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

Presenters:

Subject Matter Experts

- **Wyatt W. Decker, MD, MBA** – Executive Vice President, Chief Physician, Value-Based Care & Innovation, and Executive Director, Health Care Transformation Hub, UnitedHealth Group
- **Elizabeth Mitchell** – President and Chief Executive Officer, Purchaser Business Group on Health (PBGH)
- **Sarah Fogler, PhD** – Senior Research Director, Healthcare Transformation, Duke-Margolis Institute for Health Policy

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

Wyatt W. Decker, MD, MBA

Executive Vice President, Chief Physician, Value-Based Care & Innovation,
and Executive Director, Health Care Transformation Hub,
UnitedHealth Group

PTAC Recommendations on Value-Based Care

Wyatt Decker, MD

Executive Vice President & Chief Physician, Value-Based Care & Innovation

UNITEDHEALTH GROUP | Optum | UnitedHealthcare

UNITEDHEALTH GROUP

Wyatt Decker, MD

Executive Vice President & Chief Physician,
Value-Based Care & Innovation

Executive Director
Health Care Transformation Hub

PTAC recommendation summary

Support efforts to expand VBC

- Clear need for integrated, coordinated care
- 4.7M people in fully accountable care models at UnitedHealth Group

Support for rural and independent providers

- Additional investment in infrastructure
- Interoperability and shared data standards

Churn remains a challenge

- Annual churn creates VBC barriers
- Longer commitment periods, backed by incentives

Orient VBC structure around TIN

- Use Tax ID Number (TIN), not National Provider Identifier (NPI)
- Incentivize collaborative, practice-oriented structures

Research shows VBC models improve patient care

43% ↓

Less likely to be hospitalized for acute and chronic conditions

19% ↓

Less likely to undergo avoidable ED care

82% ↑

More likely to have annual wellness visits

15% ↓

Less likely to use high-risk medications

RECENT PEER-REVIEWED RESEARCH

The American Journal of Managed Care
Oct 2025

Health Outcomes Under Full-Risk Medicare Advantage vs Traditional Medicare

The American Journal of Managed Care
Feb 2025

Potential Spillover Effects on Traditional Medicare When Physicians Bear Medicare Advantage Risk

The American Journal of Managed Care
May 2026

Health Outcomes of Dually Eligible Beneficiaries Under Different Medicare Payment Arrangements

JAMA Network Open
Jan 2025

Medicare Risk Arrangement and Use and Outcomes Among Physician Groups

HEALTH CARE
TRANSFORMATION HUB

Engage with the Hub

Explore our research, read the blog, and follow us on LinkedIn for upcoming thought leadership convenings.

healthcaretransformationhub.com

Support for rural and independent providers

Strengthening technology and data infrastructure

Rec. 7

Transition to VBC

Move providers into full-risk models sooner

Glide path for some, faster track for others

Rec. 11

VBC measures

Data infrastructure remains a challenge

Set clear metrics and common data sources

Establish a needs-based grant program

Rec. 15

Start-up flexibility

Waivers could introduce complexity

Fund new providers through grants instead

Rec. 16

Rural providers

Help rural providers build core infrastructure

Accelerate payments to rural providers

Rec. 18

Data access

Expand patient-generated data and digital tools

Grants for data infrastructure

Integrating specialty care

Opportunities to bring specialists into VBC

Rec. 9

Integration

Integrate specialty providers into risk models

Identify high-value specialists

Share data at the point of referral

Rec. 21

Patient safety

Enable referrals to the highest-performing specialists

Incorporating the continuum of care

Broaden recommendations to include sites of care

Rec. 2

Care delivery

Greater focus on handoffs across the care continuum

Include all settings: in-person, at-home, and virtual

Site of service

Clinically appropriate sites of care

Physician-led referrals

Home care

Central to value-based care models

Expands access, improves outcomes

Challenges with patient engagement

Concerns about using out-of-pocket payments to influence patients

Rec. 19

Provider & patient incentives

Challenge of out-of-pocket payments as incentives

Disengaged patients are the hardest to reach

More access points improve engagement

Provider search and upfront costs

44%

lower out-of-pocket costs than traditional plans, with more preventive screenings and fewer ED visits

Q&A

Wyatt Decker, MD

Executive Vice President & Chief Physician,
Value-Based Care & Innovation
UnitedHealth Group

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

Elizabeth Mitchell

President and Chief Executive Officer,
Purchaser Business Group on Health (PBGH)

Purchaser Business Group on Health

Meeting the Moment

Elizabeth Mitchell, President and CEO

Who PBGH Is

Purchaser Business Group on Health

Advancing Quality

Driving Affordability

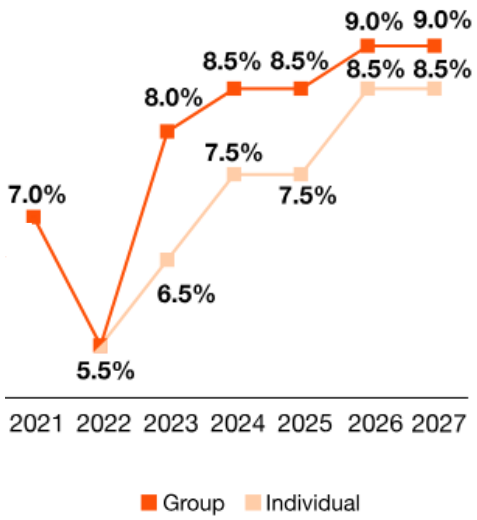
Fostering Health Equity

We are a **non-profit coalition** of the country's largest and most influential **private employers and public purchasers** working to create the health care system they are proud to offer American workers and their families.

Trends Dominating the State of U.S. Healthcare

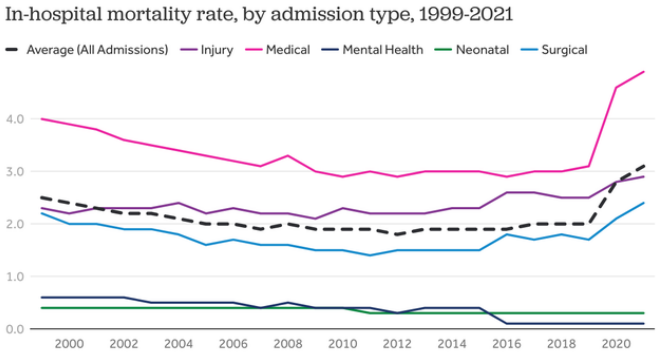
Increasing Costs

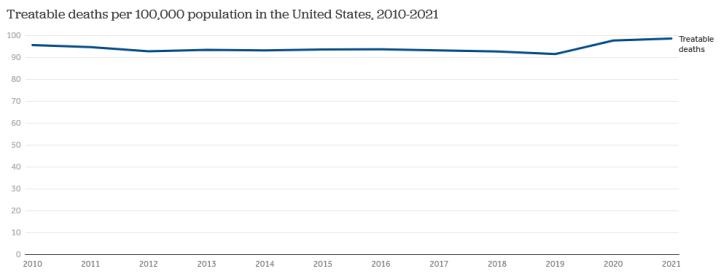
(Persistent, High Single-Digit)



Declining / Flat Quality

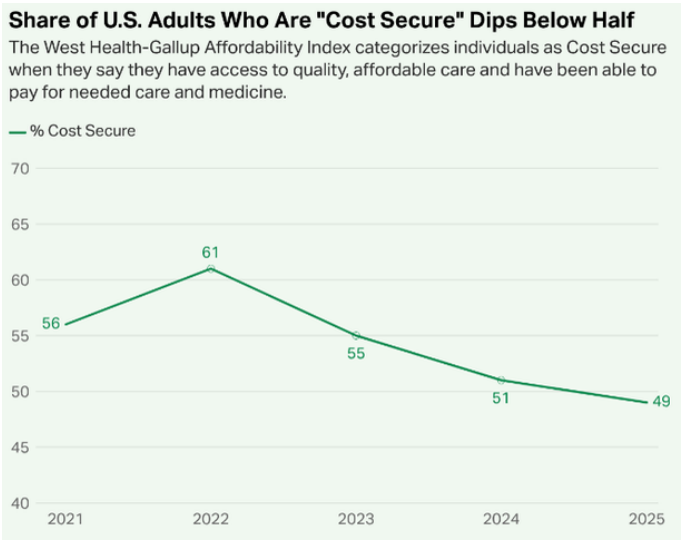
(Across Care Settings)





Declining Access

(To "quality, affordable care")



Sources (left to right): PwC Analysis | Peterson-KFF Health System Tracker | WestHealth-Gallup Center on Healthcare

CMMI's Value-Based Initiatives Have Met with Mixed Success

The NEW ENGLAND JOURNAL of MEDICINE

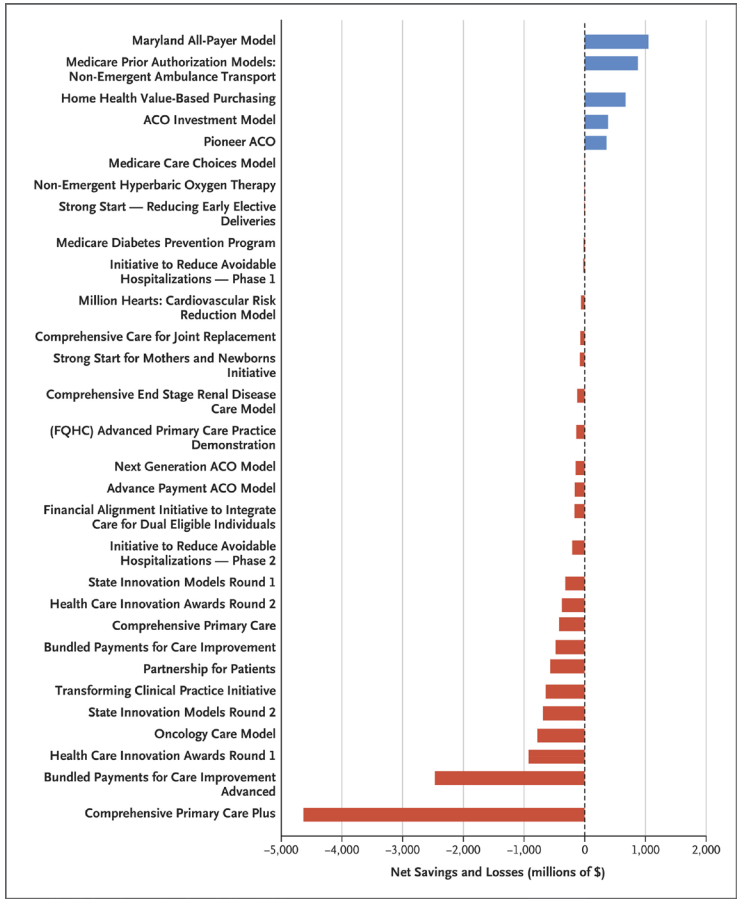
CMS Innovation Center at 10 Years — Progress and Lessons Learned

Author: Brad Smith, M.Phil. Author Info & Affiliations

Published January 13, 2021 | N Engl J Med 2021;384:759-764 | DOI: 10.1056/NEJMsb2031138 | VOL. 384 NO. 8

Abstract

The federal CMMI was created to assess new payment and service delivery models for improving health care nationwide. This review reports that during the agency's first decade of operation, some of the value-based models saved money and improved quality but most did not. The lessons learned and future directions are discussed.



In 2024, only 38.9% of commercial health care spending was non-FFS.

Even less (19.4%) had downside risk.

Source: New England Journal of Medicine

22 Recommendations

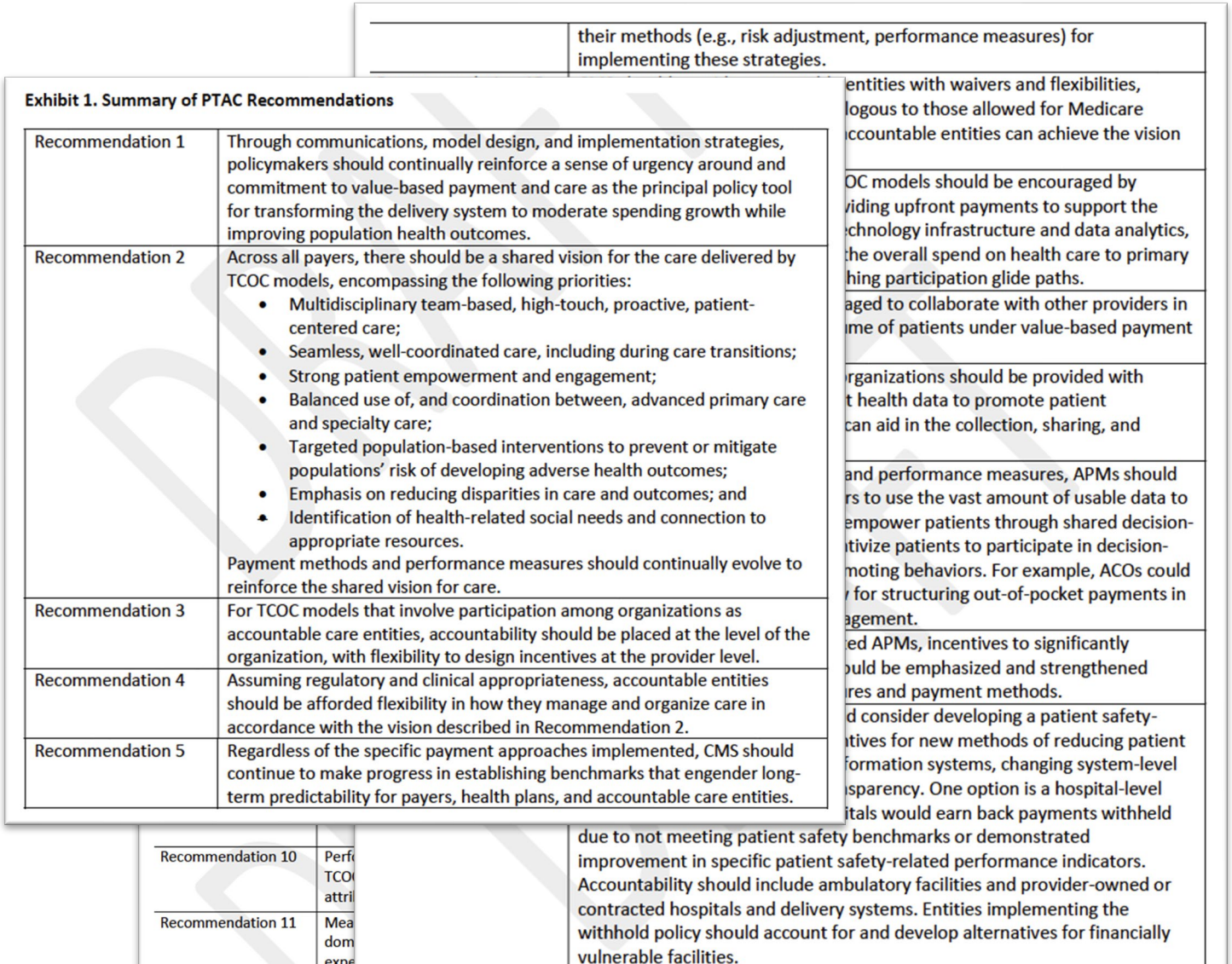


Exhibit 1. Summary of PTAC Recommendations

Recommendation 1	Through communications, model design, and implementation strategies, 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 delivery system to moderate spending growth while improving population health outcomes.
Recommendation 2	Across all payers, there should be a shared vision for the care delivered by TCOC models, encompassing the following priorities: • Multidisciplinary team-based, high-touch, proactive, patient-centered care; • Seamless, well-coordinated care, including during care transitions; • Strong patient empowerment and engagement; • Balanced use of, and coordination between, advanced primary care and specialty care; • Targeted population-based interventions to prevent or mitigate populations' risk of developing adverse health outcomes; • Emphasis on reducing disparities in care and outcomes; and • Identification of health-related social needs and connection to appropriate resources. Payment methods and performance measures should continually evolve to reinforce the shared vision for care.
Recommendation 3	For TCOC models that involve participation among organizations as accountable care entities, accountability should be placed at the level of the organization, with flexibility to design incentives at the provider level.
Recommendation 4	Assuming regulatory and clinical appropriateness, accountable entities should be afforded flexibility in how they manage and organize care in accordance with the vision described in Recommendation 2.
Recommendation 5	Regardless of the specific payment approaches implemented, CMS should continue to make progress in establishing benchmarks that engender long-term predictability for payers, health plans, and accountable care entities.

The recommendations:

- are acceptable and noncontroversial
- will not lead to meaningful improvement for patients in the near term
- do not address the needs or concerns of self-insured employers

The Industry CAN Change

Mandatory

- Hospitals and payers quickly adopted the Medicare DRG system
- "Virtually 100 percent" of hospitals were using them within 3 years

vs.

Voluntary

- Anemic uptake of APMs, despite industry saying it has been a priority for 15+ years
  - Less than half (44.9%) of all health care payments flow through APMs.
  - Only a quarter (28.7%) have downside risk.

Sources: [Special Report on the Impact of the MPPS for Hospitals] | [AHIP's APM Measurement: 2025 Methodology and Results Report]

A Current Payment Model Demonstration Project

The California Advanced Primary Care Initiative (CAPCI) implements a common value-based payment model with approximately 100 practice locations throughout California to improve patient outcomes.

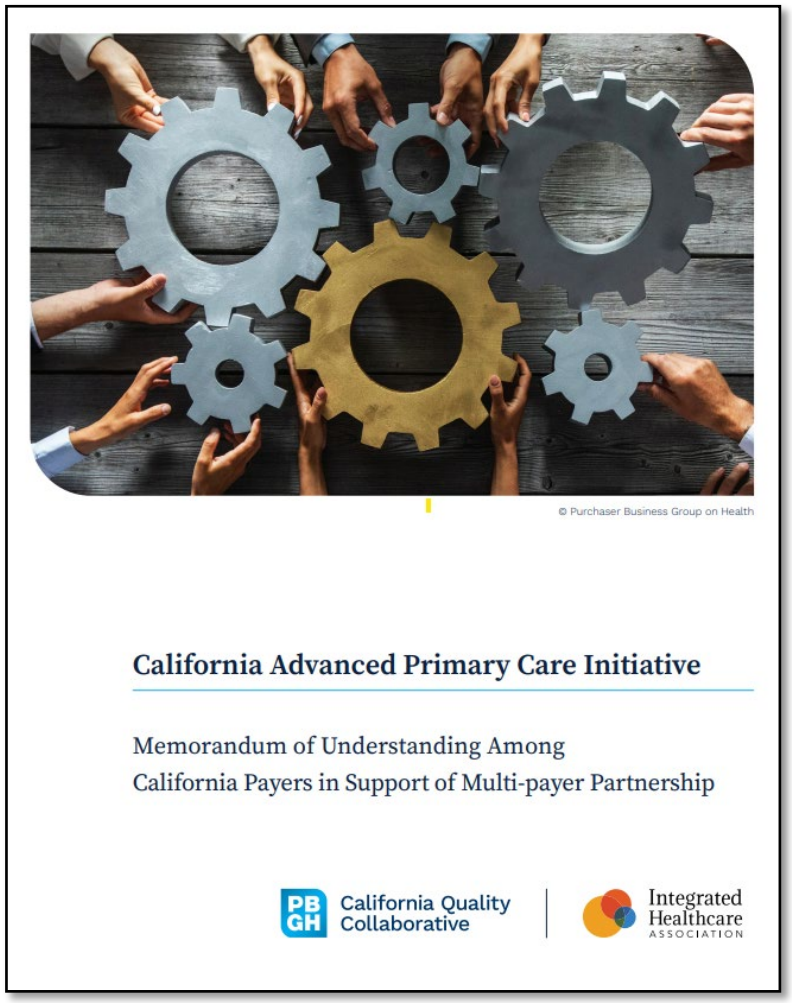
blue california

health net

aetna

PBGH California Quality Collaborative

Integrated Healthcare ASSOCIATION



Several practices achieved, or are on track to achieve, the highest VBP performance thresholds on priority quality measures.

Payment Model Overview

	Element 1 Direct Services Payment (Three Tracks)	**Element 2** Population Health Management Payment	**Element 3** Performance Incentive Payment
Track A	**Fee-For-Service Plus:** Plans continue to pay FFS for all direct patient care services.	A prospective, adjusted regular payment based on PMPM to support Advanced Primary Care attributes such as population health management functions • referral & follow up • patient outreach • coordination with other resources • transitions of care • team care • infrastructure, data & reporting, etc.	Rewards practice performance on common measure set • Payment for meaningful improvement (10% relative) if original score is between simple numerical targets loosely tied to the national 25th to 66th percentile benchmarks • Payment for attainment if scores above around the 66th percentile (higher) • Pay more for improvement or attainment on equity sensitive measures.
Track B	**Basic Capitation:** Pays a prospective, adjusted PMPM payment for E&M, all other services paid FFS		
Track C	**Intermediate Capitation:** Pays a prospective, adjusted PMPM payment for E&M and additional services, all other services paid FFS		

Payment Element 1 tracks B and C and Element 2 will be adjusted for clinical risk and social risk

Source: Common Value-Based Payment Model Guide for Primary Care Physicians & Payers

CAPCI Accountability Measures

Quality Domain	Measure	NQF ID	Population	Comm	Medicaid	CMS
Health outcomes & prevention	**Breast Cancer Screening (BSC-E)**	2372	Adult	x	x	x
	Childhood Immunization Status Combo 10 (CIS-E)	0038	Pediatric	x	x	x
	Colorectal Cancer Screening (COL-E)	0034	Adult	x	x	x
	Controlling High Blood Pressure (CBP)	0018	Adult	x	x	x
	Glycemic Status Assessment HbA1c Control*	0059/0575	Adult	x	x	x
	Immunizations for Adolescents (IMA-E)	1407	Pediatric	x	x	x
Patient-reported outcomes	**Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)**	-	Peds/Adult	x	x	x
	Depression Remission or Response for Adolescents and Adults (DRR-E)	-	Peds/Adult		x	
High-value care	**Emergency Department Visits**	-	Adult	x		
	Inpatient/Acute Hospital Utilization	-	Adult	x		
	Total Cost of Care	1604	Peds/Adult	x		
Patient experience	***New measures being tested***	-				

PBGH Employer Members ***Have*** Found Success with VBC

PBGH Member Company #1

- Preferred Partnerships across the country that require provider partners to accept **up- and down-side risk** and meet financial, meaningful quality, and patient satisfaction metrics.
- Over a period of several years, this company has seen **improvement in the health of its employees** who see providers in this Preferred Partnership (on depression screenings, blood pressure, diabetes, and cancer screenings).
- Employees and families who choose to participate benefit from **lower paycheck contributions**, **$0 generics and primary care**, and **higher HSA contributions**.

PBGH Member Organization #2

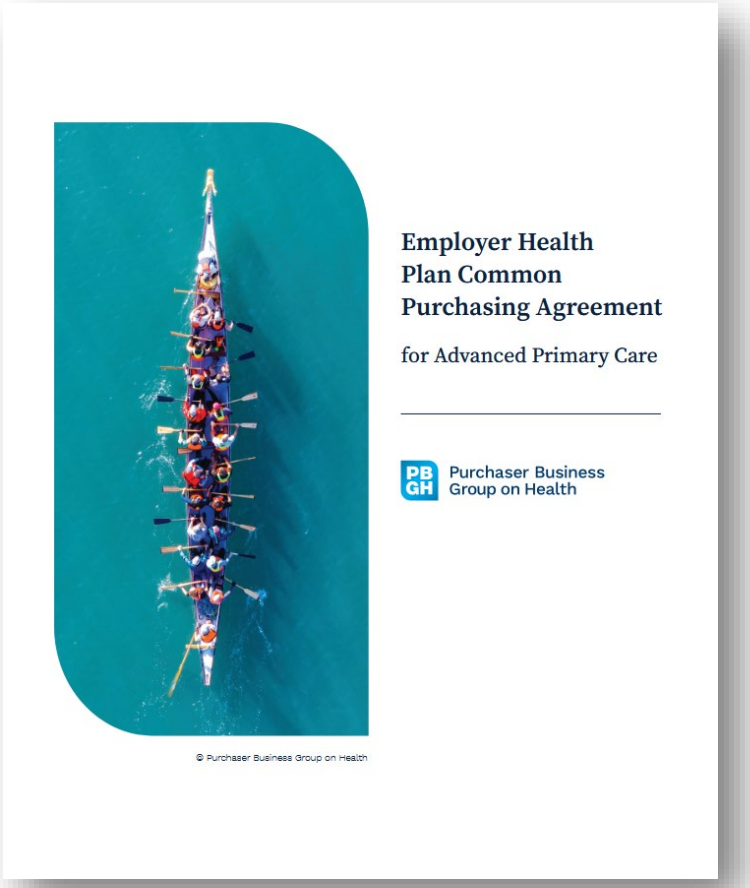
- PBM service provider partner with **significant $$$ at-risk** for financial and clinical performance:
  - **$40 million at-risk per year** if PBM cost trends exceed the agreed-upon 6.5% target.
  - **$10 million at-risk per year** if the PBM does not meet measurement and quality goals to control high blood pressure and diabetes care.
- These quality measures align with those on the medical TPA (which has **even greater fees at-risk)**.

Common quality goals result in coordination, data sharing, and effective care management.

PBGH Direct Contracting for Advanced Primary Care

PBGH members that have invested in high-quality primary care for their employees report **7 - 14% reductions in total cost of care** and **14% reduced ER utilization.**

Practices were paid with prospective population-based payments and held accountable for common outcome measures.



Sources: The Commonwealth Fund | Implementation of Oregon's PCPCH Program | PBGH's APC Common Purchasing Agreement

Direct Contracting and COEs for High-Quality Specialist Care

Northwell Direct

32BJ HEALTH

Northwell Direct and 32BJ Health Fund: forging the largest direct health care contract of its kind in U.S. history

December 19th, 2025

32BJ Health Fund projects **20% savings** on a large direct contract, expanding **access to 12,000 providers** and saving members **$5 million in co-pays.**

HARVARD BUSINESS REVIEW

The Big Idea Series / Transforming Health Care

How Employers Are Fixing Health Care

Walmart has embraced a new approach to improve the quality of care and lower costs. The results have been dramatic. by Lisa Woods, Jonathan R. Slotkin and M. Ruth Coleman

March 13, 2019

Direct contracting with collectively set provider terms **has saved employers up to 54%** on medical costs.

PBGH Members had to implement value-based arrangement themselves *without the support of their health plans.*

Sources: 32BJ and Northwell Direct Announce Historic Partnership | Harvard Business Review Article

Value-based Payment Does Not Adequately Address Pricing Problems

Example: Median prices for colonoscopy in Atlanta, GA show more than 5× cost difference depending on where a procedure is performed.

Market Benchmarks - Surgical Rates OP vs. ASC - Endoscopy

		Payer Transparency Data - Outpatient Facility					
HCPCS	**Description**	**Record Count**	**Minimum**	**25th Percentile**	**50th Percentile**	**75th Percentile**	**Maximum**
43239	Egd biopsy single/multiple	102	$847	$2,950	$3,761	$5,021	$6,915
45378	Diagnostic colonoscopy	93	$1,240	$3,073	$4,184	$5,063	$6,915
45380	Colonoscopy and biopsy	105	$1,240	$3,161	$4,184	$5,063	$9,036
45385	Colonoscopy w/lesion removal	105	$1,240	$3,227	$4,184	$5,063	$9,036

More than 5× differential

		Payer Transparency Data - Ambulatory Surgical Center					
HCPCS	**Description**	**Record Count**	**Minimum**	**25th Percentile**	**50th Percentile**	**75th Percentile**	**Maximum**
43239	Egd biopsy single/multiple	461	$420	$583	$725	$905	$4,573
45378	Diagnostic colonoscopy	465	$420	$582	$725	$875	$4,573
45380	Colonoscopy and biopsy	423	$505	$670	$800	$935	$4,573
45385	Colonoscopy w/lesion removal	428	$524	$673	$800	$935	$4,573

Source: PBGH Data Demonstration Project, October 2025

VBP Must Address Both Price AND Quality

In the Seattle area, when comparing the % of a normalized Medicare rate, the price is consistently higher for the hospital with a C safety grade.

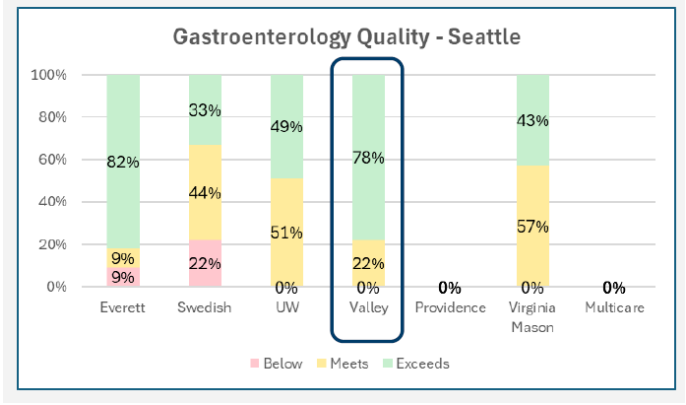
Payer Data
Payer Transparency Data
Market Data Summary

Provider Name	Leapfrog Safety Grade	Aetna Choice POS II FIP	Aetna Choice POS II FOP	Premera Blue Cross Heritage FIP	Premera Blue Cross Heritage FOP	Regence BCBS Regence Preferred FIP	Regence BCBS Regence Preferred FOP	Cigna Cigna OAP FIP	Cigna Cigna OAP FOP	United UHC Choice Plus FIP	United UHC Choice Plus FOP
Seattle Children's Hospital	n/a	n/a	630%	n/a	593%	n/a	807%	n/a	440%	n/a	n/a
St. Anne Hospital	A	387%	609%	297%	275%	370%	364%	290%	274%	394%	485%
St. Francis Hospital	B	427%	499%	326%	300%	370%	364%	290%	274%	387%	411%
St. Joseph Medical Center	A	427%	504%	326%	270%	370%	364%	290%	274%	387%	411%
Swedish Cherry Hill Campus	C	636%	428%	419%	348%	506%	472%	425%	401%	448%	n/a
Swedish Edmonds Hospital	B	295%	249%	376%	302%	252%	343%	391%	376%	n/a	n/a
	B	n/a	215%	321%	272%	285%	347%	424%	506%	459%	463%

National price reference as % above Medicare Reimbursement for comparison between facilities, carriers and networks.

Percent of Expected Color Coding
- Greater than 75%
- Between 75% to 50%
- Between 50% to 25%
- Less than 25%

The Leapfrog Hospital Safety Grade Program grades hospitals on their overall performance in keeping patients safe from preventable harm and medical errors. For more information visit www.hospitalsafetygrade.org



Quality measures will also be seen by provider and specialty groups.

Source: PBGH Data Demonstration Project, October 2025

Policy Changes Needed to Scale What Works

1 Ensure healthcare markets are competitive.

- Ban anticompetitive contracting practices
- Enforce meaningful price transparency

2 Give employers the tools to be effective purchasers.

- Ensure employers have full access to their claims data
- Eliminate data sharing and audit restrictions

3 Remove barriers to scaling employer-led innovations.

- Clarify that group purchasing is not an antitrust issue
- Permit first-dollar coverage of high-value care

4 Hold the healthcare industry appropriately accountable.

- Put meaningful penalties on industry for noncompliance
- Prevent the harmful market effects of consolidation
- Extend fiduciary obligations to intermediaries (plans and PBMs)


Demand Better,
M.Co!

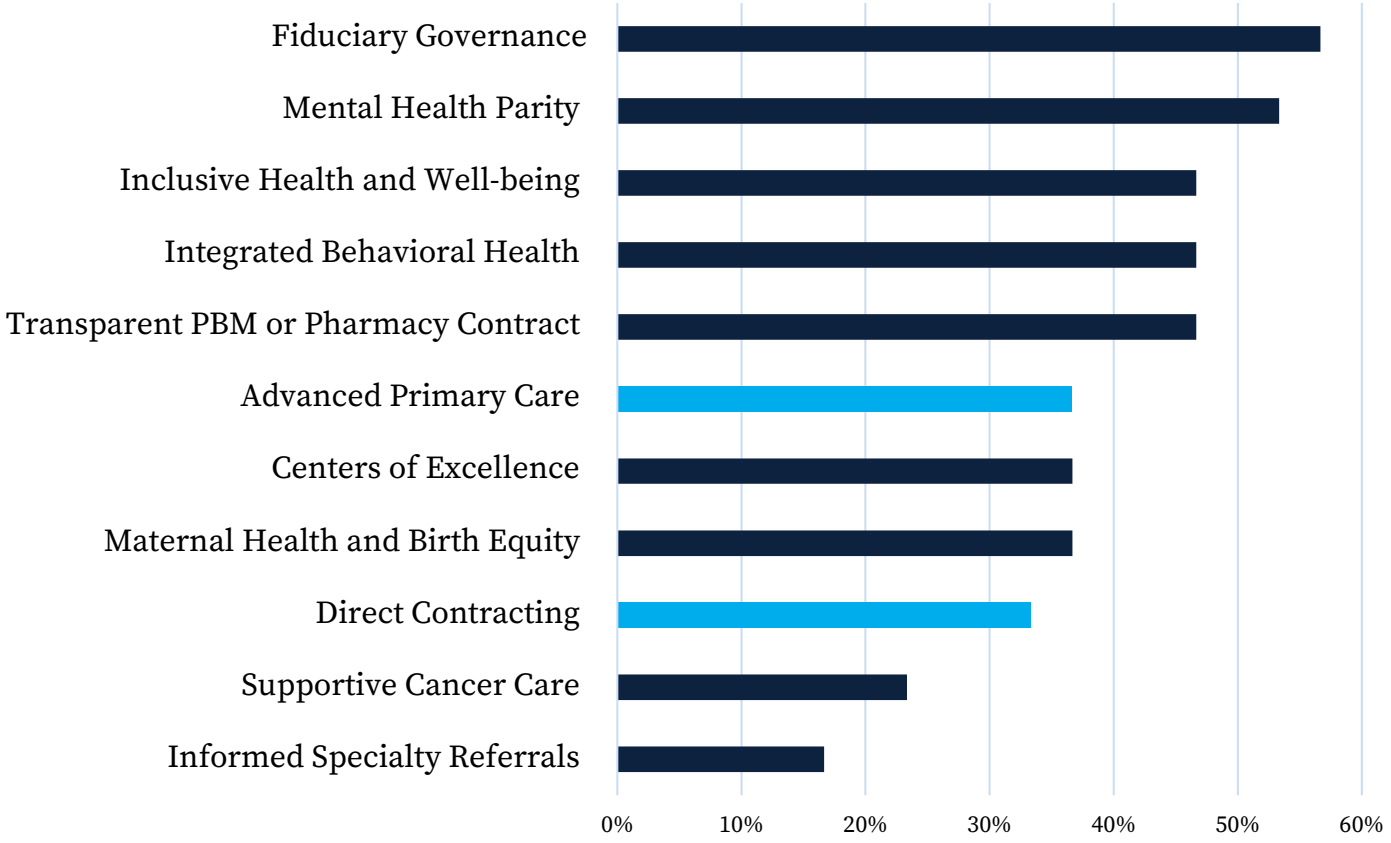
Purchaser Business Group on Health

Thank You

Purchaser Business Group on Health

Additional Slides

2026 PBGH Annual Member Survey



Percentage of PBGH members implementing listed strategies

PBGH Member Action

- Direct contracting for **advanced primary care clinics** with onsite, near-site, and virtual-first models.
- Direct contracting with **Centers of Excellence** for bariatric surgery, oncology, infusions, and orthopedics.
- Direct contracting with **regional hospitals or health systems** and establishing informed referral pathways for specialty care.

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

Sarah Fogler, PhD

Senior Research Director, Healthcare Transformation,
Duke-Margolis Institute for Health Policy

Expert Reactions to PTAC's Recommendations for Transforming Health Care Delivery Through Value-Based Care

Sarah Fogler, Ph.D.
Senior Research Director,
Health Care Transformation

Duke | MARGOLIS INSTITUTE for Health Policy

Duke | MARGOLIS INSTITUTE for Health Policy

Agenda

- Assessment of PTAC's roadmap for advancing value-based care and payment reform
- Strengths, gaps, and opportunities to strengthen key recommendations for policymakers
- Priorities for accelerating adoption of population-based total cost of care models and accountable care
- Additional policy considerations to support long-term health system transformation

Assessment of PTAC's roadmap for advancing value-based care and payment reform

PTAC's Roadmap for VBC: Overall Assessment

- Timely response to rising health care costs, mixed results from early payment models, and growing pressure to demonstrate delivery system transformation.
- After a decade of experimentation, the challenge may be less about further refining payment methodologies and more about addressing foundational implementation barriers and structural incentives that continue to favor fee-for-service.
- Important reminder that expanding participation in VBC is not the same as accelerating progress toward better outcomes, lower costs, or improved patient experience.
- The supporting policy discussion may be the paper's most consequential contribution, highlighting broader reform levers such as fee-for-service reform, Medicare Advantage alignment, mandatory participation, and model simplification.

Strengths, gaps, and opportunities to strengthen key recommendations for policymakers

Strengths

- Strong alignment around a vision for person-centered, coordinated, team-based care.
- Recognition that advanced primary care and specialty integration must work together to improve outcomes and lower costs.
- Explicit emphasis on specialist and hospital utilization incentives, creating persistent barriers to transformation.
- Acknowledgment that different provider types require different pathways into value-based care rather than a one-size-fits-all approach.

Gaps

- Many recommendations reflect longstanding VBC priorities but provide limited specificity on what will drive the next wave of adoption and impact.
- Implementation barriers, including interoperability, data sharing, and provider burden, receive less attention than payment design.
- Program complexity continues to grow, with limited evidence that incremental refinements are driving meaningful transformation.
- Limited attention is given to strategic participation, selection effects, and gaming within voluntary models.

Gaps are less about payment design and more about implementation, incentives, and infrastructure.

Opportunities

- Articulate a clearer strategy for achieving broad-scale accountability across Medicare and other payers, beyond continued expansion of voluntary models.
- Place greater emphasis on data, technology, and interoperability infrastructure required for transformation.
- Address fragmented incentives across payers that undermine investment in value-based care and care delivery redesign.
- Expand focus on implementation, learning, and scaling strategies that enable adoption of proven models at national scale.

The next chapter of VBC is less about designing new payment models and more about scaling, infrastructure, incentives, and execution.

Priorities for accelerating adoption of population-based total cost of care models and accountable care

Priorities

- Simplification of model landscape by reducing administrative complexity, aligning requirements across payers, and focusing on a smaller set of clear, outcome-oriented goals.
- Trusted data infrastructure that enables timely access to cost, quality, utilization, and outcome information for providers, patients, and policymakers.
- Flexible care delivery and benefit design paired with accountability for more significant improvements in outcomes rather than continued marginal gains in performance.
- Sustainable pathways to participation by supporting rural, safety-net, independent, and smaller practices while enabling state- and regional-level transformation efforts.

Additional policy considerations to support long-term health system transformation

Policy Considerations

Strengthening VBC will require looking beyond current reform priorities to the to the broader forces that will reshape the economics and delivery of care over the next decade.

- Transformative Therapies & Diagnostics: Modernize payment and coverage for emerging therapies and accelerate precision diagnostics and prevention
- Digital Infrastructure & AI: Build interoperable data infrastructure and scale AI and digital health adoption
- Next-Generation Accountability: Expand accountable care beyond traditional medical services and support prevention, social care, and care coordination
- Learning & Scaling: Use rapid evaluation to accelerate adoption of successful models and strengthen state-federal collaboration and policy alignment

Appendix

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Expanding Participation Isn't Synonymous with Achieving Savings of Better Outcomes

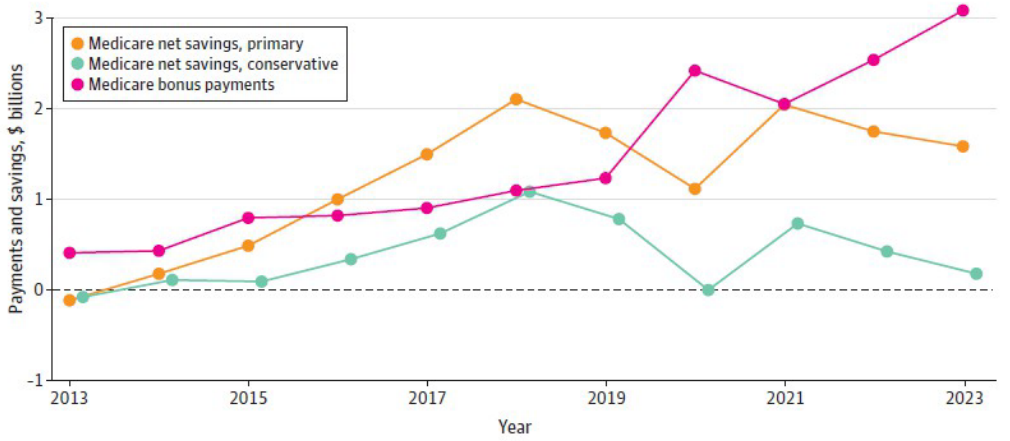
MODEL TYPE	NUMBER OF MODELS	MODELS WITH GROSS SAVINGS (%)	MODELS WITH NET SAVINGS (%)	QUALITY IMPACTS
Population-based models (ACOs)	**4** Physician Group Practice Demonstration Independence at Home Demonstration Pioneer ACO Model Next Generation ACO Model	**100%**	**75%**	Select positive impacts in some models, other models saw no meaningful change
Episode-based payment models	**5** Acute Care Episode Demonstration Bundled Payments for Care Improvement Model 2 Bundled Payments for Care Improvement Model 3 Comprehensive Care for Joint Replacement Model Bundled Payments for Care Improvement Advanced Model	**100%**	**20%**	Most models saw no meaningful change, 1 model saw select modest improvements, another model saw some decrements
Primary care transformation models	**3** Multipayer Advanced Primary Care Practice Demonstration Comprehensive Primary Care Initiative Comprehensive Primary Care Plus Model	**33%**	**0%**	Select improvements in 2 models

Medicare Payment Advisory Commission (MedPAC). *Report to the Congress: Medicare and the Health Care Delivery System. June 15, 2021.* Washington, DC: MedPAC; 2021. http://medpac.gov/docs/default-source/default-document-library/jun21_medpac_report_to_congress_sec.pdf?sfvrsn=0. Last accessed [October 2021].

VBC's Overall Impact on Spending Has Been Modest

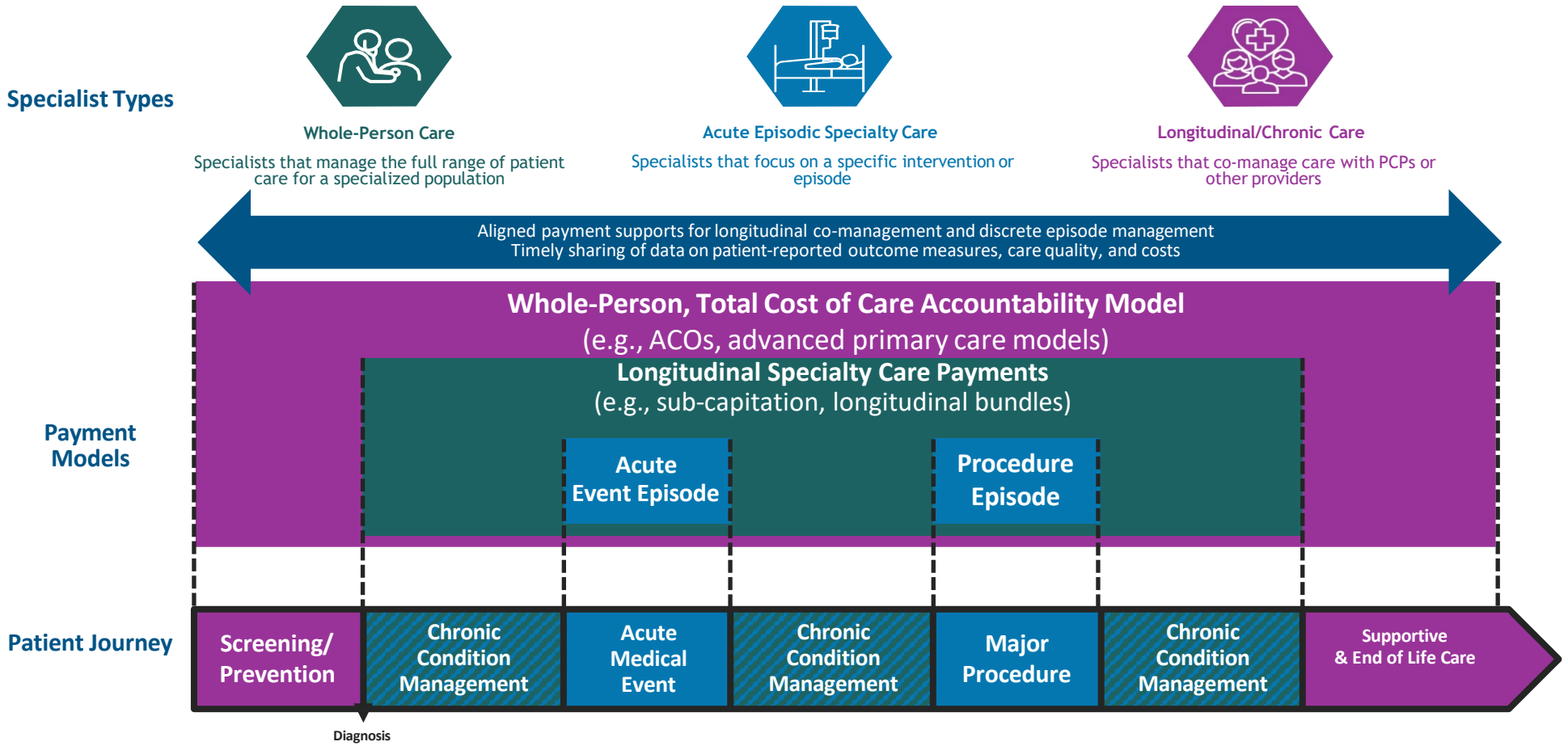
- Net Impact of ACOs is Small: Over 15 years, ACOs have achieved approximately $13.5 billion in net savings, representing just 0.11% of total Medicare spending (~$12 trillion).
- Gross Savings Remain Modest: Even before accounting for incentive payments, total savings of $34 billion constitute only about 0.28% of Medicare expenditures, underlining the limited effect on overall costs.
- Policy Implication: While ACOs demonstrate measurable efficiency gains and improved care coordination, their macrolevel impact on Medicare spending is minimal, highlighting the need for broader strategies to achieve significant cost reduction.

Figure. Medicare Shared Savings Program Payments and Net Medicare Savings by Year, 2013-2023



JAMA Health Forum. 2026;7(2):e256915. doi:10.1001/jamahealthforum.2025.6915

Framework for Integrating Value-Based, Longitudinal Specialty Care



Adapted from Strengthening Specialist Participation in Comprehensive Care through Condition-Based Payment Reforms and Engaging Specialists in Accountable Care: Tailoring Payment Models Based On Specialties And Practice Contexts

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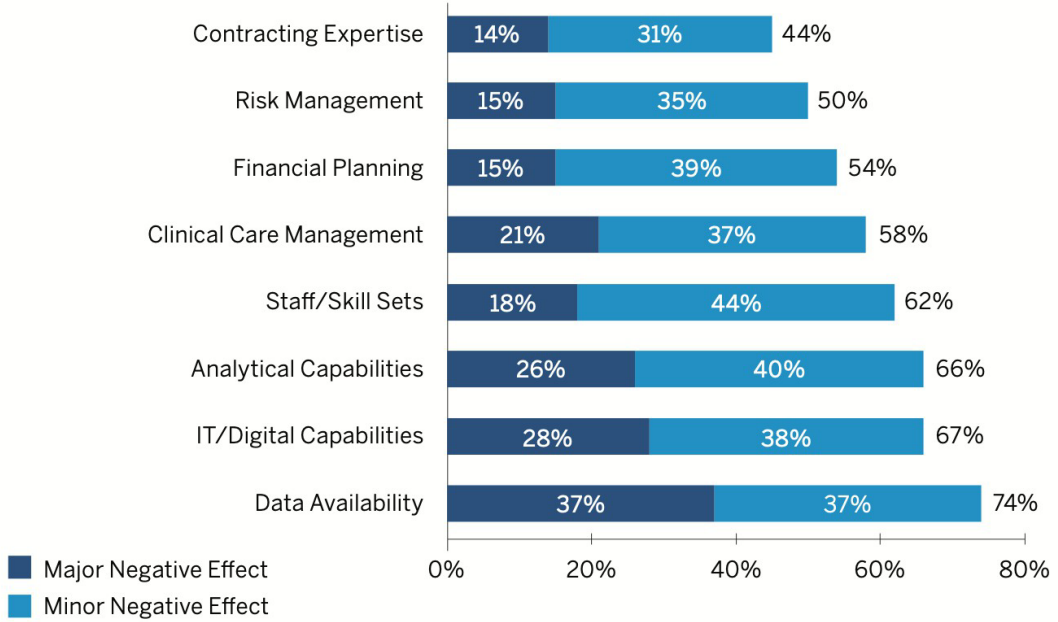
Obstacles Remain for Physician Groups and Payers To Shift to Person-Centered Care and Payment

Figure 5

Share of Respondents Saying That Capability Gaps Have Had a Negative Effect on the Performance of Their VBC Programs



- Financial supports for investments needed to move away from traditional siloed care
- Data interoperability and timely, accurate data sharing
- Workforce with needed skill sets, like specialist care
- Actionable evidence to guide decisions in financial planning, staffing reforms, digital/AI infrastructure, and other steps to implement better care models

https://terrygroup.com/healthcare-industry-survey-report-2023-perspectives-on-value-based-care/

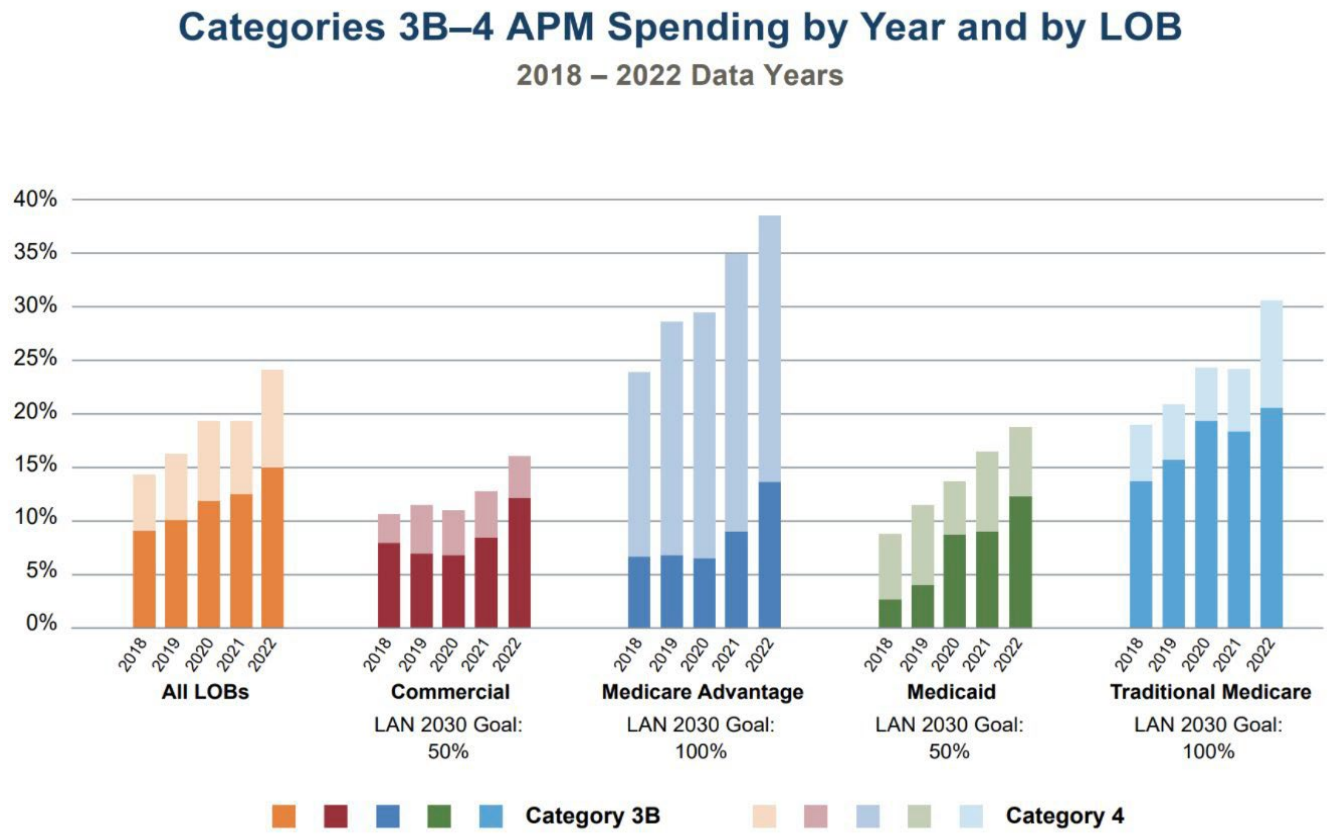
Data Interoperability

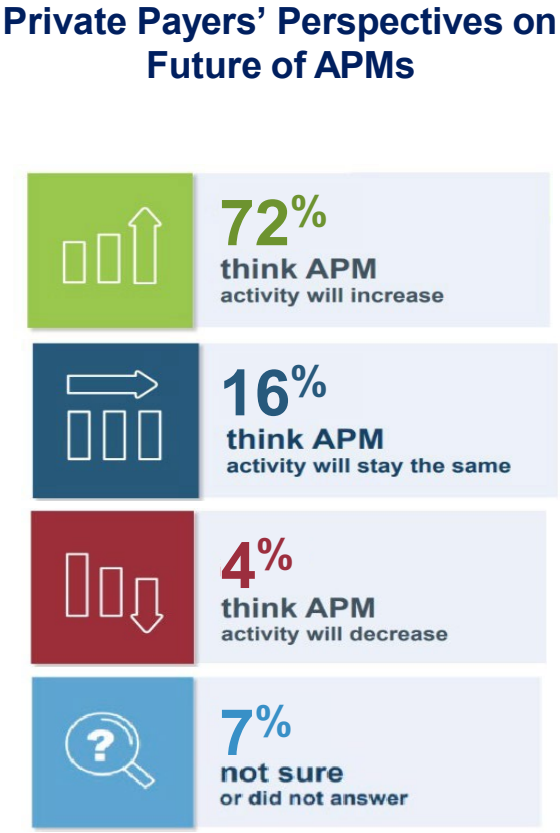
- **EHR data standards: FHIR-based data exchange using USCDI, USCDI+ standards**
  - Data definitions and standards are now CMS EHR requirements
  - "Bulk FHIR" exchange methods using APIs can support bulk data exchange among providers and with health plans
  - But not yet widely used for sharing such data for improving care or reducing administrative burden of coverage determinations and payment – still based on nonstandard forms, faxes, and claims ("encounters")
- **Secure data sharing mechanisms: TEFCA, QHINs**
  - Set the "rules of the road" and provides data infrastructure to facilitate timely and accurate data exchange
  - Adopted by growing number of health information exchanges and some major EHR vendors
  - Standards extend to payers and payer data to support care management and payment based on access, quality, & utilization

Promising Directions for Value-Based Payment Reforms

- Reforms with total cost of care accountability, especially for primary care practices – Medicare SSP and AIM, BCMA AQC
- Mandatory reforms not voluntary "pilots" -- TEAM, ASM, CJR-X
- More aligned payment reforms across payers focused on total cost of care accountability – MD AHEAD
- Aligned value-based benefit reforms with price and quality transparency – Pubished employer models
- Well-defined and targeted interventions to address nonmedical drivers – Medicaid NC HOP, FoodSmart published reform evaluations
- Clear and reliable long-term path to support increased investment over time – Medicare SSP + LEAD to improve payment reliability contracting, MA reform goals
- Specialty care integration into TCOC models

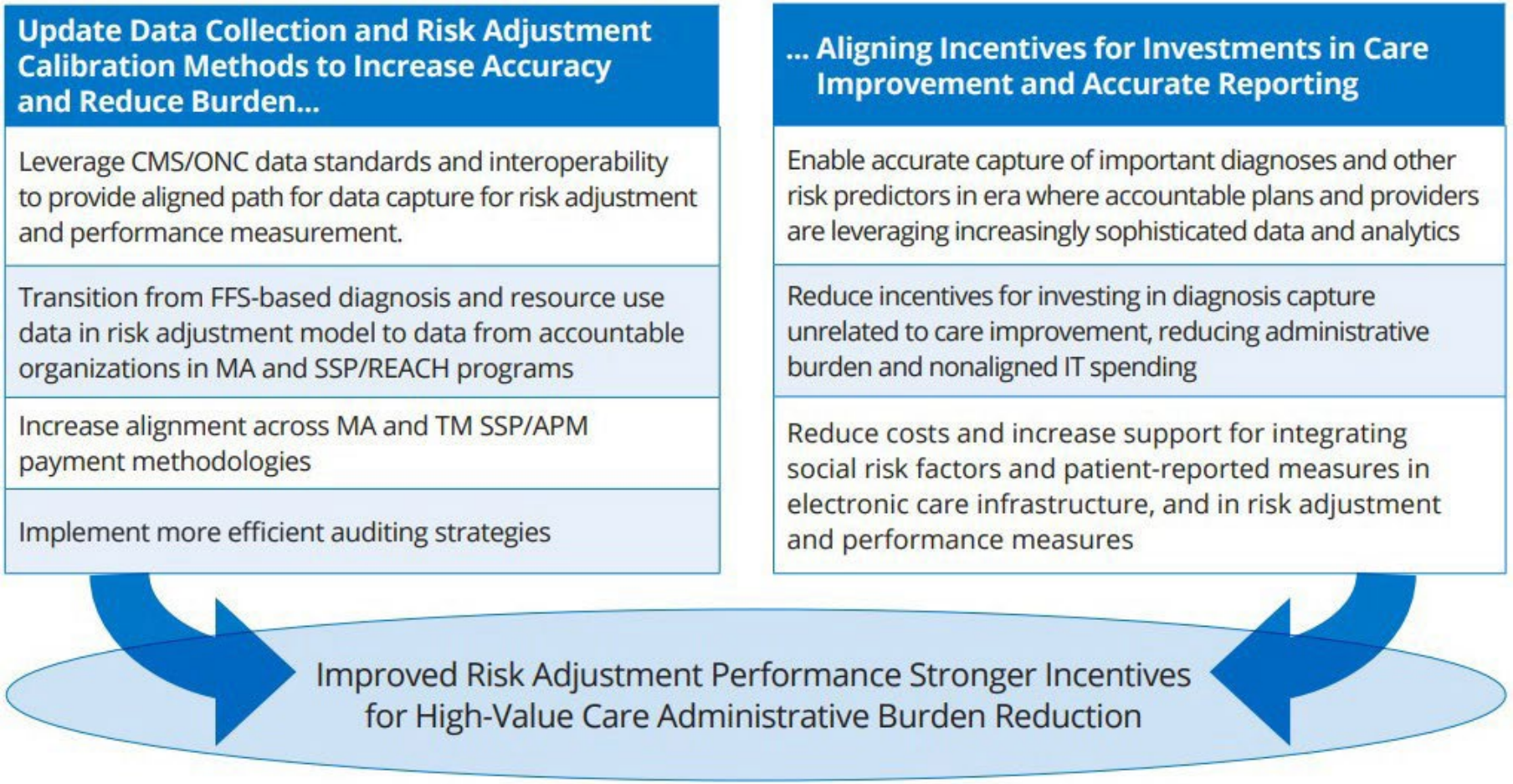
Growing Use of Alternative Payments – Mainly for Primary Care





Source: https://hcp-lan.org/workproducts/apm-methodology-2023.pdf

Key Principle for Modernizing Investment Incentives in Accountable Care Reforms



https://healthpolicy.duke.edu/publications/modernizing-medicare-risk-adjustment-and-performance-measurement

Duke | MARGOLIS INSTITUTE for Health Policy

The Future of Digital Health and AI

Great Potential

- **Administrative** applications enable improved patient experience, reduced clinician burnout, and significant reductions in labor costs
- **Clinical** applications – starting with decision support tools and extending to clinical care delivery – to improve care access and quality, and patient outcomes
- **Supports for smaller and less-resourced care providers** and increasing direct-to-patient (and direct to consumer) tools improve access and affordability
- **Transparency** on performance, safety and value of AI solutions across locations and patient populations enables informed and confident adoption

Achieving the Potential

- **Unbiased and accurate data** are available for AI training and in using AI applications
- **Financial supports** reward adoption and diffusion of AI that improves patient experience and outcomes, reduces costs – including by less-resourced providers
- **"Assurance" collaborations** support sharing and refinement of best practices for governance: AI transparency, appropriate uses, privacy/security, and ongoing assessment in use
- **Shared assessment platforms** enable secure data analysis of safety, effectiveness, and value using and appropriate evaluation methods evaluation methods