece that we need to continue to work on.

You know, being employed as a physician is one option, but we need to make sure that we're able to give more than just that one option, and people are able to remain independent. Clinicians need to have that opportunity to remain independent. So, we do believe that being able to give risk-bearing entities the opportunity,

through waivers, and through other opportunities, to be able to maintain that -- the risk-based entity, but we also need fidelity to get down to the actual provider, so that they can work together with us, and so that they can work together to really push better care. If we can go to the next slide?

Behavioral health integration is something that we -- that is, we need to touch on a little bit more within this recommendation. Certainly, total cost of care has a lot to do with the actual care models that we use, it has to do with social drivers of health, but behavioral health is its own entity that also increases our total cost of care. You know, what Mai said around people not really talking about what their hemoglobin A1C is when they're at disabilities is very, very true, and we need to keep this top of mind, that behavioral health increases our spend and increases the complexity of the care we give. Being able to incentivize models that keeps primary care and behavioral health together is really important.

Which also drives to the other recommendation, which is on the last paragraph on

Page 27, and we just want to push this from a conclusion into a recommendation, which is, we need to get away from all the piecemeal models that we're seeing out there. The more that we can start to make this into a platform, the easier it is for us to administer not just from our ACO and CIN[37], but also our ability to push care. So, if we could go to the next slide?

Let's talk a little bit about artificial intelligence, because that is certainly top of everybody's mind. It's in everything we look at, read, see, and if there's one thing that health care has struggled with in the past, it's how to get technology to actually work in our favor, as against us. So, when it comes to AI, it's really about AI responsibility right now. We don't need more mandates, we don't need more required models, but without regulation, things can get too narrow in terms of the definition. So, what we need to really be thinking about in artificial intelligence is, how do we make things easier? Now, artificial intelligence can work all over the place, but let's just think about one thing in particular, which is that we still need the

37 Clinically Integrated Network

fundamental building blocks, and part of that is administrative. And that administrative piece is taking away the burden. So, if we're able to get real-time data through AI, great, but let's make sure that we don't build something today that we regret later on in the future. So, we are all about using technology to improve care, to reduce the burdens that exist out there administratively, and really help our clinicians and our patients get the best care possible.

Which does lead to the part that is really pushing on burnout for our clinicians, which is administrative burden. You know, we really think about clinicians needing the time to do their work, the financial piece so that they're reimbursed to a point where they are comfortable, not to a point where it pushes their compensation lower, but where they need to be for their profession. And finally, the autonomy. And part of the autonomy that clinicians need, if they're within a system or they're affiliated or independent, is simplification around administration. So, we really look at the recommendations to continue to push to remove administrative burden on our clinical areas.

We can go to the last slide. Social drivers of health continue to be an issue, particularly for us who are maintaining and taking care of an entire community. For us, it's for five counties that are both rural, urban, and suburban, but it's -- those social drivers really matter. We have lots of not-for-profits that we can work with that are outside of traditional health care, but we need to have the ability to work with them, and the incentives need to flow back and forth. We don't believe that health care needs to be the ones who fix all the social drivers, but we need to be part of the solution, and having easier ways to administer that and work together is really critical.

And the final thing is, is that as a health system that's taking care of the community, we're taking care of more than just Medicare patients. We're involved, 70 percent of our core area is Medicare Advantage. So, the ACOs are important, but working with MA is important, and particularly now that we're having the downward pressures on Medicaid, and we're seeing more risk in Medicaid, we really need to be thinking about models that can reduce some of this administrative

burden, start to really bring our quality measures, so that they're more universal across all the lines of business that we can do in risk arrangement. Be that for commercial, to Medicaid, or to Medicare. And with that, next slide, I'd just like to say thank you, and I'll pass this back over to the center.

MS. HARDIN: Thank you so much, Paul, again, very valuable presentation. Really excited to hear some of the themes both of you are bringing out that we have not heard yet from other presenters. I think the discussion will be very rich when we get to the questions. Next, we are very happy to welcome Ms. Emily Brower, who is President and Chief Executive Officer of the National Association of ACOs. Welcome, Emily, and please go ahead.

MS. BROWER: Thanks, Lauran, and thanks to PTAC for the opportunity to review the white paper and to share some feedback today. I am participating today, and my role is President and CEO of NAACOs, but I bring to that role a career leading clinical and payment transformation, and what we now call population health accountable care and value-based payment. Next slide, please.

NAACOs, National Association of ACOs, is a member-led and member-governed nonprofit of nearly 500 organizations in Medicare, Medicaid, and commercial insurance, working on behalf of physicians and other clinicians across the nation to improve the quality of care for patients and reduce total cost of health care. Hello to many of our NAACOs members participating today. We represent more than nine and a half million beneficiary lives through Medicare's population health-focused payment and delivery models, including the Medicare Shared Savings Program, and the Innovation Center ACO models, REACH, soon to be LEAD. Beyond Medicare, our members participate in total cost of care and episode-based accountable care arrangements across all payers, Medicare, Medicaid, Medicare Advantage, and other commercially insured populations.

Next slide. I appreciate PTAC's white paper acknowledging the success of Medicare ACOs, and just call out this most recent publicly available data, pointing to the year over year improvements in quality and cost, as compared to the targets that ACOs work with. In just the last year, we saw again, year over year improvements,

with 40 percent of ACOs decreasing ED[38] visits and admissions, 65 percent improving readmission rates, 61 percent improving, yet again, another year, their overall quality score. And more recently, CMS has shared some of the details in those quality results, as compared to non-ACO attributed populations reporting through MIPS , where we see significant, and again, year over year improvements in managing chronic disease, such as hypertension and diabetes. These are results that get at the core work of ACOs, their provider networks, and the investments they make in improving the health of the people they serve. Next slide.

I'm going to frame by feedback on the PTAC recommendations within the NAACO's areas of action to modernize ACOs, and some of the themes that we've already heard today of sustainability, burden reduction, and innovation. Nearly 15 years into the ACO movement, if you will, the evergreen need for fair and sustainable benchmarks has hit a critical point. Many ACOs are in their third, and going into their fourth, agreement period, where the benchmark or budget of medical expense

38 Emergency department

spending has been reduced by their own success. The benchmark ratchet needs to be addressed, along with lowering, at a minimum, not adding to the program's administrative burden. And as we address some of those barriers to long-term growth and sustainability, we need to continue to add payment flexibility, especially in primary care, while creating more opportunities to align incentives across the continuum. Anyone who wants to know more about NAACO's modernized ACO area of action, you can find that on the website, modernizeACOs.org.

So, moving into the PTAC recommendations framed in these three pillars, starting -- sorry, next slide. Starting with sustainability, which is a great place to start. The key really is addressing the benchmark ratchet, which was covered in quite good detail by the last session. And I'd add there to those comments, a more robust add-back of the savings earned by the ACO to more balance the budget that they perform against, as they renew and continue through to achieve outcomes in these models. On Recommendations 3, 4, and 7, I come back to the center of accountability being primary care, and I

appreciate those comments. Health systems, integrated delivery networks, conveners, IPAs[39], enablement companies, MSOs[40], these all have important roles in bringing scale and resources, but primary care teams continue to direct the delivery of care determined by the holistic needs of the populations they serve, and that is really the heart of the work.

There will continue to be different ways to organize the network of care, the O of the ACO, and the delivery in different communities, and this should be encouraged through flexibility in the payment and organizing models, including risk and cash flow options. What cash flow mechanisms work for what entity or ACO is different? So, these options are important to preserve, especially for partial or primary care cap within total cost of care. That's a payment methodology that is simply missing from the PTAC table and the table of payment methodologies, which would benefit from inclusion.

On Recommendation 8, I want to amplify the point about continuing to improve on current models. Existing pathways can be improved, have

39 Independent Physician Associations

been improved, and that is preferable to creating new models that then take years to operationalize and evaluate to the point where you understand what works. Small, independent, and rural providers need options to stay in no or more limited downside risk pathways, at least until they achieve enough savings to have a meaningful savings add-back. For these entities, it's also important to protect against under-capture of illness burden and alignment volatility that happens with smaller populations with poorer access to care. Hybrid payment options similar to ACO REACH and Primary Care Flex Models are important to design -- incorporate into the design of primary care cap that works for the business model of the entity that is taking accountability.

And then, for networks that choose to include the full continuum of providers, hospitals, specialists, post-acute assets, in their ACO, the payment models need to recognize that higher historical cost, similar to how the new ACO LEAD adjusts for that. The point here is that there are existing model components within CMS' ability to change for these entities, and in

fact, recent model design elements in the LEAD ACO and the proposed changes to the Medicare Shared Savings Program are very helpful here.

On multi-payer alignment, I'd prioritize alignment between Medicare and ACO and Medicare Advantage. That seems within our reach, given what we know at this point about payment and delivery transformation and Medicare, and we have the support and continued commitment of CMS across administrations to accountable care models. Next slide.

On burden reduction, and that important pillar, we are highly aligned around interoperability, patient choice, and simplifying quality reporting. In the spirit of burden reduction, I suggest we rely on existing patient safety organizations and accrediting bodies for the work to improve patient safety, and not add that to ACO requirements, as duplicative and burdensome work. Next slide.

In the innovation pillar, the main point here is that 15 years in, we see that innovation grows out of opportunity and flexibility. The accountable entity, with fair and sustainable benchmarks and a reduction in administrative

burden, can and will choose what works for them. Their network, their community, their cash flow needs, their thesis and theory of change. Flexibility in payment arrangements sustains and aligns the provider network, particularly with that important center of primary care, and opens up the opportunity to reward patient-level preventative care.

On the next slide, I offer some additional feedback, not specific to those numbered recommendations. First, don't hedge. Celebrate ACO success. I love Mai's metaphor of the ballast. There are lots of points in the paper where the Committee nicely reviews the success of ACO models, and I would suggest you can reflect on that positively, pull it right up into the introduction and conclusion, make it front and center. In these days in increasing health care costs, ACOs are a bright light. Don't hide it.

Also, resist some of the old constructs of physician-led ACOs. Medicare ACOs are all physician-led, because that's what works, and also, that is in fact required by the CMS models. Whether the ACO includes a health system, if that's the distinction you all are going after,

that is really mostly a choice. Some ACOs include hospital entities, some do not. Or, it's based on a fee-for-service 10-billing construct. But either way, ACOs that had integrated delivery network ownership, even those make different choices about whether to include hospital assets and health system TINs[41] in their ACOs.

It's also important to bust a myth that integrated delivery networks and hospital systems have little or no incentive to participate. To quote the report, in Medicare they have all the right incentives, and the higher the public payer mix, the greater those incentives. While I spent most of my career in group practice, or what we now call risk-bearing provider groups, one thing I've learned from hospital CFOs[42] that I've worked with over my career, is that preventable utilization, that effective ACOs reduce. So, think of our favorite ambulatory care sensitive condition admissions. Effective ACOs reduce those, and those kinds of admissions bring no or negative margin to the hospital. So, you have Medicare ACOs enabling the reduction of negative margin business, and the opportunity to earn a

41 Taxpayer Identification Numbers

dividend, or as Mike Chernew said earlier, turn waste into an asset. And that will almost always beat out straight fee-for-service Medicare or fee-for-service Medicare Advantage. So, I suggest bringing more real-world financials to perhaps bust that myth.

Lastly, wherever there is an opportunity to promote flexibility, take it. don't constrain. Don't micromanage. Flexibility is what will drive innovation, to produce the clinical and financial outcomes that accountable care is -- as its North Star. Thank you.

MS. HARDIN: Thank you so much, Emily. These were such great presentations. I know that we could go much longer in this session. I want to invite the Committee members to turn your table tents up if you have a question for our speakers today. We want to open the discussion up. I also want to encourage you, as speakers, to comment on each other's, or ask each other questions. Does anyone have a question they would like to start with? Otherwise, I will dive in. I could ask you about 20. We haven't heard anybody really speak to the opportunity in behavioral health, and

really the opportunity to proactively address health-related social needs. I wonder if you would each like to speak to that a little bit about the opportunity, and how we can strengthen that in the report?

MS. BROWER: Well, my audio is still open, so I'll just jump right in. I really appreciated Paul calling attention to this in his comments. Integrated behavioral health is key, and we all saw the data probably 20 years ago about those conditions driving total cost of care and disintegration of care. So, for sure, that is an important feature of accountable care. And there are some good fee schedule changes, to build on Mai's comments, that can promote that, by allowing providers, even outside of accountable care, to provide both behavioral health and physical health care within the same day, see those in the same practice, integrate that care, and have that be reimbursed. So, critical opportunities in behavioral health and community care. One of the things we've seen at NAACOs is some really nice partnerships with community care hubs with our members, to really bring and leverage the community-based providers who are

addressing health-related social needs.

DR. PHAM: I think the only thing I would add on top of that is to think about explicitly encouraging ACOs and other value-based payment organizations to -- it's certain kinds of community-based providers, right?, where you may get slightly more scale than you would for individual patient therapies. So, think about peer support groups. Think about group therapies, and other models like that, and allow the revenue flexibility for ACOs to invest in that.

DR. KRAKOVITZ: All right. I brought this one up, so I'll jump on. I really like the comments that Emily and Mai just made, but, you know, a lot of the behavioral health and the social drivers, those are like the basic hierarchical needs. Before we can start really solving some of the harder stuff, we've got to be able to solve that. So, you know, models that incentivize behavioral health and primary care are great. They're hard on very small practices to try and integrate, unless you're doing this through an omnichannel approach, which isn't always the easiest. So, that's one part. The second is, is through the drivers, again, like a

three-or-four-person practice versus a large 250-person practice, the challenges of getting people through those drivers of health beyond a checkbox are a challenge. So, when we can help make incentives to that, we work better with our not-for-profits that are all over the place in our communities, that are working on individual drivers of health, letting us work closer with them and having incentives for us to do that, and vice versa, can really start to help remove some of those barriers, because we are not the ones that are going to be able to solve all food and housing insecurity, but we have lots of partners who can, and sometimes we get in our own way of being able to do that.

MS. HARDIN: Thank you so much. I'll turn it next to Lee.

CO-CHAIR MILLS: Thanks, Lauran. I really appreciate all three of your presentations. Paul, you spoke about reducing barriers and friction to drive, you know, engagement in value-based care models. We heard a lot about that from the first panel this morning, as well, about reducing friction and barriers. So, I guess I lay out the red carpet, and offer, you know, each of

you, please name, give us one or two of your favorite or most aggravating examples of things where you think policymakers could reduce friction to embracing value-based care.

DR. PHAM: You know, we -- I think this one requires collaboration between participants and the agency. Our motto, when we were standing up the Pioneer ACO Model, and then the subsequent early models, was, we would say to the providers, Emily may recall, or she may have blocked it out from trauma, we can be fair, or we can be simple, but we can't be both. Take your pick. And inevitably, providers pick fair, even when in my experience, it generates a false sense of precision and, you know, it may be hard to predict where you're going to fall on one side of the financial line or the other. So, I think part of me would throw it back at providers to say what -- in what ways are you willing to forgo precision in order for the agency to try to simplify these models.

That said, I will just take this opportunity to go off-script to your question, Lee, and say I think the huge part of the friction is what is not in the room, which is all the

arbitrage opportunities outside of value-based payment. The reason I call that friction is because that is what population health leaders at health systems and organizations have to fight when they are in their C-suite, looking for resources to invest in value-based payment work. They are fighting the friction of those arbitrage opportunities.

DR. KRAKOVITZ: I'll throw one out, which is from a health system side, which is transition in care. So, you know, as a value-based organization, one that's risk-based, our goal, which is also the goal of most patients, is to be in the hospital for the least amount of time. And transition in care, can get -- we can have friction that really gets added, particularly when we start going from acute care into skilled or into post-acute. And there's barriers that get put up -- for one reason or another, those friction points make it difficult for us to transition patients who need to leave the hospital, and sometimes that's because of social drivers, but often it's because of such great variability between the payers and their policies. So, if we could just help remove some of that

friction so that we could help with transitions in care, that simple one alone would really go a long way in helping us be able to reduce our costs, and hence, be able to pass that along.

MS. BROWER: I'll maybe add something. A little bit of another perspective around burden reduction, with one example. This far into the work that so many organizations are doing to improve total cost of care and quality outcomes, they've gotten really good at identifying and ingesting all kinds of data sources. Whether it's HIE[43], admission, discharge, and transfer notifications, claims data, clinical data, lab data, like really, really good at identifying and ingesting those data points to drive better care, and it's incredibly expensive. So, for example, that lack of standards and interoperability means when an ACO has to turn around and show the quality of care that they're delivering, they have to get it out of all those different unstandardized interoperable data sources. We've seen some good improvements that will help with some of the burden reduction around quality reporting, but increasing efforts around

43 Health Information Exchange

interoperability and data standardization is another one that I would add.

MS. HARDIN: Thank you so much. Krishna?

MR. RAMACHANDRAN: There have been some great perspectives. My question is on, Paul, you had mentioned in your sessions, around just, like, AI being a gap that we didn't sort of include in the white paper. And I do agree, there's an opportunity to expand. But I would love to maybe get recommendations from you, as well as others on the panel, what specific aspects of AI would be helpful to maybe see in the white paper, from the PTAC side?

DR. KRAKOVITZ: I feel like as soon as I get this out of my mouth, it's already going to be obsolete, because that's just the truth with AI, but, you know, we do a lot of activities that check boxes, and that they're very delayed. And when we can start to push on AI really to help us so that we have real-time actionable data, and I know that devil's in the detail on that one, but really, so that we are -- when we're looking at quality metrics, we're not just going back into an administrative burden, but where the AI can actually take that friction out and simplify it.

I think that's probably the first block of where we would like to see AI really get pushed, and being able to incentivize that, without it being a regulatory burden. You know, the other pieces around where AI is going to go for clinical care, that's probably less relevant for this conversation, although it certainly can address some of our shortages that we have in care.

DR. PHAM: So, one of my favorite child ideas is, and I believe CMS has started to move on this, is to consider deploying AI to generate an alternative to current risk adjustment models. One, because there's more data out there than just claims. Claims reflect, actually, a very small, I think, proportion of the variation in likely outcomes across beneficiaries, and you can use other data to supplement that, but secondly, while in general I am strongly in favor of more transparency for providers, transparency in risk adjustment methods has not seemed to help the system be healthier. If it's a fair black box, I'd rather have a fair black box that people can't game, and that they don't feel pressure to chase with upcoding and other activities that distract them from what they actually want to do for

patients. So, those are a couple of thoughts on the agency side.

On the care delivery side, I think there's -- the field in artificial intelligence is far too dynamic for the agency to take any sort of prescriptive stance at this point. What I would encourage is considering the use of AI as a natural option for providers who have the right overall financial and systems incentives to find efficiencies. You can trust the providers will figure out how to do that. Don't dictate how they should do that. However, I do think it's important for the agency to put guardrails on their use of AI. So, for example, under no circumstances do we -- I think, think that AI should replace a human care relationship in the long term. Especially for patients and populations with complex needs, like Medicare beneficiaries who are either aged or have disabilities or qualify on the basis of ESRD[44]. None of those scenarios are straightforward clinically. That requires an integrative intelligence that actually knows the person, knows the community, and can have human conversations about the trade-offs in clinical

44 End-stage renal disease

outcomes and life outcomes that come with complex decision-making.

MS. BROWER: I would build on Mai's point about the physicians and other clinicians in accountable care models as having all the right incentives to innovate in this area. And in fact, the incentive to keep that care integrated, because, you know what we have as an alternative is lots and lots and lots and lots of innovations that are point-to-point solutions between perhaps a technology provider and AI provider and individual patient that happens outside of that important accountable primary care relationship. So, as we continue to move through all of the new developments and innovations in the area, think of the ACO as a kind of safe place to foster innovation that is going to be aligned with that drive to integrate care.

DR. KRAKOVITZ: Can I just add one piece around this? Because, you know, we talk about, like, the risk adjustment piece that Mai brought up is really important. The way we do RAF[45] right now is clunky, and we've been through lots of different versions, and it's been painful, but I

45 Risk adjustment factor

think that black box piece is important, because we need some stability. Particularly as we're taking risk, financial risk, you know, without that stability -- we've been burned in the past, and maybe it's been abused in the past, but I would just help us be thoughtful so that we don't end up in a situation where our payment models drop out from under us, and we're unable to continue to do value-based care, and to be able to do what we think is right, to take clinical, financial, and operational risks. So, excited about where AI can actually simplify some of this, but at the same time, I think we're all a little bit nervous of where it can be, particularly living through how technology has improved health care, but from the physician lens, has often made it a lot more complicated.

DR. PHAM: Yeah, I would just add to that. I agree with you, actually, but I would add to that that providers now spend enormous sums of money and time on their RAF scores. That is not where we, or they, want them to pay attention. It's not why they went and got clinical training.

MS. HARDIN: Great points. We have time for one more question from Walter. And we've got

about four minutes left to answer this one. So, go ahead, Walter.

DR. LIN: Thank you, Lauran. Fascinating discussion. Thank you so much to our experts. Dr. Pham, one of the most provocative statements that I heard today was the idea that the Medicare Physician Fee Schedule can be a value-based payment model. And now, I understand where you're coming from. I actually agree, but within our Committee, we've historically thought of fee-for-service as the antithesis of value-based care, and the Physician Fee Schedule as an enabler of that. And we often talk about how the way we promote uptake of total cost of care models is through making fee-for-service more uncomfortable. I think what you're saying, though, is the fee schedule will play a very important part in total cost of care models by setting volume incentives and service mix because of it. And what you're suggesting, I think, is not an incremental change of the fee schedule, but more of a wholesale redesign, if I understand you correctly. How should PTAC think about going -- recommending this redesigning the fee schedule to the Secretary? It just seems like a really big undertaking,

especially understanding that one man's waste is another man's revenue.

DR. PHAM: Well, that is the story of health care in a nutshell, but I would point out, first of all that the agency -- CMS has already started moving in this direction, not just in this administration, but in previous administrations, too. Thinking about overvalued services and how to crack those prices, and undervalued services, such as, for primary care E/M[46], and trying to correct those distortions. I think that what has always hampered the agency was, in part, operational funding to do the research and the work, but secondly, it's the political fortitude of policymakers. When -- there have been numerous occasions where the agency has tried to reduce pricing distortions and really been undercut by policymakers.

So, part of this is a collective political fortitude, but part of it, too, is it's now generating so much discomfort and poor outcomes in the system that it's really not sustainable anymore. So, you go from revaluing specific codes to thinking about okay, well, let's

46 Evaluation and management

try to prevent future distortions. How can we do that? Can we get more creative with the sources of data that we use for pricing, and not just rely on the RUC[47] Committees? Don't need to do anything to remove the RUC Committees, that's one source of data, but you can inject other sources of data that would require some budgeting, right, for the agency, through the president's budget. You can -- I think if you simplify codes into payment families, that is something that the agency has also considered. Many of these ideas are not brand new to the agency. So, the Secretary should not be shocked to receive such recommendations from PTAC. I think the new paradigm is to think of the fee schedule as within the purview of the Innovation Center's work and the agency's work as a whole, as a value-based payment model.

I will also say, I never, ever bought into the premise that fee-for-service by itself, sort of, you know, undressed, was the enemy of value-based care. There are many things that we want to pay via fee-for-service. If there is a service that is critically important for health that is not being delivered reliably, I want to

47 RVS [Relative Value Scale] Update Committee

pay that fee-for-service, right? I want to pay for preventive services via fee-for-service. I want to pay for house calls via fee-for-service. As Jamie Robinson once famously said, from UCSF[48], the three worst ways to pay physicians are fee-for-service, capitation, and salary. Take your pick. I think the best that we can do is to find the right constellation of those different elements to send the most income neutral signals to clinicians, in order that they can be freed to make the decision that is simply best for the patient sitting in front of them at the time, and not be trying to calculate in their heads which one will get me the higher margin, which one will put me into a deeper financial hole? That's the goal. And if that's your goal, then fee-for-service is a tool, just as population-based payments are or shared savings percentages are. Does that help?

MS. HARDIN: Very valuable answer. And I know we are at time. Emily or Paul, is there anything quick that you wanted to add to that?

DR. KRAKOVITZ: Yeah. Fee-for-service is not the enemy for value-based care. I just would

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double down on that. It definitely -- we shouldn't be thinking about it that way. So, I really appreciate those comments.

MS. HARDIN: We want to thank these experts for really, really valuable input, historical perspective, and so many different scenarios that you have been a part of that have informed this presentation today. We -- at this point, are now going to take a break until 2:20 Eastern Time. Please join us then, as we have a great lineup for our third session today, with experts who will continue the discussion of PTAC's draft white paper, and recommendations on value-based care. Thank you so much to our experts who presented.

(Whereupon, the above-entitled matter went off the record at 2:13 p.m. and resumed at 2:21 p.m.)

*** Session 3: Expert Input on PTAC's Recommendations on Value-Based Care: Part 3**

MR. RAMACHANDRAN: Welcome back, I'm Krishna Ramachandran, one of the PTAC members. In our third session this afternoon on PTAC's draft white paper on recommendations of value-based

care, we will hear from three distinguished experts. You can find their full bios and slides posted on the ASPE PTAC website and the public meeting registration site. Welcome to our three experts today, including one in-person participant. And for our remote participants, please turn on your video if you haven't already. Perfect.

After all the experts have presented, our Committee members will have plenty of time to ask questions. First up, we're happy to welcome in-person Dr. Wyatt Decker, who is Executive Vice President and Chief Physician of Value-Based Care & Innovation and Executive Director of the Health Care Transformation Hub at UnitedHealth Group. Welcome, Wyatt.

DR. DECKER: Thank you. Okay. Well, thank you. It's a pleasure to be here with all of you. Krishna, great to be with you. And I had the pleasure of listening in both remotely this morning and the last hour or so here, and I would really commend the Committee, but also the thoughtfulness in who you've invited to contribute and comment on your white paper. Obviously, I've read the white paper a number of times. I've

shared it with some colleagues. And what I'll share back to you today is primarily my personal reflections and thoughts on the direction of the paper, but also includes input from policy experts in and around UnitedHealth Group. So, again, thank you.

I think I've got the advance, sir. Let's see if I can get it to work. If not, I might need somebody else to advance the slides. There we go. You've already heard about me. What I would say that maybe isn't so obvious in the bio, I'm an emergency physician, and much of my early years was spent trying to solve problems that you're all familiar with, like ED overcrowding, right? And like any good Department Chair, I'd fight for more nurses, more doctors, and a few more square feet somehow, sometimes successfully, sometimes not.

But when I really started looking at root causes of emergency department overcrowding and talked to any busy ED nurse or doctor, and I'll quickly tell you that arguably any evening shift, maybe a third or half of those patients, if they had been able to get access to primary care, specialty care, sometimes even something as simple as a prescription refill, they wouldn't have

fallen into crisis, and we wouldn't have an overcrowded ED.

Now, that's a problem for burnout. That's a problem for provider burnout. It's a problem for patients because it's generally, I hate to say this as an emergency physician, but it's generally not what people want to do. They don't want to spend six hours waiting to get something taken care of in an emergency department. And it's also, of course, expensive.

And some of these patients don't have the social network around them or don't have access to the kinds of care they need in their community. I've got to get closer to the mic. So they end up being admitted. So this is a very expensive solution to U.S. health care, and we think there's much, much more affordable. I realize I'm speaking to a choir, but value-based care, I would argue, is essentially gets at that root cause. Let me see if I can get this. Yeah, if you could go ahead and advance it. I'll just have you guys advance it.

Next slide. So this slide is kind of the take-home slide, and I thought I'd start with that, which gets at my main recommendations. So

we all strongly support expanding value-based care. I don't know if I agree. I do agree that fee-for-service is not an enemy, but I do think it's the root cause of most of the dysfunction in U.S. health care. I think we should acknowledge that. And it's volume-based. It's not quality-based. You don't reward particularly primary care physicians for keeping people healthy and well. We reward them for doing things.

So the other quick observation on the first headline around expanding value-based care is, just remember, we did a little market survey of both policy elites, as they call them, people like you, but also John Q. Public. When we use the phrase value-based care, to policy elites it means a bunch of different things that mostly they're suspect of. Like, has it really worked? Has it run its course as value-based care?

So just the phrase is going to, when your paper is ready to put out there, it's going to engender a lot of different emotions from your policy colleagues. For the public, it just sounds like cheap care, right? Like when you say, do you want value-based care? So think about, you know, you're checking out in the grocery store line. Do

you want value-based care? Probably not.

Okay, let's rephrase that. Would you be interested in a care delivery system where there was a team that was focused on keeping you healthy and well, that actually reached out to you proactively to make sure you knew about your appointments, you knew about appropriate health and wellness screenings, and that you were engaged in your health care? Now, most people would say yes. Most people wish that's what the U.S. health care system had, and fortunately some people actually get to experience that.

So when we think about value-based care, the other quick comment I want to make is value-based care, we've only scratched the surface, in my opinion, in true, fully accountable value-based care at the provider level. And there are some care delivery clinicians and groups in the country that are doing this pretty well. We at Optum Health, which I used to serve as CEO of, serve about 4.7 million people at the practice level in fully accountable arrangements.

And I'll have a slide here in a minute, but we see pretty dramatic results, as have others, as has Kaiser and other value-based care

providers. So I think that that's really important. It works, and it is the right direction. Actually, go back. I'm still working through this. I wanted to hit on that. Thank you.

Churn remains a challenge. Of course, I'm thinking primarily of Medicare Advantage here. There's about a 15 percent, it varies in different studies, but 10 to 15 percent churn rate annually. It isn't people getting out of Medicare Advantage. About 12 percent of that-ish is people jumping from plan to plan to plan. So I think when we think about value-based care constructs, think about incentives that can reward people for staying in a plan or staying with a plan longer. Because when you do that, it creates more incentive for that plan to think about long-term prevention as opposed to what's going to work in the next six months, and that creates value.

Same could be said for employer health plans, as you all know. You move employers, you change plans, and the churn continues. So just thinking about that is one suggestion.

I was delighted to see in the paper a fair amount on rural providers and independent

providers. As you all know, about half, rule of thumb, of physicians are employed these days by hospital-based systems. A quarter are employed by more atypical systems. It could be an Optum Health, it could be a private equity group. And about 25 percent, so 50 percent, 25 percent, employed in more atypical settings. And 25 percent are still independent.

And we think it's super important to make that independent pathway viable. And I heard some of the other speakers I fully support recognizing how much harder it is for a group of 10 or 12 physicians to do any of this stuff. They're not just going to need a waiver; they're going to need partners. And we do this, and other value-based care aggregators do this. But I think recognizing that small independent groups and rural providers are going to need help. And they might need, and we'd have to think about what's appropriate, grants or subsidies that help them partner with a vendor as opposed to somehow waiting for them to figure this stuff out themselves, which is unfair and not likely to happen. Yeah, please.

Okay. So this slide just shows, and again, this is not news for all of you, that fully

accountable value-based care works. These are Medicare Advantage studies. I'm showing you 43 percent. And it's a range of really, on different studies, 20 to 40 percent of patients, fewer acute hospitalizations. So that's serious savings. I mean, how much better is it to just keep somebody out of the ER[49] and acute care hospitalization than it is to fight with hospitals about their rates for that hospitalization? So let's just keep people healthy and well, and it solves a lot of the U.S. health care spend problem.

And down the list, the second column across highlights some studies that we've helped conduct with America's Physician Groups and others. One really interesting thing is we've measured and quantified spillover effects so that, not surprisingly, when a group of primary care doctors is mainly focused on longitudinal value-based care, they actually do a much better job with their fee-for-service patients. But it does blur the boundaries.

So when you look at, say, traditional Medicare patients across the country, they've actually gotten a lift from increased value-based

49 Emergency room

care as that has grown more prominent. So it clouds the differences a little bit, but I think it's super important.

And then a pitch. I think there's not enough, at least easy, access to research on value-based care. And so to help fill that void, we launched something that I run called the Health Care Transformation Hub. And just think of it as a clearinghouse for peer-reviewed research on health delivery systems that are being innovative and trying things. Now, some of it's from us, some of it's from elsewhere. But that's available to all of you as you go forward.

Next slide, please. So we organized the response kind of by theme. So really strongly endorsed all of your decision around supporting rural and independent providers. I've already touched on that. And then we looked for the thread through various recommendations. So when you think about transitioning to value-based care, I think there are groups or hospital systems that have been in this space for decades and could actually be asked or incented or required to go much bigger and further in this fairly quickly, right? They're pretty sophisticated, and they

could do this.

And then as mentioned, I think we have to go slower and be a bit more thoughtful of the kinds of support that are going to be needed for small or independent or rural groups. Measures, you know this, but the HEDIS[50] measures are complex and a source actually of administrative and bureaucratic frustration in value-based care, right or wrong. I mean, the intent is really good, but the trouble is it's like the wedding party because now every specialty group wants a few measures in there, and it's over 90 measures today with many subgroupings, and it's just unwieldy.

So as we think about and you think about your recommendations for quality, my plea would be keep it simple. And I get it, there's somebody who's not going to be happy because their specialty or their interest may not be represented. But we need to keep it fairly high-level and fairly simple in my opinion and probably automated as well.

Start-up flexibilities. I like grants. I like making things easy for small organizations that are trying to get into this, and I like a

50 Healthcare Effectiveness Data and Information Set

list of vetted partners so they don't have to start from scratch or go with like a big four consulting group and get ripped off. Why not have a vetted list of partners that works well for them?

We believe strongly in rural providers. They need help from both the federal public sector as well as private sector. And so at UnitedHealthcare, our insurance arm, we've accelerated payments to rural and Critical Access Hospitals just in the past 12 months because of the obvious need there. So that's just one. We've also dramatically reduced, nearly eliminated, prior auths in those settings. So I think getting payers to look at what they can do as well as the government I think will be helpful.

And then of course data access is going to be critical. There's been a lot said about it, so I don't think I need to repeat that. I think integrating specialty care is something that we on our care delivery arm, Optum Health, we spend a lot of time on this. And what we found is that there's enormous opportunities to refer preferentially to high-quality specialists. And even in a fee-for-service contract. So Medicare

Advantage sometimes gets criticized because it's still a lot of fee-for-service.

But even within fee-for-service, you can actually now -- and there's groups like Garner and others, and vendors that will provide quality metrics and utilization metrics. So with a group of cardiologists, you can look at what percent of cardiac casts show clean coronary arteries. Because that should actually be a fairly rare event if you use CT Angio as a screening tool, right? You shouldn't have negative casts or very rarely.

So when you see a lot of those or you see a high stent rate, you might want to not refer to that group. You might want to actually -- when you have the options, and it does take enough specialty groups, you can begin to refer to groups that you believe, based on evidence, are practicing high-quality, appropriate, and thoughtful evidence-based medicine, and that can actually shift behaviors within markets. So there are ways to include specialists that are very powerful that actually don't require changes in our incentive system. And then of course we can talk more. We could probably devote hours to ways

to incent specialists. But it's an important topic.

And then I actually agree with the previous speaker that said just be careful on patient safety. It's sort of a whole other area. It's different than value-based care. Certainly, referring to high-quality and safe specialists is one way. Another is just saying you have to have a safety program. But who's going to oversee it and how many metrics you're going to require, I'd just be careful there. It's necessary. It's super important. We should all expect that as kind of table stakes.

I liked Recommendation 2. Of course your early recommendations are broader and strongly support developing kind of the next gen primary care solutions that are sophisticated with data and analytics in the team. I also think you might add to the paper more focus on things like transitions of care, because that's, you know, just from our own family members and things, that's often where things start to go south. So that transition out of the acute care hospital.

Should they be in a rehab unit? Should they be in a skilled nursing facility? Can they

be at home safely? If so, what support do they need? Home is the best and least expensive option, but it has to be done thoughtfully with the right support, or it fails, and now you have a 90-day readmission problem. So that's for consideration.

Site of service is a big deal. It's here right now. So ambulatory surgical centers versus inpatient hospital or outpatient hospital settings, right? So there are major cost differentiators there.

And when you look at the quality data, now some of you would quickly point out to me appropriately that some of these -- some of moving patients to lower-cost settings is cherry-picking. You pick a healthier population. And I would say absolutely, like that's what you should do. You don't want your heart failure diabetic going in for a knee or a hip in an ambulatory surgery center where they might have a complication or might just be more than they can handle. But you actually do want patients that don't need all the infrastructure of the hospital going to the lower-cost care settings.

So site of care is a quick and easy way to think about. We have to think about how to

send it appropriately. But it's a great way to lower cost of care and generally improve the patient experience because patients tend to like these settings. And then home care, I often describe home care as really the next frontier of value-based care. How much can we appropriately do in the home and, obviously, when does it make sense? But that's a critical element of all this.

Next slide. Just two more slides here, I'll wrap it up. Be very, very careful about out-of-pocket as incentivizing and disincentivizing patients. As you all know, but the experiment that's kind of failed with high-deductible plans, it tends to just serve as a barrier to getting health care, and it tends to disenfranchise patients. So it's a very challenging area. That said, something that we have seen at UnitedHealth Group is when you offer savings for patients to incent certain behaviors, you can actually see positive results.

And so one example for us is in the commercial space where you see the big bold 44 percent on the slides. So we see up to, and I emphasize up to, it varies, but pretty substantial total cost of care savings, as well as out of

pocket. When we use a plan, we are ours. It's not the only one, but it's fairly new in the marketplace. But when you present a patient who's going to have, say, a procedure, let's just say it's a knee replacement, you present them with the options in their communities, and they pay more or less depending on where they go.

And they can choose to go to a more expensive setting if it's important to them, but it may cost them more. And they can choose to go to a lower-cost setting. And as you all know, but it's always, you know, to the lay public, this is not well known, cost of care and quality and experience are not linked in U.S. health care, right? So just because you pay more doesn't mean you're less likely to get a wound infection or more likely to get a cappuccino or something in the lobby. So your experience and your outcomes are not related to cost.

So why not make sure it's a high-quality offering? But if it's a high-quality offering in a lower-cost setting, how you can let a patient enjoy some of that savings? So those kind of incentives do work. I think I'm on to my last slide. So appreciate everyone's time. I think

we're going to do Q&A after my colleagues speak, but thanks.

MR. RAMACHANDRAN: Yeah, thank you. I appreciate it. Next up, we're excited to welcome back Ms. Elizabeth Mitchell, who is President and Chief Executive Officer of the Purchaser Business Group on Health. Go ahead, Elizabeth.

MS. MITCHELL: Thank you, Krishna. It's nice to be back. Thanks for having me. So just level setting here, we represent jumbo employers. We're a 501(c)(3) nonprofit coalition of many of the country's largest private employers and public purchasers. We've been around for about 40 years, had the same mission, quality, affordability, and equity. And unfortunately, I think we are further away from that goal than we were when we started.

Go to the next slide. Essentially, what we see when we look at the commercial market, we have increasing costs, declining or flat quality, and declining access. So employers are paying considerably more. I think we're on our third year of double-digit increases with no improvement in care and increasing barriers to actually accessing care at all. And this is for employers like the size of Walmart and Amazon and Microsoft.

That's who I work with. So if they are challenged to do this, imagine how hard it is for an individual patient.

Next slide. And when you talk to those who actually pay for care and receive care, this is essentially their view of the U.S. health care system. It would be hard to overstate the level of frustration with the current system. There are very few defenders that I work with. And frankly, many of our members believe that we have about three to five years to fix this system before it completely implodes. It is not serving employers or their workforce.

Next slide. I have to say I have done stints at many of the bodies that have had input into this work. I was on the LAN[51] 1.0, the Executive Committee. I was on PTAC. I was on the NQF[52] Map and on various National Academy of Medicine groups.

And 10 years ago, we were essentially talking about the exact same things. And there was significant enthusiasm and momentum for change. But unfortunately, you know, in the last couple of years, we are still at around 38.9

51 Health Care Payment Learning & Action Network

percent of the commercial health care spending outside of fee-for-service. And in terms of downside risk to the extent that we think that that's a priority, we haven't even broken the 20 percent mark. So there's a lot of good thinking, a lot of effort, but not much to show for it.

Next slide. If you can advance the slide, please, whoever's doing slides. So I had no concerns about the recommendations. I thought they were thoughtful. I thought they were reasonable. Frankly, they're entirely non-controversial from the purchaser perspective. Unfortunately, they're also not likely to lead to meaningful improvement for patients in the near term. My sense from the recommendations as this is a 10-year horizon. Again, I don't believe we have 10 years. And the desperation with which patients are asking for relief on affordability, on better care experience, better care outcomes, is far more urgent than this paper would suggest.

So again, perfectly fine recommendations, but they also don't address the needs or concerns of self-insured employers. So one of my asks of this group is to actually think about the

commercial market, to include those paying for care. I'm not talking about health plans. They sort of move money around. We're talking about the people actually paying for care, meaning businesses, U.S. businesses, public purchasers, trusts, unions, and individual families. And unfortunately, I don't think we're going to see adequate impact from these recommendations.

Next slide. I do think it is a will rather than a skill problem. There are so many smart people in health care, there are so many successful pilots that show us what's possible. But we do not have any evidence that the industry is taking this move particularly seriously, at least from our perspective.

And we know it can happen because when DRGs were mandated, you know, everyone made the change within three years. We're like about, I don't know, 15, 20 years in on APMs. And again, you know, it's even lower in the commercial sector, but still less than 50 percent across all payers. So again, I do believe it is possible when people have the will.

Next slide. I did, instead of just being all doom and gloom, I think there are bright spots

all over the country. I happen to run an organization based in California. We've got, I think, a really remarkable track record doing multi-payer payment reform initiatives with multiple health plans, also indirect contracts, which I will also share. But we have a current advanced primary care initiative going in California with over 100 practices.

You can go to the next slide. I think this actually really goes to sort of Mai's comment. It could be fee-for-service, it could be prospective population payment, it could be capitation. It's really a matter of matching it to the desired outcomes and then creating a shared form of accountability. So in this particular pilot, we offer all three. We have heard repeatedly from practices that they want flexible population-based payment. And in many cases, that is happening.

I will also say it is more often than not having to happen with a non-health plan, because in many cases, the actual payment capabilities aren't scaled. But in our pilots in California, we are seeing health plans make these changes. We have common standards and meaningful payment

incentives. Go to the next slide. We also have shared measures. We just heard about the importance of having a simple, concise, high-priority measure set. We could not agree more. We have actually tested and developed and utilized this measure set across practices, and many of our employer members are actually deploying these measures through their direct contracts.

We've had less uptake with health plans, but we believe that these are meaningful, even if it's not the perfect measure set. It's a consistent and meaningful measure set, and we've had really good uptake.

Next slide. A couple of other examples. Again, from the commercial side, we've got PBGH[53] members, employers who are doing preferred partnerships with up-and-downside risk and meaningful quality and patient experience and financial metrics, seeing significant improvement in the health of employees, everything from, you know, depression to cancer screenings, and lower out-of-pocket costs and total cost of care savings. We also have, I know PBMs[54] aren't really the purview of this Committee, but we are seeing

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similar success with value-based contracting for some of these other partners.

Next slide. In our direct contracting work for advanced primary care, again using that same measure set you just saw, our members are reporting 7 percent to 14 percent rejections in total cost of care, reduced ER utilization, meaningful savings. Unfortunately, these, though, have been pretty limited to regional efforts where employers have adequate headcount to drive change.

But those regional pilots have inspired our membership to recently decide that they would like to scale this nationally with a directly contracted national advanced primary care network, because we know that it is possible to achieve these significantly improved outcomes. And it's really important to note here that these are all paid with prospective population-based payments, and practices who participate are accountable for those common measures. So, again, it is very doable with the right will and supports.

Next slide. And again, finally, I'll stop with the examples, but I do think it is worth noting that we are seeing more and more uptake of

direct contracts with providers who are raising their hands saying they are willing to meet these employer standards. A recent highly visible example was with 32BJ, one of our members, is a fund in New York with Northwell Direct.

Again, the providers who are participating in these arrangements are up to the task. They are taking on these standards, this accountability, and so, again, really just showing the readiness of the market, in my view. And then PBGH actually ran a Centers of Excellence network for about 10 years where we directly contracted for specialty care for our members. And this is the *Harvard Business Review* article, Walmart had 54 percent savings. But more importantly, from their perspective, they had significantly better outcomes and very high patient satisfaction. So again, all of the, I think, the pilots demonstrate that it's time to scale much more quickly.

Next slide. And then finally, this may be a little bit out of bounds, but we think it is incredibly important, at least for commercial, to really think about pricing. We did a data demonstration project recently using the HPT[55] and

55 Hospital Price Transparency

TIC[56] data, and the price variation is wild. This is one example. It's a 120-page report. Happy to send it to you. We saw this all over the country, didn't matter about the market or the facility. The price variation is amazing, and there is immediate savings to be had when you use the lower-cost providers, including lower out-of-pocket costs.

If you go to the next slide, and as you heard from our last speaker, there is zero correlation between quality, safety, and price. This data is now available, and I think it should absolutely inform value-based models. One of our members who participated realized that they were paying the most for a hospital that had a D safety rating. And when they learned that, they were prepared and have undertaken steering their patients -- their employees away from that facility. So, employers are ready to take action and ready to pay differently when they know where the high-quality, high-value care is.

Next slide. I know this is focused primarily on payment models. Appreciate that. We also have some other priorities. You will have

56 Transparency in Coverage

these slides, but we really need to ban the anti-competitive contracting practices that are alive and well in the industry. That actually keeps us from steering to high-value providers. We absolutely need the price transparency to identify those providers, and purchasers are ready to lead. They are not waiting anymore for someone else to fix the system, but they have to have access to their data.

You talked about data sharing. We have been talking about that for decades. Literally, as of 2026, it remains unbelievably difficult to get claims data, even when the law makes it absolutely clear that they are entitled to it. Data sharing is just critical for all of these models. So again, multiple opportunities here, and I will also underscore what Mai said about political fortitude needed because these changes have not been made because there are plenty of actors who are actually very comfortable with the status quo.

Next slide. I had the privilege of serving for three years on the Office of Healthcare Affordability in California. I recently wrapped up my term, but I think the most

important thing that came from that experience was monthly public forums with actual normal people, teachers, carpenters, hotel workers who came to hearings. They took the day off from work to beg for change. They were crying. They were people who had lost their jobs and their homes because of medical bills.

We are so far behind the general public in the urgency of change. This was a photo from one of the hearings. This was not unusual, the size of the crowds, the intensity of the demand for change. So, I hope we will be courageous in honor of the people we are supposed to be serving. So, thank you for your time. Happy to answer your questions later.

MR. RAMACHANDRAN: Thank you, Elizabeth. Excellent insights and perspectives. Next, we're pleased to welcome Dr. Sarah Fogler, who is Senior Research Director of Healthcare Transformation at the Duke-Margolis Institute for Health Policy. Welcome, Sarah.

DR. FOGLER: Thank you so much. So, I really appreciate the opportunity to react to PTAC's roadmap. I've focused on outlining kind of the comments that I feel are most compelling in

the report, where there's some gaps, and where I see priorities for accelerating accountable care and population-based payment models. So, let me jump into how I've structured the four points that I'd like to walk through. So, an overall assessment, key strengths and gaps, as I just mentioned, priorities. And then, I also added a couple additional considerations that may help shape transformation over the next decade for consideration into the report.

So, we can move to the next slide in terms of overall assessment. I think my overarching message here, if we could just jump to the next slide, is that PTAC is definitely asking the right questions, but I think we may be at a different stage of maturity than many of the VBC[57] discussions assume throughout the paper.

So, a couple kind of highlights here. The roadmap, I think, is a timely response to rising costs and growing pressures. What resonated the most for me is the recognition that expanding participation is really not the same thing as achieving better outcomes or lower spending. And I think, you know, the several

57 Value-based care

presentations that you've heard this afternoon are putting an exclamation point on that finding. We've been at this for a decade and a half or two decades, and I think one of the data points just shown was that, you know, cost is not translating to improved quality.

In fact, one of the lessons learned, I think, over the last 15 years, and in some of my appendix slides in the back, there's some data to support this, that in the specific case of ACOs, they've generated some measurable savings and improved coordination, but their overall impact on total Medicare spending has been relatively modest. So, net savings have been approximately $13.5 billion over roughly $12 trillion in Medicare spending.

It doesn't mean that accountable care has failed. It means we should be asking what's preventing broader impact and scale. That's why I think the most important contribution of this report may actually be the policy discussion around broader reform and implementation barriers.

The comments that were just made about data interoperability and exchange. I mean, we've been at that for decades, and it continues to be a

significant barrier now with the advent of AI, for example, as an additional intelligence layer, not having the data infrastructure intact and functioning properly is really going to limit kind of the opportunities there as well, in my opinion.

Let's go ahead and move to slide 6. I think one more, yeah. So, the strengths in my view of the report are that the vision is directionally correct. I absolutely agree with the strong emphasis on person-centered, coordinated, team-based care. I also appreciate the recognition that advanced primary care alone is not enough and that specialty care has to be integrated into accountable care strategies. Otherwise, achieving whole-person care is not going to be realized.

One of the most important opportunities is certainly creating payment approaches that better align specialty care with population health goals. And I would just take this opportunity to agree with several of the other panelists that, you know, we need different payment approaches across different provider types and different types of events, which, you know, lend themselves to fee-for-service payments, accountable care

structures, or other value-based care constructs like bundle payments, for example.

I think it's important to recognize in the particular case of specialists that they play different roles from episodic management, procedural management, to longitudinal chronic disease management, and payment models need to reflect those distinctions. So, I think a lot of those points were captured nicely in the paper and would just agree that those are our strengths throughout.

Slide 7, I outlined some of the key gaps here. I don't know that I think the biggest barrier anymore is payment design. I think we have a whole host of different payment strategies that are appropriate for different, again, provider types and different circumstances along the patient care journey. And I think, you know, many of the reflections, and this may be a thematic comment that you've heard throughout the day, but I think a number of these recommendations reflect the priorities that we've been at and been discussing for the last many years now.

And so, I think this point around, like, urgency and whether the recommendations are

actionable is a good one. I think the bigger question, as I mentioned at the top here, is like what's going to drive the next wave of adoption and impact? How do we scale, again this point around like there's all this evidence from various pilots, both at the local, at the state, at the federal level, and we're still kind of slow rolling the movement to value. So, I think the big question is, what's it going to take to move those pilots into permanent programming?

I think another kind of key point I wanted to call out here is a gap that I would see is that, you know, this point around data interoperability, also workforce capacities, financing for transformation, actionable evidence for implementation. I think there's a number of barriers that are in the way of full-scale that need to be addressed. It's not just about like introducing new payment strategies because, be honest. I think we have like a very strong and comprehensive set of different ways to enter risk-based arrangements and different payment methodologies.

I also think, and Mai, I think, touched on this early on, that we need to be more explicit

about issues such as like strategic participation or selection effects and gaming within voluntary models. So, the remaining obstacles in my view that, you know, could be added to the report, I think increasingly look like infrastructure and implementation challenges rather than payment design problems.

If we could move to the next slide. I would emphasize here four opportunities for moving from the model design to the system transformation kind of lens. The first is creating a clearer strategy for broad-scale accountability. The second is investing in data and technology infrastructure.

The third would be better aligning incentives across payers, and I love the earlier points around multi-payer alignment. I know the focus on that has seemed to ebb and flow, but it's critically important for system-wide transformation and to protect against provider burnout, among other issues. And then, a heightened focus on implementation and scaling.

I think if we could just jump to the next slide. Some priorities for adopting or accelerating adoption of population-based care. I

think this is really the centerpiece of what I wanted to talk about today in terms of my reactions. If we could move to the next slide. There's, again, kind of four big buckets that I've thought about here to share with the larger group.

The first is around simplification. I don't know that simplification in the payment design or the model design, as Mai was pointing out earlier in her remarks, that there was like this tension between fairness and simple. I think it's simplification on the number of models that we have. Out and about in the market that we're trying to evaluate or the agency is trying to evaluate through the CMS Innovation Center, I think we need fewer models. I do think there's some refinement on reporting requirements, and there needs to be some greater attention on outcome-focused goals rather than, you know, care delivery models per se.

The other big bucket that I would identify here that is thematic throughout what I've been talking about is having, you know, working towards a trusted data infrastructure. Providers are still struggling, as many previous presenters discussed. They're struggling to access

timely and actionable data.

We've definitely made some progress with FHIR[58] standards, USCDI[59], TEFCA[60] and other related infrastructures, but the challenge remains moving from actually landing technical interoperability to the routine use of data that improves care and reduces administrative burden. So, I think there's a lot of work to do there still, and it should be a priority for moving the needle on accountable care moving forward.

Flexible care delivery and meaningful accountability, I want to place particular emphasis here. I think definitely we should give organizations greater flexibility in how care is delivered and the benefits that are designed, but we do need to hold them accountable for more substantial improvements in outcomes rather than continued marginal gains. That figure I noted at the top with, you know, a handful of billions on savings on top of trillions in spending is not going to bend the cost curve.

And sustainable participation is the last on this slide. We definitely need pathways that

58 Fast Healthcare Interoperability Resources
59 United States Core Data for Interoperability
60 Trusted Exchange Framework and Common Agreement

work for rural providers, as was pointed out in the report. Independent practices, safety net organizations, and transformation, I think we can all agree, will not happen if participation remains concentrated among well-resourced organizations, and we keep tweaking around the edges of existing accountable care models and programs.

The last, I think, section that I had here was around additional policy considerations. So, let's just move to that next slide with my remaining time. I think the main points I wanted to make here are just that the environment around value-based care is changing and the future of the health care system and transformation efforts will be shaped by forces that extend beyond today's payment reform discussions.

For example, transformative therapies, cell and gene therapies, precision diagnostics, advanced prevention strategies, are all going to require new payment and coverage approaches. Digital infrastructure and AI, as I've heard mentioned before, you know, there's this great promise of AI as being an enabler to accountable care, and administrative applications can

certainly reduce burden. Clinical applications can expand access and support better outcomes. But if not layered on a functional, interoperable system, the reach of this new promise of digital health is going to be limited.

Next generation accountability. I think we need to think beyond traditional medical services to prevention, care coordination, and social drivers of health. And then, the big piece here is faster learning cycles and stronger alignment across states, CMS, and other payers. So, that multi-payer alignment piece, but also really trying to hone in on the successful pilots and bringing them into permanent program at scale.

So in closing, I would just say that my overarching reaction is that the PTAC's vision is largely the right one in this report. I think the challenge is that most of the remaining obstacles to transformation are no longer about payment model design. They are about data infrastructure, implementation capabilities, aligned incentives, and creating the conditions that allow accountable care to succeed at scale. So, if we address those issues, the next decade of value-based care may look very different from the last. And I'll close

with that. Thank you.

MR. RAMACHANDRAN: That's great. Thank you, Sarah. Yeah. I appreciate the next chapter perspective as well that you have. Fantastic. Well, thank you all. Appreciate all the experts for their excellent presentations. We'll open the discussion to our Committee members now. So, this time, PTAC members, please flip your nameplate if you have questions for our folks here. And virtual Committee members, raise your hand if you have a question as well. All right. Chinni, we'll go with you first.

CO-CHAIR PULLURU: Thank you. This question is for Dr. Decker and any of the other panelists that would like to opine. Part of the challenge, and you articulated it very well, was these sort of different archetypes of organizations, groups, whether it be rural, urban, large, small, independent versus affiliated versus employed.

So, when you think about moving towards value-based care and the constructs that have already existed in MSSP and the chassis, what do you see as a future of how we can simplify in an environment where it can encompass some of these

variations? And how do you think about workforce restrictions in this situation?

DR. DECKER: Yeah, thank you. Personally, I think it's really about creating the right partnerships and enablers for the different groups. So, if you think of large, sophisticated hospital systems, they can do this. Most of them already have, say, ACOs that have generated modest savings. Why haven't they done a whole bunch more? Because it isn't worth it to them. Like, they make so much more money in employer-based, procedural-based fee-for-service. It's, like, you can't really compete with that.

So, if we want to see more from the large players on the provider side, we would need to create bigger incentives, right? Make it worth more to do more appropriate value-based care.

And then, I think for your question around rural, small-independence, inner-city, safety net, I think those groups need partners. And there are partners out there. I mean, we do it at Optum Health, but so do, you know -- there's probably several dozen potential partners, and some are better at tech enablement, some are better at contract management, some are more

comprehensive.

And so, then I think then the question would be, what's the role of state and federal government in helping to sift through the morass of partners and potentially offer grants or a funding vehicle for, you know, to facilitate? And it probably shouldn't be forever, but it could be for the first three years of a rural group to get on their feet and say, you know, we, the taxpayers, are going to subsidize this for three years while you get on your feet. And then, the expectation is you and whatever partners you select are going to fly on your own after that. Something to that effect.

MR. RAMACHANDRAN: Thanks. Other panelists?

MS. MITCHELL: I would just add that the California Quality Collaborative, which is part of PBGH, ran a demonstration project. It was, like, I don't know, six or seven years ago now with CMS. And small rural practices had just as good outcomes as the larger, more well-resourced ones because they had data, and they had technical assistance. Not expensive technical assistance, really, like coaching on team structures and, you

know, relatively simple changes that could be made.

So, I really do think that that is a high potential investment, and I do believe that partners do exist to help with those transformations. So, I think that they are capable with the right supports, and I think we should really explore that with a bit more urgency.

DR. FOGLER: And I would just add on Dr. Decker's, I think, one of his first points in the response around, you know, it not being worth it to health systems to kind of get in the game and stay in the game. I think the thing you have to like talk about attention. It's like you can't -- there's not unlimited incentive structures to provide, right? And so, you have to marry up the incentive structure with kind of the actuarial projections when you are thinking about spending to incentivize a different type of behavior.

So, I think it's this, it has to be this mix of incentive structures with, you know, like carrots and sticks, a nice balance, because everybody has to win in order for these models to become a permanent part of the Medicare and

Medicaid and other programs. So, just would add that layer.

MR. RAMACHANDRAN: Great points. Walter, do you want to go next?

DR. LIN: Thank you. Wyatt, you know, you asked us to think about broadening our recommendation to beyond the clinic, to different sites of service, transitions of care, and home care as essential to value-based care. I work in a practice that focuses on nursing homes and assisted living, and include those sites of care as well in your recommendation. But I want to ask you about this a bit, because I know Optum has spent a lot of its own money to develop expensive models of care to address these really high-cost, high-utilization patients.

We all know that Medicare spending is highly skewed, and despite the expensive care models, as Landmark and maybe some of the I-SNP[61] models that Optum deploys, they realize the ROI[62] on that because they're able to decrease utilization of these really high-cost patients to a much greater extent.

And so, you know, Medicare doesn't have

61 Institutional Special Needs Plan

anything like that. And in fact, I think, back to our Physician Fee Schedule discussion in the previous session, it seems like the Physician Fee Schedule will, in fact, disincentivize seeing these high-cost patients because they're so time-intensive, and it takes a lot of resources to see them. So, I could see five patients in the office versus one patient in a nursing home, and why wouldn't I do the former because they're much healthier, easier to see?

My question is, what would you recommend us to put in this report as a way to communicate something along the lines of what Optum has built to address this high-cost population of patients so that they can be better taken care of?

DR. DECKER: Yeah, thank you for that. It's an important question. The way it works in a group like Landmark, and just to level set for everyone, you know, this is sort of in-home primary care for complex like dual special needs patients. And as you all know, dual special needs have a very high per-member-per-month payment. And so, if you can get ahead of it, and they're not calling 911 every week or twice a month, then

62 Return on investment

you bend the cost curve. And it's obviously good for the individual, but there's a business model, and you can actually afford to pay primary care doctors, even geriatricians, usually with nurses in between and stuff, to go visit them in their home.

So that's one vehicle, is the comprehensive care model, fully accountable care delivery at the provider level. It's probably, you know, the most mature form of value-based care, arguably. And so, then I think, as you all think through payment mechanisms to physicians, I would suggest you think -- we think about a complexity multiplier, right? So, the two factors that I guess I would want if I was responsible for 10,000 complex patients in a metro area or something would be I'd want to incent the doctors to spend that extra half hour that it does take when they come into the office, right?

So, you'd want that, and you'd want to reverse them, but you might hold either a bonus payment or part of the increased payment. You might hold back until you see over a period of six months or something that you're actually getting the decrease in ER visits or utilization

downstream.

And so, the question is, could you build that? And it's sort of a blend of fee-for-service, oh, we'll pay more for a more complex patient. I mean, as you all know, we kind of do that today with complexity coding. But we will give you even more for that extra time, but we need to know over time that we're actually bending the cost curve all in on total cost of care. So, I wish there was an easier way to get at it, but that's what comes to my mind.

MR. RAMACHANDRAN: Yeah. Are there panelists with any perspectives on that? All right. Lee, over to you.

CO-CHAIR MILLS: Okay. I want to focus in on a minute on the issue of patient churn, and why it's something you said made me think back to my days in commercial plan, where, you know, golly, 40 percent of small groups turned over yearly, and large groups have fought like heck to keep, but they still change on average of every three years which, of course, you know, from the employee purchase plans keeps them locked in a cycle of chasing lower costs, which keeps both the employer and the plan locked in a spiral of never

investing in the things that really change the cost curve.

So, what are ideas or what are your best recommendations PTAC could recommend to build into some models to try to impact the issue of churn which, of course, impacts Medicaid hugely, but also Medicare? And so, you know, if we're using Medicare as the lever to enforce change across the ecosystem, how can we take on churn?

DR. DECKER: Yeah. Well, I would break it down into the type of patient member, right? If they're in Medicare Advantage or some other ACO program, I actually have always felt that the longer they stay in the program, the richer the benefits should be, right? And right now, a plan puts together benefits for everybody. And so, of course, you get plan jumping because you're like, oh, look, I get a healthy food card over here, and next year it's, you know, a gym membership over here. So, you're sort of chasing these bright objects.

And what if, instead of that, we created a, you know, or we incentivized Medicare Advantage providers to provide benefits? And I like benefits that sort of common-sense maps back to

better health outcomes. But instead of gift cards, I like to see things like more coordinated care, vouchers for travel, and maybe arguably some of the social determinants topics should be included.

Employers harder because it's always linked to employment, right? So, with employers, unless you want to go with, you know, a non-employer-based alternative to employee health care, I'm curious, Elizabeth, your comments on that. Like it creates a problem because we can't, at the health care policy level, fix the fact that people move jobs every two or three years, especially the younger generations. And so, that one, it really, is it a consortium of employers? Is it a different non-employer-based solution, which is complex? But that's, I think, a fundamental challenge with the employer marketplace.

DR. FOGLER: I would just add in the Medicare space. So, I spent almost two decades actually at CMS working on the value-based care portfolio, and I would say in the Medicare space, original Medicare space, at least in the ACO context, this was a concern very, like, early on

in the years of implementation, that beneficiaries, because they maintained freedom of choice in original Medicare, were deciding, you know, how many, which providers to go to at any given time.

And ACOs were losing their beneficiary counts, and, you know, weren't able to kind of have a consistent pattern, and the beneficiaries attributed them from year to year. It's been a while since I've looked at that data, but I think over time, the stickiness of the patient improves, and so, I think it's a slightly different answer in the original Medicare space that we're seeing higher percentages of beneficiaries stay within the ACO construct on the fee-for-service original Medicare side for multiple years. So, I would just highlight that difference.

MS. MITCHELL: I would just say that employers have not been the opponents of Medicare for All. That has been hospitals and health plans, and I think as costs continue to rise, there are going to be more and more employers increasingly open to that option. But that will have a very significant impact on pricing, because, you know, obviously the price issues are

in the commercial market, and if that was more of a Medicare approach, I think you would have some political opposition.

I know a lot of people are talking about ICHRAs[63] for all, but that just moves the price problem onto individual patients instead of large purchasers. So, I don't know that employers are so excited about staying in this game, but they are, because they actually have the shared incentives with their employees and their families of lower cost, better care, healthier outcomes. So, they are at least aligned with their employees, and they have not only the incentives, but the scale to make a difference.

MR. RAMACHANDRAN: Very helpful. Thank you. Maybe one last thought before we close it out. I mean, just this whole day, we have been sort of struggling with the tensions between mandate or non-mandate, flexible or prescriptive. Just any closing advice from all of you, particularly for the Committee and for the white paper, as we think about the future of value-based care in the decades to come?

MS. MITCHELL: Krishna, I just would

63 Individual Coverage Health Reimbursement Arrangements

suggest that we not think in decades. I think we have to have meaningful improvement within five years to actually create relief for patients and people using the health care system. I think we have tried voluntarily, and I think we have the results to date. I am all for flexible. Flexibility is great, but I don't think you can be flexible about accountability.

So, if you can achieve total cost reduction, better health outcomes, and better access, however you get there, I think we are supportive, whatever payment model works. But I think there has to be accountability, there has to be transparency into outcomes and cost, and I think, you know, if we don't see an acceleration of the voluntary approach, I think we really need to rethink that and think about what it will take to make actual impact.

DR. FOGLER: I agree wholeheartedly with those sentiments. And I would just add that, you know, of the Innovation Center models that have been tested in both the Medicare and Medicaid space, only about five or so, I think this is the report, have scaled. And of those, the majority were mandatory tests, and there's a reason for

that, which is selection bias into these models. Only those who are going to win participate and stay in. And also, when the actuaries look at the final data, if there's not generalizable information to be garnered, then they're very reluctant to move these pilots into permanent programming. So, I would second the vote for more permanent mandatory testing and change.

DR. DECKER: And I might just offer a slight, maybe it's a minority opinion, but I'd push back a little bit and suggest that Medicare Advantage is a voluntary program, and over 30 million seniors, more than 50 percent of our seniors have opted into it. Similarly, payers don't have to participate, but most payers, or many payers, do. And same with primary practice groups. They don't have to participate at risk, but many do.

And I don't dispute the CMMI results. So that makes me kind of ponder, maybe it isn't voluntary versus mandatory because when you make programs mandatory that aren't fully tested, you have unintended consequences that can be a debacle. So, then I would suggest that voluntary might be right, but we have to really think

through. Is it worth the trouble? Like, is it worth the bureaucratic headaches, the learning the system, the change management? Is it worth it if you're a patient signing up for a program? Is it worth it if you're a clinician or a group of clinicians? Do we make it so that, you know, the old expression is the juice worth the squeeze?

And to me, that's the most critical factor, is making it powerful enough so that it's weighted heavily enough so that that health system C-suite says, you know what, we're going to have to work hard, but we see this is the right thing to do for our community, and we can enjoy some upside in our health system. It's not just a window dressing thing that looks good, but doesn't actually help our bottom line.

MS. MITCHELL: If I could just add one parting shot, apologies. But I think we also need to think about the upside for employers and families. I understand that the health systems are all looking for their upside, but we are the ones paying for care and experiencing care --

DR. DECKER: I agree.

MS. MITCHELL: -- and I just hope that that is equally weighted.

MR. RAMACHANDRAN: Well said, yeah. You should have the parting shot, Elizabeth. With that team, thank you all. Appreciate the expertise, appreciate the discussion, the passion and, of course, the urgency as well. So thank you all. We will switch to a break, maybe a five-minute break now, and then the Committee will end the day by deliberating.

(Whereupon, the above-entitled matter went off the record at 3:27 p.m. and resumed at 3:34 p.m.)

*** Committee Discussion**

CO-CHAIR PULLURU: Welcome back. PTAC convened this public meeting to obtain input on its draft white paper recommendations on value-based care. We now have time for the Committee to reflect on what we've learned today from today's lessons and to consider areas for revising the white paper. We will hear from more experts tomorrow, but we want to take the time to gather our thoughts now before adjourning for the day.

Committee members, I'm going to ask you to refer to the potential topics for discussion document during this discussion. To indicate that you have a comment, please flip your name card up,

and for our virtual Committee members, please raise your hand on Zoom. Who would like to start? Lauran.

MS. HARDIN: I'm going to dive in because I have a mediated comment. This was a really, really valuable day. The richness of the speakers, the diversity of their expertise, and how deeply they understood this document and their historical connection with value-based payment was so valuable today. I feel like I really need to read the transcript to completely take it in and look at it side-by-side with the actual document.

But some of the themes I heard today, the importance of flexibility, overall, the general comment was this document is on target, but maybe needs to go further. Elizabeth's comment is resonating in my ears. We have five years or less to move the dial on delivery because of the complexity and difficulty of what's happening for people directly in care, but also employers, and that it's not a sustainable situation. So, change needs to happen sooner.

We heard a lot of interesting -- I heard some things that I thought we need to go back and look at, emphasizing even more, which is the

integration of behavioral health, health-related social needs, and really thinking about maybe another level deep around the diversity of what needs to be provided for rural success versus urban.

And then Jennifer said something that I thought was really -- really struck with me, is that we have to plan for the lack of system-ness if we want to see change. We have to design in the dollars for that, the attention to that, and someone to hold that sort of centralized infrastructure. We started to hear a little bit about hubs. We heard a little bit about incentive dollars, maybe for a few years to pull things together to have a sustainable system, but paying attention to that in the document as well. So, I will leave it there and say I really want to go deeper with the transcripts and compare it to the document, but it was a valuable day.

CO-CHAIR PULLURU: Thank you, Lauran. Krishna?

MR. RAMACHANDRAN: Yeah. Like Lauran, I thought it was a super helpful day. Really great to see the perspectives from across the spectrum. It was a good -- so great job to all of you as

well for the recommendations of the speakers. I thought we had people with such breadth and depth of value-based care.

Obviously, they brought their very different lived experiences into the mix, and so certainly their comments reflected some of the variations as well, and some of the tensions that came about, like the mandate or not, and prescribe this, and be flexible here, and give us room, but, you know, fix the benchmarks, and align on measures. The tensions were clear, but it's all coming from people's very valid and genuine lived experiences as well.

A few takeaways for me from a white paper perspective. One was on just Medicare Advantage, making sure that we sort of factored that in. Obviously, our broader charter includes models beyond traditional Medicare, so I thought that was a helpful reminder for us to sort of take a look and see if we need to change anything in the white paper related to that. The member incentives, so benefit design to further value-based care, I think is an important third leg of this tool. Much of the VBC conversation has been on payer-provider alignment, so the people that pay the

bills, and then the people that deliver care.

And so, Shawn brought up the comments on member incentives and copay waivers, and so those are important elements as well, including in our mix. Certainly, data interoperability, strengthening and sharpening the pen on the white paper on that, I think is a takeaway for us. Conveners and what it means for other stakeholders. I think were applicable, I think, incorporating those as well into our white paper. And then, a conversation we were having on just residence, training, graduate student type aspects, and what it means from our workforce is another element we should factor in as well. So, those are some things that came to my mind.

CO-CHAIR PULLURU: Lee.

CO-CHAIR MILLS: Yeah, really, really rich day of conversation. Some things that we heard reflected over and over was about sense of, you know, expressed different ways, but sense of pressure, sense that, you know, things need to go faster, not slower. Definitely a lot of talk about reducing -- as opposed to building incentives or new payment models, we heard lots about just using policy authority to reduce

friction, make it easier to get clarity, to join a model, to deal with the metrics, deal with the rules, that sort of thing, and that certainly seems possible.

Heard a lot about prospective payments, and both Shawn and Jennifer this morning spoke to that. And in conversation with them after, I asked them, you know, what percent of total payment should be prospective across different areas? And they were both aligned saying, you know, for rural areas, we just need to get them resources, so they'd say, you know, 90 percent or plus of total expected payment actuarially should be prospective to rural areas.

And independence in non-rural areas, not in systems, may be as high as 60 percent, which is when you talk to plans doing prospective payment for value-based contracts, if there's any prospective payment at all, it's usually less than 10 percent. So, it seems like there's a vast gulf between what the provider community is saying needs to be paid prospectively and what the employer and plan community is saying, and so there's something there to unpack and think through.

And really interesting statements here, most recently about the, you know, transparency is well and good, and everybody says they want more transparency, and they kind of have that mixed up in our mind tied to fairness. But yet transparency around risk adjustment has not been useful, led to any improved outcomes, and it just leads providers to obsess in chasing risk adjustment, and some can even game the system if they get good at it.

And, of course, there's a whole vendor ecology around risk adjustment and MA and other venues that have problems. And so, I think her statement where I wrote down was consider I'd be happier with a fair black box than the system we have under risk adjustment now, which is really fascinating.

I heard a statement this afternoon about, you know, waiting for independent or rural providers to join voluntarily and just figure out value-based care is magical thinking, and that really struck with me, that it's really, it probably isn't about incentives for rural providers, because it's just too hard to join and figure it out, and they don't have any time,

bandwidth, or resources to figure it out. They're going to keep riding the truck they're on. And so, of the arguments for a glide path towards mandatory, I heard it applied to actually the rural group, which is a group I had in my head as more voluntary, right? Which is really interesting. I may have more later. Let me pass for now.

CO-CHAIR PULLURU: Lindsay.

DR. BOTSFORD: Yeah, thanks, Chinni. I mean, I think we heard themes that we've heard in other meetings, the importance of removing friction, simplifying. I think there's a couple things that I heard from the speakers that are maybe tweaks on things we've heard before. The idea of rewarding longevity on plan, both potentially for the beneficiary and the provider as well.

And I think just generally the idea of developing more incentives instead of just sticks, especially incentives at the consumer level, such as the co-insurance or copay waivers, and then incentivizing primary care and preventive services, as well as high-performing specialists, I think was mentioned, too. So, how can we make

it financially beneficial for the patient to make the right choice and make it easy to do the right thing?

A couple of things around model testing that were interesting. One around maybe it's not what new model we need, but what we need to take away or reduce from existing models and just simplify or have less models in general. I think coalescing questions around whether the quality measures we're using right now are getting us the right outcomes that we want, and I think especially some of the conversations around could quality measures function more to focus on the bottom and making sure someone is not bad as opposed to ensuring a certain level of how good they are.

We heard multiple times the needs of rural areas. I think the interesting part was more around this isn't a payment model for rural. This is just more payment, and that payment needs to be different for people in isolation, sometimes regardless just of the geographic practice setting. And then, as far as the model testing, I think, you know, interesting point around maybe we don't want to show a cost savings in primary care.

Maybe that's preventing us from testing important things in terms of what investment can do. That's not going to reap benefits during a testing period.

I think a couple of things that have been hit on that are less clear that remain in payment models but could be laying the groundwork for more value-based care, the interoperability and data sharing. It's less clear if that's really in a payment model or just needs to be in the infrastructure that exists to make value-based care happen. And then similarly, I think, again, outside of a payment model, but we heard flexibility in terms of mode and modality of service from multiple of our speakers. And so, things like extension of telehealth flexibilities would also support some of the things that we've heard that are essential to driving value. I think that's all for now.

CO-CHAIR PULLURU: Thank you. Walter.

DR. LIN: So, my fellow Committee members have covered a lot of ground, which I won't repeat. I think one of the things that struck me the most about today was this whole whiplash we had around whether we should be mandating models

or not. This morning, it was definitely no mandates, and this afternoon it was very much go mandatory models. I think maybe how I'm reconciling this in my head is what Shawn Martin said about how well-designed models shouldn't need to be mandatory. And there's some discussion around how Medicare Advantage is the kind of clearest example of that proposition.

Now, I guess in my mind, I'm not sure that's really a good example because a lot of experts would argue that Medicare Advantage has grown so much because it is paid more than traditional Medicare rather than being better designed. But I think there are some probably lessons that traditional Medicare can take from Medicare Advantage and incorporate it. And we spoke about some of the models that Optum has around the care of the seriously ill and chronically complex. That makes a lot of sense.

And then, the other thing that struck me about Medicare Advantage, I didn't expect this session to be so much about Medicare Advantage, but Mike Chernew started out by saying we need to reform Medicare Advantage, otherwise it's going to swamp APMs and kind of traditional Medicare. And

I think that's a good word of caution to reiterate.

Other things that struck me from today, the whole discussion around quality. Maybe we've kind of gotten off track a bit with the current focus on quality metrics. I didn't really expect Mike and Shawn to say what they said around, maybe we don't need to look at quality the way we're looking at quality now. Maybe the total cost of care can, in large part, and I don't want to put words in their mouth, but I think they said, in large part, obviate the need to have a focus on quality metrics.

And then lastly, I think what Mai said around the Medicare Physician Fee Schedule being a value-based payment model in and of itself is super important. I know we've discussed this amongst the Committee somewhat in terms of the need to reform the Physician Fee Schedule because, even under the most value-based care models, the most blue blood value-based care models, the fee schedule still plays a very important role in terms of incentivizing volume of care and service mix.

CO-CHAIR MILLS: I want to just pick up

on what Walter just said about quality, and it was really kind of the first time I really heard that, that the drive for reduced friction and simplicity and the dangers of measuring the wrong stuff has gotten so bad that actually, in little evidence, that the rush to move quality measures higher is actually changing care fundamentally. Actually, we ought to go the opposite direction, simplify, and just use quality measures to ensure in a total cost of care system that people aren't getting bad care.

So, right, we should measure the low side and not worry and adjust for it somehow or have negative incentives, but not worry about trying to incent good to great. And that makes sense mathematically. Your best gain is poor to average, not average to great. So, that was interesting.

I want to pick up a few more threads which was a really good conversation in our first panel about technology and is it a tool, is it a partner, is it a model, should it be separately paid, or is it just expected the practice will use the technology they need for the model they're part of? And I really think we need to pull that

thread a bit more and have some recommendations about what we've heard about technology historically.

I mean, I think I feel like I react kind of negatively to technology or AI tools or clarity at the point of care. Any of that, it should be its own model, right? I think to some degree anything that we would frame up and model out and value and build a model around is going to be obsolete before we could ever get it on the street, right? So, it's more like smart use of technology hooked up to your data and your point-of-care systems to drive better outcomes is just expected, right? That's table stakes already, right? So, technology is an enabler, and it's a partner, and it's a tool, but it's really not a model in and of itself. And I think the Committee can take a stand on that a little bit.

Really heard a fascinating sentence I've never quite heard before, I'm forgetting who said it, about that we can either be fair or we can be simple, but not both. And maybe the pendulum is swung too far, and as I'm busy trying to write value-based models and contracts and specify out all the ways it's fair for providers and manage

Medicaid in Oklahoma right now, I'm really seeing that live out that providers don't trust us.

They want to see spelled out all the math, but when you ask the actuaries to spell out the math, it gets so incredibly complicated about what's going to happen and how the drip is going to work 36 months from now that it literally can't be operated. I think there's something real there that we ought to really double click on and emphasize.

And then lastly, I was really struck by this last panel that value-based care has a branding problem. In the policy and legislative world when you say value-based care, it dissolves, it immediately fragments into two dozen different perspectives and passionate arguments for policy and legislative types about whether it's good, it's bad, it's this type, it's that type. And to the wider audience and public, value-based care just means it's a cheap hamburger, and we don't want the value menu, right? We want something better than that. So, I think there's a branding issue, and maybe we have an opportunity to talk about what's a better lens for this. So, those are my last thoughts that I pulled out of my

notes.

CO-CHAIR PULLURU: Josh.

DR. LIAO: Really great conversation today. I won't rehash what other Committee members have said, but maybe I'll just kind of roll up my comments in a couple of themes that I thought I heard today. I think several of our panelists observed that some of the issues reflected in our white paper aren't new, and I think that's fair on one hand, but actually I think that's part of the value of memorializing what we've learned from the Committee's work, from stakeholders across health care and bringing them forward into the present and really using those lessons to sharpen the conversation I think we need to have now.

So for example, I think many thoughtful people, including the organizations and stakeholder groups represented today, have been working on these challenges for years. So, noting them is important and yet the fact that we continue to confront many of these same problems I think should prompt us, the Grand Us, capital U, Us, to ask more directly what continues to stand in the way of progress. I think a few panelists

offered some suggestions, but I think more is there, and I think the white paper has a key role in pushing that conversation forward.

And I think the other kind of, again, theme, kind of meta theme that I heard in today's comments was really about, even though it wasn't stated explicitly, was the distinction between kind of a flaw in a fundamental strategy for how we pay for care versus a flaw in implementation of care. That a payment approach or a model or an incentive in its full form could be very good, but we've implemented it poorly versus just even in its full form, if it can't achieve the goals that we want.

I think that I'll push into that a little bit more in my comments tomorrow, but I think that's really critical here. And I think the point here is that, from my view, the comments today helped me kind of realize that these are the areas in which policy aspiration meet, like, operational reality, and I think our white paper can help us focus that conversation.

Another thing I heard from multiple people is that, you know, we're not about measuring participation, we're about measuring

outcomes. And this is true, but also participation is necessary to achieve those outcomes, and we still struggle with that. And a few of our panelists noted the penetration issues that we have. So, we just have to grapple with that reality.

Walter's points about, you know, if models are sufficiently attractive, accessible, workable, we don't need mandates, and yet, I think all of us in our careers in health care know that mandates are needed in some cases. And so, we can't just say that as a nice concept and move on. The white paper, if it serves a value in surfacing these things, although not new, although it can’t fix health care tomorrow, helps us grapple with these things, and I think we should stand in that moment here.

Final kind of example of that, and then I'll stop, is that, you know, there's some comments around things like burden in quality reporting and measurements. And so, I think that when we think about reform, I appreciated , Mike Chernew's comment about restraint and it's easy to say and very hard to do, but I think that the kind of regulatory safeguards we'd want to implement

against favorable selection or measurement distortion, et cetera, et cetera, can strengthen kind of a model's integrity, but each of those safeguards adds reporting burdens, compliant costs, implementation friction, et cetera.

So, I think the comments about simplicity is good. But even there, we have to tussle with, you know, too much one way is not good. And these are good concepts and aspirations, but just as Mike was mentioning with his example of the PCMH, you know, Patient-Centered Medical Home, concepts around medical homes is great. When you start measuring and accrediting and credentialing people around that, it gets much harder.

I think you'll find in each of the areas that I think that I've raised today and many of the others from other Committee members, that's where the hard work is. And I hope our paper, in taking this feedback and refining that feedback, can help achieve that. So, you know, really great conversation. Look forward to more.

CO-CHAIR PULLURU: Is David online?

MR. TYSON: Yes. Can you guys hear me okay?

CO-CHAIR PULLURU: Yes. Hey, David. Go

ahead.

MR. TYSON: Yeah. I think -- obviously, I was unable to join this morning, but the afternoon sessions were excellent, and I thought that the thing that really stood out to me was Elizabeth Mitchell's comments around urgency. The affordability challenges that are out there right now, the overwhelming narrative that is sort of taking hold of Washington, rightfully so around affordability, creates the sense of urgency, and I think she's absolutely right that, you know, a 10-year horizon is not something that people are going to be able to tolerate.

And I think also, kind of piggybacking on what other folks have noted is, I think, the reassuring thing is obviously our sample size today is all people who believe and support value-based care, so, you know, not exactly a perfect sample. But I think there is overwhelming agreement. I think that we're arguing around the margins, there's different ways to accomplish these things, but I think fundamentally, the goals are shared. And I think that what is really, you know, interesting is that you have people on there who have been on this Committee and have been

talking about these things for 10 years.

I mean, to Josh's point, I think that that is actually a positive that we know a lot of what the answers need to be. It's a matter of actually executing on them. And so, I hope that we can continue talking about that. And, you know, I've seen that play out here at my health system where I work. You know, I've been saying some version of these same diatribes about how we need to shift to value and trying to get buy-in at the physician level and all this stuff since I got here in 2017. So, it's certainly not anything new, but I don't think that's necessarily a bug, probably is a feature. So, I enjoyed the conversations this afternoon and look forward to tomorrow.

CO-CHAIR PULLURU: Thank you, David. So, I'm not going to repeat, I guess, the extensive insight that the Committee has provided. The day was surprising to me to some degree, because if I had to sum it up, the concept that we need, one, there was obviously a lot of agreement that we need -- that value-based care is important, it's where we need to go and that's the direction. But the theme around deconstructing what exists versus

reconstructing or constructing new things was what I took away.

The second theme was obviously reinvesting in primary care in a version that incentivized continuity, and not necessarily in a version that separated out different types of primary care, but just incentivized more global continuity as a mechanism for quality and then deconstructing quality.

The other major theme that I saw, and this is probably the last that I'll add, is the concept that we do need to treat different geographies differently. This has come up before, but to the drastic extent that was articulated today surprised me. So it was, you know, in rural, we really do need to have a significant amount, I mean, 90-plus percent, which I don't know if we'll do, but a significant amount of prospective payment without extensive quality gating, without extensive regulation, you know, deconstruct everything in its current form and hold people accountable to, obviously, a value-based care alternative payment mechanism.

And then, why it's speaking to, you know, you have to up the incentives for large hospital

systems, which largely exist in urban areas, and throw more money into it. So, you know, in a budget-neutral environment, that's a higher percentage of money that then you're attributing towards certain value-based care initiatives and taking it away from procedural initiatives. So, it's a drastic shift in how the American health care system is paid. So, you know, I'm sort of using broad strokes, but those are the sort of elements of today that surprised me. I'll stop there.

CO-CHAIR MILLS: Apologize for taking three bites of the apple, which has never happened before, but I also heard what I think is a quantitative opportunity, Steve. And I'm aware that we have a Kaushik , and I'm not afraid to use him. But put this in the hopper for when we can get to it type of thing. But Dr. Pham talked about voluntary models will always underrepresent the highest-cost providers, and I get it. That feels quantitative.

Can we get back in the data set and say, imagine the published ACO, like next-gen savings? Imagine if those geographic areas, penetration was not what it was who participated, but it was 80

percent of the market, including all the higher-cost providers who didn't participate. What would the savings with the appropriately increased benchmark representing the geography truly have been? What would the published savings have been then, right? I think that's really fast, and that feels quantitative, that we probably could figure out whenever there's capacity to take that on. I mean, Kaushik, is between 2:00 and 3:00 a.m. is still free in your schedule.

*** Closing Remarks**

CO-CHAIR PULLURU: So at this time, I want to thank everyone for participating today. Our wonderful session experts, my PTAC colleagues, and those who joined us in person and online to listen. We'll be back tomorrow at 9:00 a.m. Eastern Time. We'll be joined by four incredible experts who shared their perspective and input during the session on PTAC's draft white paper, *Transforming Health Care Delivery through Value-Based Care Payment Models and Care: A Roadmap*.

*** Adjourn**

There will also be an opportunity for public comments related to the meeting topic tomorrow morning at 10:50 a.m. Eastern Time before

the meeting concludes with the Committee discussion. We hope you'll join us, and thank you. This meeting is adjourned for the day.

(Whereupon, the above-entitled matter went off the record at 4:04 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: PTAC Advisory Committee

Before: PTAC

Date: 09-14-26

Place: virtual meeting

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