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 Ave. S.W.
Washington, D.C. 20201

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Tuesday, September 15, 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
JOSHUA M. LIAO, MD, MSc*
WALTER LIN, MD, MBA
KRISHNA RAMACHANDRAN, MBA, MS
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

A-G-E-N-D-A

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

8:59 a.m.

*** Welcome and Co-Chair Overview - PTAC Recommendations for Transforming Health Care Delivery Through Value-Based Care Day 2**

CO-CHAIR MILLS: Good morning and welcome to Day 2 of the public meeting of the Physician-Focused Payment Model Technical Advisory Committee, known as PTAC. I'm Dr. Lee Mills, and I'm one of the Co-Chairs of PTAC, along with Dr. Chinni Pulluru.

Yesterday, we had a number of experts share their perspectives on PTAC's draft white paper, *Transforming Health Care Delivery Through Value-Based Payment Models and Care: A Roadmap*. The Committee has made considerable effort to include a wide variety of perspectives in this two-day public meeting.

Later this morning, we'll have a public comment period and welcome participants to share a comment related to the meeting's topic. As a reminder, public comments are limited to two minutes -- three minutes each. If you have not registered to give an oral public comment but

would like to do so, please email ptacregistration@norc prior to the public comment period today at 10:50 Eastern Time. Again, that's ptac registration@norc.org. Then the Committee will discuss our comments related to revising PTAC's draft white paper and recommendations for the report to the Secretary of HHS[1].

*** PTAC Member Introductions**

CO-CHAIR MILLS: Because we might have had some folks here today who weren't able to join yesterday, I'd like the Committee members to introduce themselves and share your name, organization, and relevant background. And I'll start. I'm Dr. Lee Mills. I'm a family physician. I serve as Chief Medical Officer at Aetna Better Health of Oklahoma, one of the state's three Medicaid plans. Spent most of my career in operational leadership in medical -- specialty medical groups and health systems, where I had the privilege to operate and lead five or six different CMMI[2] pilots over the years, depending on how you count. And now 10 years on the health-plan side, where we've been leaning into value-based care and contracting heavily

1 Health and Human Services
2 Center for Medicare and Medicaid Services

under a current state statute mandate to increase the percent of spend in primary care from 3 percent to 11 percent over a three-year time period. So next, I'll turn to Chinni.

CO-CHAIR PULLURU: Hi, everyone. I'm Chinni Pulluru. I'm a family physician and health care executive. Spent much of my career building and scaling value-based care models at Duly, which is one of the largest multispecialty physician organizations; then at Walmart Health, where I led clinical transformation and value-based care initiatives; and, most recently, at Stellar Health, working on national ACO[3] strategy and clinical engagement. Today, I'm working from the patient consumer side, cofounded Agentic Healthcare, where we're creating a health care system for patients and consumers to help with a complete medical record, benefits clarity, and using agentic technology to navigate to partner with providers for high-value care. Thank you.

MS. HARDIN: Good morning. I'm Lauran Hardin. I'm a nurse by training and Chief Integration Officer for HC2 Strategies. HC2 is a mission-driven firm really focused in working

3 Accountable Care Organization

deeply in Medicaid innovation, cross-sector community collaborations to serve complex populations, rural health transformation, and value-based payment. My background includes innovation in models with early design of children's hospice, one of the first palliative care programs, complex care model that scaled to six states within the Trinity Health System. And I was part of the team that started the National Center for Complex Health and Social Needs at the Camden Coalition. I've worked with communities, states, government, multistate health systems, and very tiny rural frontier individual organizations designing approaches for complex populations.

MR. RAMACHANDRAN: Thanks, Lauran. I'm Krishna Ramachandran, Chief Information Officer for UnitedHealthcare Operations and Experience. Health care for 24 years, payer, provider, and technology sections. Fifteen years of it has been in value-based care in various aspects from model design to care delivery work, as well as analytics-type work, as well. So good to see you all.

DR. BOTSFORD: Good morning. I'm

Lindsay Botsford. I'm a family physician in Houston, Texas. I serve as the Regional Medical Director for Amazon One Medical, supporting our practices in the Midwest and Texas and continue to see patients as a primary care physician in Houston. For the last five years, I've also served on the governing body as the Chair of Iora Health network, now One Medical Care network, which is an ACO REACH entity, which has delivered shared savings over the last five years.

DR. LIN: Good morning. I'm Walter Lin, Founder of Generation Clinical Partners, a medical practice that is focused on caring for frail Medicare beneficiaries in nursing homes and assisted living facilities. We have participated in a number of episodic and total cost-of-care models from bundle payments to MSSP[4] programs to PACE[5]. And I'm also currently serving as the Clinical Chief Strategy Officer of LTC ACO, which is the original ACO focused on LTC --long-term care beneficiaries.

CO-CHAIR MILLS: Okay, thank you. And now we'll go online. Josh.

DR. LIAO: Good morning, everyone.

4 Medicare Shared Savings Program
5 Program of All-Inclusive Care for the Elderly

Josh Liao, internal medicine physician and National Associate Vice President for Clinical Transformation at Ascension, where I lead remote patient monitoring, digital engagement, other technologies deployed around population health and encompassing the care of groups including Medicare, Medicaid, and VBC[6] populations; have done work generating evidence-leading strategy, implementing different programs related to a bunch of the models that PTAC has talked about and convened and engaged stakeholders with. And I'm looking forward to continuing the conversation today.

CO-CHAIR MILLS: Thank you, Josh. And David.

MR. TYSON: Hey, good morning. My name is David Tyson. I'm the Senior Director of Policy & Regulatory Affairs at Novant Health. It's an integrated delivery network of 21 hospitals and thousands of providers, primarily in North and South Carolina. Among the many health policy areas in which I focus, I partner very closely with our pop. health and value-based care teams as we navigate Alternative Payment

6 Value-based care

Models across all payers. So we have about 700,000 covered lives in value-based arrangements, including MSSP, MA[7], and commercial contracts. I've been on PTAC for about a year now, so I'll be celebrating my one-year anniversary soon. So happy to have you all join us this morning.

CO-CHAIR MILLS: Thank you. Dr. Larry Kosinski and Dr. Henish Bhansali were unable to join us for this meeting today. Now I turn it to Chinni.

CO-CHAIR PULLURU: At this time, I'd like to take a brief moment to acknowledge and recognize seven PTAC members who have already or will be leaving the Committee this year: Dr. Henish Bhansali, Dr. Jay Feldstein, Lauran Hardin, Dr. Larry Kosinski, Dr. Josh Liao, Dr. Walter Lin, and my Co-Chair and partner in crime here, Dr. Lee Mills.

For many of these departing Committee members, they've served on PTAC for the past five to six years. On behalf of PTAC and ASPE[8], I'd like to extend our sincere gratitude to all of these departing members for their time, their

7 Medicare Advantage
8 Assistant Secretary for Planning and Evaluation

contributions, and the outstanding work during their service on this Committee. Those of us who are remaining are excited to welcome new PTAC members later this year. We will definitely miss all of you guys. Back to you, Lee.

CO-CHAIR MILLS: Thank you, Chinni. Today we've got a great lineup of experts on the panel who help us understand and continue the discussion of PTAC's recommendations on value-based care that are laid out in the Committee's draft white paper. PTAC's draft white paper and other materials related to the public meeting can be found on the public meeting registration site and on the meetings page of the ASPE PTAC website. Following this public meeting, PTAC will prepare a final version of its white paper to submit in a report to the Secretary of HHS.

As a Federal Advisory Committee, PTAC will base its final white paper and recommendations on information that has been shared or discussed at the open public meetings. PTAC's final white paper will be posted on the ASPE PTAC website. I'd like to note, as always, the Committee is ready to receive proposals or innovative approaches and solutions related to

care delivery, payment, and other policy issues from the public on a rolling basis. We offer two different proposal submission tracks for submitters, allowing flexibility, depending on the level of detail of the payment methodology, and you can find information about submitting a proposal on the ASPE PTAC website. And now I'm excited to turn this over to Walter to welcome and facilitate our first session.

*** Session 4: Expert Input on PTAC's Recommendations on Value-Based Care: Part 4**

DR. LIN: Thank you, Lee. Hello, everyone. I'm Dr. Walter Lin, one of the PTAC members, and I'm happy to say we have invited four esteemed experts to share their perspectives 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 four experts today, including our two in-person session participants. And for our two remote participants, please go ahead and turn on your video if you haven't done

so already. 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 discussion. Presenting first, we are pleased to welcome, in person, Mr. Marc Boutin, who is the President and Chief Executive Officer of IVI, the Center for Innovation & Value Research. Marc, welcome.

MR. BOUTIN: First, thank you for the opportunity to be here. I appreciate the time with all of you. My name is Marc Boutin. I am the CEO of IVI, which seeks to transform health care through a shared definition of patient- and whole-family-centered value. I began my career many years ago as a civil rights attorney. About five years in, nearly everyone in my family was diagnosed with a different disease over a period of just two and a half months. I found myself helping them to navigate doctor's appointments, health care insurance, and eventually, clinical trials. A few years later, they all passed away. Half of them passed away because there were no effective treatments for their conditions. The other half passed away even though there were highly effective treatments, but we couldn't get

access to them in time.

Unfortunately, too many people experience health care tragedies like that. While they were dying, I was diagnosed with cancer for the first time. I started volunteering with the patient advocacy community and found myself really enjoying that work and eventually went to work for them. I set up the patient advocacy function at the American Cancer Society, went on to become the CEO of the National Health Council, an umbrella organization of patient advocacy organizations, where we helped to drive the creation of the Patient-Focused Drug Development Program, PCORI[9], and the elimination of the preexisting-condition exclusion.

From the National Health Council, I moved to Novartis and set up their patient-engagement function. And through some really interesting impact measurement, we were able to demonstrate that patient engagement, the involvement of patients and families throughout the life cycle of medicine's development, was really good for patients and families, good for

9 Patient-Centered Outcomes Research Institute

health care systems, and really good for the bottom line. Come back to the nonprofit world, where at IVI we have a core value that is, we look at the root causes, not the quick fixes. And when I look at the recommendations, you guys have done a pretty good job.

You've covered a lot of ground with a lot of items. I think you should feel really, really good. However, we're doing what we do all the time in the United States, and that is that we ignore the big pink elephant in the room, pretend it's not there. And the elephant really is that for the last 80-plus years, we've been reforming payment delivery regulatory systems without actually agreeing across all stakeholders what are we trying to achieve.

You know, the United States is really, really unique, and for decades we got access to the best medicines, best treatments, best doctors. We were known for that. But the reality is, people are having significant challenges accessing what exists. Where we used to get access to innovation first, most of it is denied first time around. Data is quite compelling. And we are the only country in the

developed world, where we intentionally insert friction into the system as a mechanism to control cost. What universe does that make sense?

When you look at the cost, medical bankruptcy is still the number one cause of bankruptcy. You can be somebody caring for a loved one who is sick, working a job, raising kids, trying to live your life, and working full-time with the administrative burden of trying to navigate health care. When you look at constituents across the country, they are complaining, and they are unhappy. But the reality is, the evolution has occurred over time, and we simply accept it as normal. But as somebody who's lived abroad for quite some time, in four of the current reference countries for Most Favored Nation, I can tell you, you don't get access to the best innovation, but you get access to care the same day, without friction. Something's gone awry in the United States.

I think, more importantly, we continue to define our outcomes incredibly narrowly. The reality is, people living with disease and their family caregivers, they want to live their best

life possible. And I can tell you they do not live their lives to get a pre-authorization approved. They don't live their lives to see their doctors. We love you, don't get me wrong, but we don't live our lives to see you. The reality is, patients experience health care through episodes. Sorry, patients do not experience health care in episodes. They experience for the rest of their lives.

They want to ensure that the clinical outcomes that matter to them are addressed, but they want their mental health addressed. They do not want financial toxicity. They want their family to be stable. And if you look at families now, the numbers of children deciding not to go to college, deciding to go to a college near home, living in a different location than they want, these are all issues that are going to impact them for the rest of their lives.

At IVI, we're looking at three major policy domains, some of which you've covered quite well in your document, but I would argue not fully covered. We need to look at the core outcome sets and really define the measures that are relevant to patients and families. And as I

said earlier, that goes well beyond the clinical outcomes. And we need to codesign them with patients and families, and we need to hold our health care systems accountable for them. We need to ensure that we have the right systems in place, incentives, and oversight to hold the multiplicity of health care systems accountable in the U.S.

And I'll go back to the issue of preexisting-condition exclusion. At the time, everybody said that was impossible. We couldn't possibly do it. It could not work in the U.S. The U.S. system was too complex. It can work if you account for adverse selection, if you account for how we value the plans. There are ways to do this that allow us to create a system that focuses in on long-term outcomes.

Imagine for a second if people were in plans for five years. Imagine if you were in a plan, and you had a high-value, long-term intervention, and future plans had to reimburse for that. We can make this sustainable and create a system where plans are competing on the long-term outcomes. And imagine if you do all of that with patient engagement, true bidirectional

decision-making patient engagement, not just looking at the color of walls or did I do a good job. You start to create a system where the recommendations you put together in your report, they don't work around the edges; they truly integrate into the health care system and create monumental impact.

Last thing I want to say is this: Everybody in the health care system says that they are patient-centered. Twenty-five years ago, none of us said that. It was the patient community that inserted itself and said, Look, you got to do better. And then it became kind of paternalistic and a pat on the head. The reality is, most patients and most families do not think we are patient-centered. They recognize that this is big, big, big business, second only to technology. Technology only took it over recently. This is big business, and the reality is, patients and families are the poorest and weakest stakeholder in the health care continuum.

We need to focus on whether or not what we do truly restores them to control over their own lives and destiny. That takes a longer view than simply addressing the issues in a short

window of time. The question for me is not whether the recommendations are good. They are really good. You did a really good job, and we're going to tinker around the edges today, and I look forward to the discussion because I have some specific thoughts.

The question really is, are they sufficient? Without a shared definition of patient- and whole-family-centered value, we simply continue to try to optimize a health care system that was never designed to deliver what matters most to patients and families. I look forward to our discussion and congratulate you on your report. Thank you.

DR. LIN: Thank you, Marc. We are saving all Committee questions until the end of the presentation. Next, we are thrilled to welcome Dr. Reena Duseja, a Physician Executive at Oracle. Reena, please go ahead.

DR. DUSEJA: Thank you so much. Marc has given us really a compelling picture of what the system should ultimately deliver for patients and families. I want to focus my remarks today on what has to be operationally true for us to get there. Patients experience health care as

one journey, but we organize that journey through separate encounters, contracts, records, and handoffs.

And too often, it really is the patient that is the person trying to connect all those pieces. So my central point really today is that value-based care cannot run on a fragmented system. If an organization is accountable for the patient across 365 days, then we must have the information, the responsibility, and the measurement have to work across those same 365 days. Next slide.

I've seen the same gap from several different parts of the system. In emergency medicine, I saw it at the bedside, especially when patients were moving between settings and no one had the whole picture. At CMS[10], I saw how payment and measurement influence what organizations actually prioritize through their regulatory levers. And at the VA[11], I saw that quality and safety improvement depends on a learning system. So not simply a retrospective dashboard with data that's two years old.

And in my current work, I see what it

10 Centers for Medicare & Medicaid Services
11 Veterans Administration

takes to really connect the data, the people, and the workflows in practice. So the test I applied as I was reading this report is pretty practical. Is the right information visible? Is responsibility clear? And is there a feasible next action? So -- next slide.

So I think, just like Marc, I think the destination is right. You know, population-based total cost of care does create that right kind of longitudinal organizational-level accountability. The key point here is -- but financial accountability does not automatically create operational accountability. So let me make this concrete. Consider a patient that's going home after a heart failure hospitalization. The hospital changes the medications, the cardiologist updates the treatment plan, and the primary care team just may not get the full picture in time.

So who's left to kind of connect all these pieces is the patient. They're left with several instructions, appointments, precautions for return, but there's no clear owner for what happens next. So we have an organization that's accountable for the patient across the year, but

the next action is still fragmented across teams. So we have the patient year as the unit of accountability, and the encounter is still the unit of the workflow. And we cannot keep expecting our patients to be the integration layer. Next slide.

So what would it take to fix that? The first point I want to make is that accountability without capability becomes unfunded responsibility. Organizations cannot build care management teams, longitudinal data capacity, safety infrastructure, and new workflows on unstable economics. We need to have predictable benchmarks that make investment rational. We need prospective support that makes investment possible before savings appear. And then graduated accountability, as the report nicely outlines, really does give organizations a realistic path into risk.

So, in other words, our payment models need to purchase an operating capability, in my opinion, not simply enrollment in a model. And that pathway can be identical, obviously, depending on where it's being practiced, whether it's a rural area, physician-led ACO, or an

integrated delivery system. Our goal really is to have the broad, equitable, and sustained participation, not participation at any cost.

So my next slide actually gives the heart of my recommendation for the Committee. We need to translate financial accountability into accountable operations, and I think there's a simple way to test that. One, can the team see it? Do they have the timely events and the longitudinal context needed to understand what is happening? Second, does someone own it? Is there a named person or team responsible for the next action, including review and escalation? And third, does the system close it? Do we know that the referral, the result, the transition, or follow-up was completed? Or if appropriate, was the work escalated when there's an unmet need or gap?

And I don't mean to imply that that means one person owns everything. I think primary care should often anchor the longitudinal plan, but the appropriate care team owns the work, and then the accountable entity should own whether the system functions and whether the loop is actually closing. And so ultimately, we want

to have a one-patient, one-counsel longitudinal plan and clear ownership of the next action. Next slide.

So, I think the good news here is that much of the core technology to do this is already available. And certainly where I sit at Oracle, I see this day in and day out. Although we know that it's unevenly implemented today, we can exchange clinical and claims information; we can provide event notifications; we can share care plans. We can also, albeit it's not actually -- it's fragmented, but we can track referrals and transitions with technology, and we also can communicate with our patients, the care teams and patients across settings.

But the point I want to make is connectivity is not coordination. Coordination means the information reaches the person who can act, responsibility is clear, and the action is tracked to completion. In my current job, I certainly see AI[12] actually has made this much easier by summarizing, prioritizing, predicting, and routing. But the point I want to make here is that AI cannot compensate for fragmented data

12 Artificial intelligence

or an undefined workflow or unclear human accountability. So the policy gap is not simply the absence of tools; it is that models do not consistently resource, govern, and measure connected operations. Next slide.

So once we define the operating model, measurement should follow the workflow, not sit beside it, as it too often does today. I actually think that measurement actually has three different jobs. First, external accountability. Is the whole-population value improving? Second, model evaluation. Is longitudinal coordination actually working? And third, internal improvement. Where is the workflow breaking down, and what should the teams change?

And I would also add a measure budget, so that for the external metrics, we should replace, retire, consolidate for every new one that comes in. So we're not continuing to add to the measures that PTAC mentioned in the report. And also, I think that core set should be linked transparently to payment, and those measures should really allow for feedback returning when they're still timed out, which right now we know

many of our measures do not do. Next slide.

Safety is where this becomes really real. And so my point really here is that many series failures occur exactly where information and responsibility change hands. And those are coordination failures, and they are safety failures. So at a minimum, the system has to detect the unresolved risk, assign responsibility for the response, and learn from what happened so the same failure is less likely to reoccur. So I strongly support the report with stronger safety incentives, but the design cannot reward underreporting or penalize organizations simply because they are better at finding harm. Last slide.

So I will leave you with three changes. First, let's make the transformation investable. Second, let's make responsibility longitudinal. And third, let's make outcomes and safety longitudinal. Investable means predictable economics and accountable prospective support. Longitudinal responsibility means see it, own it, close it across settings and models. And longitudinal outcomes mean a small, meaningful portfolio with timely feedback and

transparent links to payment.

And I also would add, when we have multiple CMS models touching one patient, the expectation should be that there should be one reconciled plan, explicit roles, coordinated outreach, and a closed-loop action. I think the next chapter should not be more financial risk layered onto fragmented care. It should connect the payment, information, responsibility, patient support, and the governed technology across the journey. And this is how I see accountability become factual and how value-based care becomes real. Thank you.

DR. LIN: Thank you, Reena. Next, we are excited to welcome back in person Mr. Sean Cavanaugh, who is Chief Policy Officer at Aledade. Welcome, Sean.

MR. CAVANAUGH: Thank you very much for having me. I'd like to start by saying, it's kind of cool to be back here. As you mentioned, I've testified -- I think this is my third time testifying before PTAC, and I've followed some of your other meetings, as well. So to have provided input to the Committee, to have heard other people's input to the Committee, and then

to see a work product come out of it that clearly reflects a little bit of what I said, a lot of what other people said, is kind of satisfying. So I appreciate the opportunity to give you sort of my final observations before you publish the paper.

As you mentioned, I'm the Chief Policy Officer at Aledade. I'll tell you in a second a little bit more about Aledade, and I'll be bringing that perspective to my comments. The other perspective I bring is I -- prior to Aledade, I've worked for CMS for six years, three years at the Innovation Center. In many ways, PTAC was created to bring more input into the activities of the Innovation Center, and I worked there before you existed. Would have greatly benefited from the input of this Committee. And then three years at the Center for Medicare, where among all the payment rules I was responsible for included the Medicare Shared Savings Program.

But just briefly about Aledade, because I think we're a microcosm of a larger point I'd like to make. We help run physician-led ACOs around the country. This is -- you can

-- you know, we like to say you can see Aledade from space. These are all the practice locations. So thousands of practices across the country, largely independent primary care, which includes quite a number of community health centers. But also increasingly, we are working with health systems, as well.

We're very fortunate. We've been in the program since 2015. In 2024, we generated gross savings of about $1 billion collectively for the program, improved quality. But the important thing is not just what we've done, and this is a map showing the health professional shortage areas that we've worked in. And I think this is an important part, not just of Aledade but of the Medicare Shared Savings Program. I'm a student a bit of CMS and its history in value-based care. CMS has a long history of running a variety of demos in value-based care, many of which were successful at single site, single provider, meaning, there are people who can do extraordinary things, and where they often stumbled was trying to take it from that one site, spread it to other providers, other types of providers, other providers of the same type.

One of the extraordinary things about the Medicare Shared Savings Program is, it has been successful nationally across many different geographies. We are largely primary-care-based, but as I said, we're increasingly working with health systems. So there are different provider types have come together and been successful. So I really appreciated that in the report there was a recognition of the importance of total-cost-of-care models, ACO models, and even the specifically mentioning the Medicare Shared Savings Program.

But I think we should -- my first recommendation in -- well, my first recommendation in that regard is, could have gone deeper, could have been more specific, and I'll get to that in a second. But I foolishly took your instructions quite literally, and you asked for recommendations on the structure of the report. And this -- I'm drawing on my experience at CMMI, the way I reacted when people came into CMMI -- I needed to know one -- first of all, before they got into what I should be doing, I wanted to know whether our values were aligned. Were they driving at the same -- were they trying

to accomplish the same goals?

I think in many ways it builds on the work you're talking -- do we have the same conception of value? So I -- when I opened the report, I was looking for a statement of values from PTAC, which I think I know them because I followed your work, but I'm not sure someone naive to the report would know. So that's actually in many ways asking you to go to a higher level, so more abstract. But then when I was at CMMI, I wanted people then to quickly go the opposite direction. All right, we're aligned. I think we're aligned. Then, these recommendations are all wonderful. I'm not sure I could find one I disagreed with.

But I think you could get -- to be more useful, you could get even more granular and more specific. Don't tell me to have more outcomes-based measures. Tell me which measures I'm supposed -- I should be using that I'm not using. Tell me which measures I should throw away. And maybe the PTAC is doing that separately in offline works, but I think it could really make the value that this Committee and its report for future work really helpful, both

publicly but also specifically to the agencies that it's advising.

But to return to MSSP, I think one of the untold stories is the success of the MSSP. The report both points out the successes but also that it's not quite as successful as everybody hoped. I was one of those people that had grandiose expectations of the model. As I've grown older, seen many models try and fail, look more of the history of CMS and models, I've grown to appreciate the success more. One, when we started, literally, there was a question of whether people would show up. We now have 14 million Medicare beneficiaries in some type of ACO model. Clearly, there's an appetite for it.

There are repeated studies that it saves money and improves the cost of care. I have a quote just from this year's CMS proposed rule that says that when MSSP increases, they see quality improvements and increased savings and trust. Not as much as any of us like. We've got a million ideas to make it better. The reason I bring this up is, I think both the report and many of the recommendations could be more focused on, this is the program that is sort of -- that

we're building around.

It's not a finished product. There's plenty of work through PTAC. Many of the recommendations are still applicable just as written, but be more specific that this is -- and we've given this advice to CMS, as well -- this is the mother ship that we're building around, and there's a lot of challenges, and PTAC has taken on some of those. But I think grounding on this program and any similar models, the kidneys ACOs, the CMMI ACOs, would be helpful.

Then there's three other areas that, some of which you touch on, some of which you don't, that I thought I'd like to expand on a little bit further. Risk adjustment has gotten a lot of attention in recent years, but so much of the public debate around risk adjustment is between CMS as a payer and Medicare Advantage plans. Is it being optimized? Is it being gamed? Is there fraud? Even if there isn't fraud, is it achieving the goals? Clearly, the public policy perception is that risk adjustment is broken between CMS and the plans.

There's a lot of things happening. One of the repercussions of that, and I'm

partially responsible for this, is, when we turned and did risk adjustment in Medicare Shared Savings Program and other models, we use the HCC[13] model, but we shackle it. We say, well, risk can only change by a certain amount in quarters. Because the thing is, we fundamentally don't believe it's measuring true risk, and we don't want to pay for things that aren't real. But this -- but essentially, so we're -- I mean, the failures of risk adjustment are not just between MA and the plans, but it's permeating the entire program, and it's undermining the future of any of these payment models.

So I'd love to see PTAC spend more time on particularly not just plan-based, because there are plenty of people, but what does it mean for physician-based models to get -- what would a better risk-adjustment system look like? Less gameable, truer, more accurate measure, less selection, whatever the concerns are. I'd love to see that perspective in the risk adjustment discussion.

Next, a lot of what PTAC talks about, to their credit, and a lot of what CMMI and CMS

13 Hierarchical Condition Category

have been talking about is, yeah, MSSP is working, but there's not a dearth of specialty involvement. And that's true in the Aledade ACOs. And CMS, to their credit, have tried repeatedly different initiatives, data sharing. They're now proposing this thing called CARA[14], where CMS will administer bundles and other relationships.

They're trying a lot of policy-oriented fixes. What I want to suggest is that I think they're missing, and I didn't see it in the report here, what we've run into -- which are very practical problems. So the first is, when we run a primary-care-based ACO and go out to local specialists to talk about, hey, we're now in an outcomes-based model; we'd like to share that accountability with you. There's no interest. Specialty groups are not asking to help us bear risk on accountability. And I think that's because our doctors often entered the ACO models because fee-for-service was failing them.

A lot of specialists are not at that point where they feel fee-for-service -- they may not think it's a perfect system, but they're not running toward risk, which is something, you

14 CMS-Administered Risk Arrangements

know, inherent to the ACO model. So, one, before you even get to tools, are you aligned? And I don't know what the public policy response to that is, but I don't think that's acknowledged it. Our conversations just don't get anywhere.

Second, and you do, to your credit, get to this, and CMMI gets to it, but we've made very little progress -- is one of the problems with the ACO model is, we periodically go through rebasing, where very successful ACOs have their benchmark come down dramatically. And when we try to -- whether it's specialists, care management groups, or any external partner that we try to work with, when we explain, like, oh, by the way, five years from now, most of this revenue disappears, and we're all starting over again, our docs understand it, don't like it, but the external docs don't buy it. And that ends a lot of conversations, too.

The last thing, and, again, I don't know what the public policy response to this is, but I think this is a real hurdle. If we have a very large ACO next to a very large specialty group, we still have, at an episode level, very little overlap. The patient numbers get very

small very quickly. And so CMS has offered to help build bundles and so forth. But for -- if you want to -- and we have the capacity to do it ourselves, the numbers get small and very unreliable. And so there's just an operational challenge to trying to be careful about pricing those things.

Lastly, and then I'll end my remarks, I applaud PTAC's attempt to refocus a patient and renew a patient-safety discussion. When I was at CMMI, some of my colleagues, I can't take credit for this, launched the Partnership for Patients, very national, very successful patient safety, and I feel like a lot of the momentum from that has dissipated. I love your effort to renew that. This gets kind of granular, but in the paper you referenced, maybe we could use something akin to the Health Care Innovation Awards to launch that. I would discourage that as a model and ask PTAC and the ASPE staff, who actually were involved in Partnership for Patients, to look at Partnership for Patients as a more collaborative regional approach to patient safety, as opposed to a grant -- a competitive grant-making process.

I think the Partnership for Patients allows an ongoing dialogue and for things to adapt over time where federal grant-making like we used through competitive grants is a very rigid structure where people are obligated largely to stick to what they originally set out to do. Partnership for Patients was much more flexible and allowed more collaboration between the government and the recipients. And with that, I'll just thank you so much for inviting me.

DR. LIN: Thank you, Sean. Last, we are happy to welcome Dr. Robert Wachter, who is Professor and Chair in the Department of Medicine at the University of California, San Francisco, and my former medicine attending. Please go ahead, Bob.

DR. WACHTER: Good to see you. Thank you so much for having me. I'm going to take my opportunity to really focus on AI, which seems to me to be the most potentially disruptive force here and one that really can move the value-based movement in, I think, a positive direction. But obviously, as with all things, AI is somewhat complex. Let's go to the next slide.

So I wrote a book about AI meets health care; it came out about six months ago. And when you write a book, you look for thought leaders to give you blurbs. And this is Eric Topol, a best-selling author, cardiologist in Southern California. And Eric's blurb for the book was an engaging, hype-free case for informed optimism. And I'm going to try to leave you with that sense that we should be optimistic about AI in health care, even though, obviously, there are a lot of reasons to be concerned about AI in the news these days.

But I think in the specific use case of health care, and I'll talk more about why I feel this way; we should be optimistic. And one of the sources of optimism for me is that the system is stuck. So to a very large extent, value-based payment has been around the corner for 25 years. You've heard some examples of where it is working, but I think we all know there's much more that can and should be done. And my argument here is that AI provides an opportunity both to move things along in value-based payment and also to support it in ways that really are somewhat unique.

I think Reena made the compelling case that we need to have the data, and it needs to connect through the system in new ways. We heard about new models of care that really will move this along. But I think AI may be the disruptive force that sort of gets us over the line to make value-based payment sort of the reality as the dominant way we pay for health care in the country. Next, please.

This is a Gallup poll from a year ago. It's matched by more recent polls. In fact, things people have gotten more sour on AI. But what this basically shows: Orange is you think AI is going to have a net negative impact on society. Green is people who think it will have a net positive impact. And what you see is, people are pretty grumpy about AI in general. And obviously, this has gotten worse in the last year or so with the push against data centers and in the last month, the Hugging Face hack and the Jacob Coxon memo from Anthropic about the potential risks of unfettered AI.

So there's a lot of negativity about AI out there, and it's understandable, and I share a fair amount of it. The one area in which

the public is enthusiastic about AI is in health care. I think they recognize its potential, in some ways unique compared to almost every other aspect of society. People recognize the potential for AI to do far more good than harm, and I share that view. Next, please.

And why is that? Well, partly because the new AI, generative AI, large language models, et cetera, is really quite good. I'll give you a demo in a second. But I think it's also important to recognize the unique attributes of health care that make us a particularly fertile ground for AI. And in fact, many of the obstacles that I saw in -- hinted at in the PTAC report, really relate to things that overwhelm the health care system with data and connectivity and ability to analyze all of the data coursing through the veins of the health care system.

And this is the way I think about it. November 29th, 2022, that's the day before ChatGPT was released to the public, it wasn't like I or anyone else that I know was saying, I need a better search tool than Google. In fact, I personally couldn't imagine a better search tool than Google. Google seemed to me to be the

epitome of search. You put something in a box, and you get a bunch of blue links, and you're good to go. And then the next day, ChatGPT came out, and it was like, wow, this is better. This is a better way of doing search. And obviously, the tools has become much, much better over the last four years.

And I think a lot of AI in our life, and part of, I think, the pushback about AI, is it is offering potentially incremental improvement in many fields, like search. But it wasn't like people were desperate for improvement in those areas, whether it's in travel or retail or finances or search. Next, please.

However, health care is different than those fields. And I actually don't know anybody on November 29th, 2022, the day before ChatGPT was released, that said, you know, the health care system is just perfect. I can't imagine anything better. And no patient, no family member of a patient, no doctor, no nurse, no policymaker, no health care leader said that, because they wouldn't be sane if they said that. We all know the health care system is wanting in every aspect, whether it's quality or safety or

convenience and access or equity or cost.

Just to give you a few quick examples of where it was obvious, at least to me, that the health care system needs AI in order to perform at the level that our society is asking it to. This is a wonderful drawing that a seven-year-old girl did about 10 or 12 years ago of her recollection of the visit to the doctor. And you see her on the exam table, mom, sister in the corner. And then in the far corner, this was what she recalled of the pediatrician, his back to her typing away. It's a wonderful depiction of the modern state of medicine. The only thing she got wrong is the smile on the doctor's face, because I can tell you, as a physician, no one is happy having been turned into an expensive data-entry clerk.

This is a problem that AI is now fixing in a scalable way. Many of us at UCSF[15], where I work, all have access to an AI scribe. Most of us use it. Most of us find it quite satisfying. It improves our efficiency, but more importantly, it improves our ability to focus on patients, and patients notice this, as well.

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Next, please.

That's one of the data problems, which is the data we collect in the visit with a patient. A bigger problem, in a way, is in order to take care of a patient, I need to know their past history, their surgeries, their medications, what's gone on before. Most patients that we see have pretty extensive past histories. This is a wonderful study that came out a year ago. What it showed was, one out of five adult patients has a medical record longer than Moby Dick. If you've forgotten your classics, Moby Dick is 600 pages long. The idea that I will be able to review this in detail and not miss things in the two or three minutes I might have before a patient visit, of course, is a cruel joke on me and the patient. AI now can do this, review a 600-page chart in a few seconds, summarize it, and do it relatively accurately. And it's getting better and better. So here's another data problem that is overwhelming and for which we need AI. Next, please.

And the third is, in order then to make a decision about the diagnosis or the right treatment, I need to look at the medical

literature. I spoke to first-year medical students yesterday at UCSF and told them, we're teaching you a lot of great stuff, but about half of it will turn out to be wrong in 20 years. There are 8,000 medical articles per day. There's no way a human can keep up with that. AI can. So these are three areas that doctor-patient or clinician-patient encounter in terms of what's wrong now. The patient's past history in terms of what their background tells us and the medical literature that require a tool like the new generative AI for us to get on top of, which is really why I'm so excited about it in health care. Next, please.

I'm going to do a quick two-minute demo for those of you that are not clinicians and haven't had a sense of how this works on how I interact with AI all the time. At this time, I'm not paid to do this. AI company is not paid to do this, so the health care system had to figure out how to find the money to allow us to use tools like this. But I -- these tools are being used everyday millions and millions of times by clinicians and increasingly by patients to navigate the health care system and to get useful

medical information. Next, please. We'll see if it works.

DR. WACHTER: I am taking care of a 35-year-old woman who presents with two days of shortness of breath, pleuritic chest pain, and a swollen left leg. She smokes, takes oral contraceptives, and had a tibial fracture that was traumatic two months ago that left her immobilized until last week. What do you think is going on?

DR. WACHTER: Searching the medical databases. Checking the clinical guidelines. Acute pulmonary embolism with a left-leg DVT[16] is by far the most likely diagnosis. She has, essentially, every major provoking factor stacked together: recent tibial fracture, prolonged immobilization, estrogen contraceptives, and smoking, plus the classic triad of dyspnea, pleuritic pain, and unilateral leg swelling.

Her pretest probability is high, so skip the D-dimer and go straight to CT[17] pulmonary angiography with a leg compression ultrasound to confirm the DVT. Get an ECG[18] and troponin to

16 Deep-vein thrombosis
17 Computerized tomography
18 Electrocardiogram

assess right heart strain and to keep acute coronary syndrome, aortic dissection, pneumonia, and pneumothorax on the radar, though those are much less likely here. If she's stable, start anticoagulation with a direct oral anticoagulant. If she's hypotensive, treat as high-risk PE[19] and activate your PE response team for possible thrombolysis.

DR. WACHTER: What's the point of getting the leg ultrasound if I'm getting a CT of the chest anyway? If I find she has PE, won't I assume that she has a DVT? And if her DVT ultrasound is negative, does that really lower the probability of pulmonary embolism?

DR. WACHTER: Looking into the clinical data. Good instinct. If CT pulmonary angiography confirms PE, you don't need the leg ultrasound to make treatment decisions, since the anticoagulation is the same regardless of whether you image the clot in the leg. Its real value is when CT is nondiagnostic, contraindicated, or negative, but suspicion stays high.

A positive leg ultrasound then lets you treat without further chest imaging. And

19 Pulmonary embolism

you're right that a negative leg ultrasound does not rule out PE, because many emboli have already left the leg or came from pelvic veins, so it can't lower your probability meaningfully in this high-pretest patient. So if you're getting the CT anyway, the ultrasound is optional up front.

DR. WACHTER: Great. Thanks very much. Okay, next, please. That's just to show you really how remarkable AI is today, and that may have been Latin for some of you, but I think you got a sense of how really conversational it is and how the answer I got from the AI is really no different than the answer that I would hope to get if I ran into a specialty colleague in the hallway and try to do what we call a curbside consult. This is Ethan Mollick, professor at Wharton, who writes about AI in work in general. And one of his mantras is, "Assume the AI you're using today is the worst you'll ever use," which I think is a reasonable way of thinking about it.

Next, please. So, just very briefly, want to toggle to, really, the topic today, which is, now that you've seen sort of how good AI is, how much we're using it and part of the reasons for its massive use is not only how good it is

but health care's really unique needs and data needs for AI. Here are some of the things to just mention to you because I think it's going to be important for you to integrate mature thinking about AI into your considerations in value-based payment, because I think this really could be the game changer. Talk a second about the cost paradox that AI might raise or lower cost depending on the payment game that has been created, the business case for AI. In fact, there may not be much of one under fee-for-service, and some of the things that AI can do that may actually facilitate or promote value-based payment.

Next, please. First, the cost paradox.

One of the hopes of course is, and maybe one of the most important things AI could do, would be to lower costs, total cost of care, through needing fewer tests, less administrative waste, better prevention, maybe some labor substitution, although this will be the subject of most labor negotiations going forward, and particularly, clinical decision support that one hopes guides physicians, and maybe patients, to

more cost-effective options. The problem to date is, under fee-for-service, AI appears to be raising the cost of care, in part because all the stakeholders are using it to create a return on investment, and that, in our current fee-for-service environment, means, quote, better billing: changing the notes to provide a higher payment rate, arming providers to succeed in the prior-auth war, finding more findings, which in fee-for-service may lead to greater workups, which leads to bigger payments, and of course somebody's got to pay for the cost of AI itself, because in most cases it's not reimbursed by the health care system. So, the current dynamic, even though AI continues to have, I think, the potential to lower total cost of care, the current dynamic under fee-for-service is actually raising the cost of care, which is not what we want to have happen.

Next, please. The second, how could AI help in a value-based payment environment? Well, AI creates the opportunity to improve quality and safety measurement because it can now do something that was impossible until five years ago, which is to, quote, read the medical record,

and so better than the garbage in, garbage out one gets when using administrative or billing data in order to, for example, measure a case complexity or measure quality or measure safety, AI now creates the possibility, at least, through being able to read the medical record, read the current note, et cetera, to give a much more, I think, realistic and much more credible measurement of quality and safety that should get better over time as we measure more and more patients through AI.

Risk adjustment can also be improved by reading the chart again, rather than reading the billing notes but looking at what actually is happening to the patient in real time. Might be not just the doctor's note but also vital signs, lab tests, radiology results, et cetera. Doesn't mean that gaming will go away. The gaming now begins to focus on the notes themselves, rather than on the documentation of diagnoses and complications, but it at least creates the potential of much stronger ways of doing risk adjustment.

And AI can also help in operationalizing value-based care, facilitating

panel management, closing care gaps. If you think about it, once we have a fully interconnected system and have robust AI working, the opportunity to really do population-based health, to connect with patients in new ways, to do prevention, to do counseling and coaching in real time, rather than dependent on the office visit, is really turbocharged.

So, lots of potential for AI to help make value-based payment real, do better risk adjustment, and actually much, probably the most important thing, actually make it real that we actually are improving health care value, in part by extending our reach. And also doing what I just showed you in that demo, which is allowing me, as a generalist, to practice in some ways above the top of my license because I now have access to specialty-level knowledge.

Next slide, please. And finally, just in some ways, the main point here is, I think AI may be a facilitator or promoter of value-based payment, in part because it demonstrates quite vividly the problems with fee-for-service. Under fee-for-service, health care organizations and AI companies are going to seek separate

reimbursement for AI tools. But it's probably not the way we want to pay for AI, that every AI tool I bring in, and it may be at the end of the day, I'm bringing in hundreds of different AI tools to predict and recommend, et cetera. Paying for each one may just be unworkable. And I think over time, AI-enabled tools and agentic AI will be so ubiquitous that separate payments will be silly. It'll be like going and buying a car and having a separate charge for an AI-enabled brakes, AI-enabled steering wheel, AI-enabled wipers.

At some point, you just have to say, what does the whole thing cost? And have you created an incentive, essentially a bundle, so that the parties involved have an incentive to use AI if it helps them provide better value, and they absorb the cost, and they know they'll recoup them if they provide better quality, better safety, and lower total cost of care?

Next, please. So that's the main thing I wanted to get across. First of all, AI is here to stay in health care. There are going to be obstacles, regulatory stakeholder concerns, liability. And now, I think this week

particularly, the general AI backlash is not going to -- health care will not be immune from it. It will slow things down a little bit, but I don't think it will stall it out. Plus, we'll inevitably have our KitKat moment. KitKat was the poor little cat in San Francisco that was run over by the driverless car by the Waymo. There must be hundreds of cats that are driven over by cars every day, but this one made international headlines. Why? Because even though Waymo has driven more than 250 million miles without a human fatality, just the running over of the cat in San Francisco becomes an international headline.

The same thing will be true in health care. There will be some moment where AI kills someone, and then that will become the source of some backlash. But I do think AI creates the best opportunity I've seen in my lifetime to rethink the payment system by offering tools that facilitate value-based payment, as well as challenging the fee-for-services way of paying for helpful adjunctive technologies. And I think AI does have the potential to bend the cost curve in the right direction. Maybe the most important

thing that it does of all the things it could do, but it will only do that if we change how we pay for care. And right now, under fee-for-service, I think there's a risk that AI will actually raise total cost of care, which is obviously not the direction we want to go in. Next, please. And that is it. Thank you so much for the opportunity to talk with you today.

DR. LIN: Thank you, Bob, and thank you to all our experts for those wonderful presentations. Now, let's move to the discussion portion of the session. At this time, PTAC members, please flip your name card up, or for our virtual Committee members, please raise your hand on Zoom if you have questions for our experts. Additionally, we want to encourage our experts to share any additional comments. You can signal that you have a comment by flipping your name card up or raising your hand on Zoom. In the interest of ensuring balance across different perspectives and questions, we encourage experts to keep each response to a few minutes. Krishna.

MR. RAMACHANDRAN: Hi all. Great job. Krishna Ramachandran. So AI and health care,

topic close to my heart and professional work, as well. Bob, we heard your perspectives that's very thoughtfully laid out on sort of the opportunities, as well as the current sort of trajectory there, as well. We've certainly been wrestling on this, like, pay or not pay, payment model or not aspect of it, and so I appreciated hearing your perspective. Love to get other panelists' thoughts as well on just where you think AI is going, particularly for value-based care and then just how we should think about payment.

MR. CAVANAUGH: I would just say briefly that I think the most important thing Dr. Wachter said was, and I'll summarize, context is incredibly important. So, we're in value-based care. We're embracing AI carefully but wholeheartedly because we see many of the things that were in Dr. Wachter's slides, which is, the potential is enormous. But the potential is enormous for whatever you do. And we like to think what we're doing is pursuing value; in fact, we are. And so the potential to improve quality, to improve efficiency is only limited now by our imagination of how to use it and by

the rate at which, as Dr. Wachter says, it gets better, because that's our sense is in the, you know, the last 12 months, we've seen the models we've been using improve.

And there's a number of examples I could give that I don't think were even mentioned in Dr. Wachter's slides, like, we're participating in the ACCESS[20] Model with CMMI. We're managing chronic kidney disease and other conditions. But just the communication with the patient, where we used to have call centers of humans calling and just saying, hey, you know, reminders, now having, you know, automated interaction, which patients largely embrace as less intrusive. And learning how to do that better and learning, it just allows you to scale positive interventions tremendously. So, we have a lot to learn, and I don't want to say, like, it solved these problems, but, like, it's given us a pathway on a lot of our value-based care initiatives that were unimaginable 12 months ago.

But by the same token, I used to work in a health system that was struggling. It was a fee-for-service machine, and I know a lot of ways

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I would have used this just to churn throughput. And then, as Dr. Wachter said, it seems like a gold mine for simply amping up the coding wars on both sides, because I, you know, I've seen as providers start using these technologies to better identify diagnoses, the payers are going to have to respond with AI to push back. And so, you just get more of the friction that Mr. Boutin was referring to.

MR. RAMACHANDRAN: To pay or not to pay separately, payment models, do you have any reactions there, sir?

MR. CAVANAUGH: To me, to pay or not pay, like stepping back in quality in particular and efficient -- we always talk about, we got to move more toward outcomes. And then, the notion that, oh, here's a new technology; we'll pay for the technology, seems so out of step with what we're trying to do. And also definitionally of what is it you're paying for and – Other thing, I put my old CMS hat on, like, how would I pay? Like, how would I value these actions that are so hard to even explain, like, what went into it? So, I lean heavily toward no, we pay for outcomes, and if you're smart, you're using AI to

achieve those outcomes. But it's not pay for it explicitly.

DR. DUSEJA: I would agree with that, if I may add. I think that, you know, I agree with Bob that AI doesn't have an inherent cost trajectory, but I think, you know, the purpose of how we're having this conversation today, AI certainly reduces friction. We've seen it reduce friction, including what Bob's mentioned with our customers in reducing administrative burden, cognitive burden. So, there's a lot of value there that, in terms of provider satisfaction, as well as patient satisfaction in care delivery. But I think, you know, in these models, I would evaluate it on the core principles of what we were trying to do, which is improve the coordination and the outcomes, the safety, as well as workforce capacity and avoidable total costs.

So, those are some of the things that come to mind. It's like the net value that AI can bring. And I'll lastly say that, you know, I think when you put AI on fragmented workflows, back to what I said in my presentation, it can create more friction and more issues. So, we

really need the, you know, the underlying tenets of the connected data to really see true value.

MR. BOUTIN: The only thing I would add is, AI has become an incredible tool for many people trying to navigate health. But the underlying system is still stacked completely against them. You know, I take a medicine for an autoimmune response condition that came as a result of a previous cancer treatment. It is on the World Health Medicines list of essential medicines. When I was at Novartis, which used to be part of Sandoz, I knew how much that medicine cost, less than 0.03 cents per pill. Since I've been back in the United States, I have to go through three utilization management processes to get it, and then my out-of-pocket cost has been over $450 per month. Where does that make sense?

I've been a patient advocate for decades. I've worked in health care policy for a long time. Most people give up, and if I give up, I go on to a biologic, which is covered at a huge expense to the system. We have to look back at what the system is doing to people. The numbers of folks who want to work with you and be part of your high-valued care system are opting out

because they can't afford it. They're choosing between food, college for their kids, retirement. They get so frustrated after spending 20 or 30 hours a week, they stop.

If the end users, patients and families, cannot participate, even when they're using AI, you're only working around the margins. So, what I would say is, we have to step back and look at the system. Let's make it sustainable for payers. Let's bring in the value-based tools for the system and for providers. But let's eliminate the friction that has intentionally been put into the system that is now not serving anyone.

And the reality is, and I think a few people have said this, we're all frustrated. Nobody's happy. Payers have evolved or devolved into the most hated industry in the United States. That's not a comfortable place for them, but they're responding to the myriad of delivery systems that are in place. They don't have any choice. This is one of those few moments where we could actually all come together, where all the stakeholders are so frustrated but work to cross-solve each other's problems and truly

elevate outcomes for patients.

DR. WACHTER: I guess I'd add, first of all, I appreciate everyone's thoughtful comments. I, you know, recognize this is a very hard problem, and I completely agree that the system is incredibly fragmented, incredibly frustrating, filled with friction, and there's a risk that AI will just be a Band-Aid on that system, that unless the system becomes substantially cleaned up, it probably does help at the margins to help patients and families navigate it, but it's still a screwy system that needs to work better.

In terms of individual payments, I think that's going to have to be pretty nuanced. If we're talking about an AI tool embedded in a technology, I think in some ways it's analogous to other kinds of advances in technology where under fee-for-service, we had to figure out, you know, how do we price an MRI[21]? How do we price robotic surgery? Et cetera, et cetera. So an AI embedded in a mammography tool that demonstrably provides better readings and better outcomes, right now, there's no payment for that. There

21 Magnetic resonance imaging

probably should be, or there's no incentive for systems to purchase to spend the incremental money.

But the idea that we're going to pay incrementally for every piece of AI when AI is really ubiquitous and just marbled through every health care system, whether it's a primary care practice or a big academic medical center like mine, you know, we may be using hundreds of different AI tools that are doing everything from predicting to suggesting diagnosis to recommending tests to recommending therapies. There's just no way that it's going to work to say that, you know, that's an incremental cost of $0.37 because you used AI to predict the risk that someone's going to have a pulmonary embolism or tell you what the right treatment was. So in some ways, we have to sort of divide this into sort of AI embedded in existing things that we already pay for, where we probably do need to look at the incremental cost of that and see whether it's worth the benefit, versus the kind of decision support that I think is really the game changer here, where I think paying for it separately, I can't see how that can possibly

work.

MR. RAMACHANDRAN: Makes sense. Yeah. Great perspectives. Thank you all.

DR. LIN: I think next up we have Chinni.

CO-CHAIR PULLURU: This question is for Sean and then everyone else. So, Sean, first of all, I applaud you for getting us very tactical feedback on the white paper. You mentioned that there were some very specific things we should be on, and point well taken. You know, one of our people yesterday said the same thing, sharpen, not soften. But when we look at tactical things, you know, and the diversity of the sort of population out there, the archetypes, you know, urban, rural, small, big, employed, non-employed, providers, you know, all kinds of different things makes it very hard for us, as an organization, to specifically put that sort of tactical recommendations into policy. And so as a policy guy, my question to you is, what are maybe three things you would recommend if we were to put it in that would cover the landscape?

MR. CAVANAUGH: Yeah. And I think

that's a very fair question based on the input I gave. And I don't know that there's three things that would cover those bases, and then you wash your hands of it. It's probably more of an ongoing thing. But so, I'll talk to you about something existential that we've been dealing with in the ACO world, which is, when the first ACO model was tested at CMS, it was called the Physician Group Practice Demo. And it ran for a couple of years, and it was a moderate success, depending on whose evaluation group. But it's interesting, at the end of one of the evaluation reports, there's one sentence that said, you know, we never rebased; we never changed the benchmarks.

But if this ever became a permanent program, you need to rebase periodically, or you'd be paying for savings in perpetuity, period. And then Congress comes along, creates the ACO program, and says, you got to rebase periodically. And now, like MedPAC[22], Harvard researchers, a number of people have said, Actually, this whole notion of rebasing and constantly tying an ACO's benchmark back to its

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actual costs significantly diminishes their incentive to generate savings. And CMS just proposed some tinkering with this for next year. But I think this is an existential issue. If we're asking doctors, hospitals to fundamentally change their model away from volume and towards outcomes and value, but we've got this weird quirk that every five years, so now our doctors treat this money as sort of like a bonus, but not their business model, because they know five years from now, if they're really not -- if they're just okay or mediocre, the government's going to leave it alone. But if you're really good at it, the government's going to take a lot of that away.

So I think the notion of rebasing, and I think there's language in the report about, you know, long-term financial incentives, which I read as meaningless. But to get more granular and to see what CMS is proposing in this reg and say, this is good, this is not good, would, I think, the collective wisdom of the Committee could be, you know, influential in CMS discussions and others. And these discussions spill over. Private, you know, commercial

insurers have these value-based models. They often look to CMS as the model. They don't always follow what CMS does, but they often look like, how are other payers approaching this? And they plan similarly. So, there is sort of this existential issue. It reaches across different models, but it's most relevant in total cost of care. It's unresolved. On the one hand, observers think it's a huge disincentive to really generate savings. On the other hand, CMS is really nervous about opening the floodgates that they might just lose control of the program. So, having the collective wisdom of this Committee weigh in, who I think would be helpful.

DR. LIN: Would anyone else like to comment? If not, Lee.

CO-CHAIR MILLS: Sure. Sean, I want to pick up on something you said, which has kind of been a passion or obsession of mine for a while, which is just kind of the failure or the problems in risk adjustment, because, of course, you know, need to compare, whether it's a quality metric or cost metric across patients, and adjust for their disease severity is pretty critical. And you look at any given, you know, risk

adjustment system; I mean, there's no risk adjustment system with a prospective R squared more than about 0.2.

Any given system is, you know, bad to compare to the next system, which is equally bad or worse. So, I mean, I'd love to get more tactical and granular in our recommendations about what to do with risk adjustment. And so, we'd just love all four of you to, you know, give us your best advice about how to improve the risk adjustment, which is kind of a underlying leg of the three, you know, a three- or four-legged stool for value-based care, and yet it just fundamentally doesn't work.

MR. CAVANAUGH: So, CMS a while back had started doing periodic reports to Congress on risk adjustment and, in that process, had to adopt principles of risk adjustment. And they referred back to them periodically. I mean, even if this Committee were to review those principles and say, are these outdated? Are they even adhered to? Which ones I think are important for the future. I think could be helpful to weigh in and say, hey, this isn't just an MA plan problem, and point out where it permeates the system.

One big question I think that's floating out there that people aren't addressing: Everything CMS does in payment and risk adjustment quality measurement is very transparent, meaning consulting firms can spend a lot of money and replicate exactly what CMS did. Some people are talking about, well, maybe we should have an AI black box that does risk adjustment that looked at so many measures, but by the nature of AI, it won't generate the same result every time. And are people comfortable with that? Are people comfortable with if CMS used a more accurate but less transparent process? I've actually kind of, having been a public servant, I'm kind of nervous about not having a system that I could explain and say, and you can replicate it. But a lot of these AI models, I think, would involve giving up on some level of transparency.

And then there's a more tactical, like Zeke Emanuel and others at Penn have come up with a system they say relies on the current inputs into the HCC system but runs better models on top of it and generates better results. I think there's enough different areas that the Committee

could try to figure out where they can add, you know, what plays to your strengths to work at the level of principles or models or the principle of transparency versus accuracy.

It's not easy. I mean, if it was easy, we would've solved this problem. And then, I want to always acknowledge there is the technical aspect to risk adjustment, but we've seen, and I saw it when I was at CMS, and CMS went through it a couple years ago with V28[23]. There's a political element, too. Like any change, huge amounts of money flow one way or the other. And so, having people who are not part of the political system but just weighing in objectively, I think is always helpful.

DR. WACHTER: Yes, I'll chime in. I like that idea, Sean, very much, that the idea of it -- the trade-off between the transparency of, you know, demonstrable, reportable measures but then truly both gameable and not really credible, versus an AI-based system that looks at a million patients and in some ways is a little bit of a black box. You may not be able to tell what measures are being used, but more reliably says

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patients with this set of characteristics have a risk of death in 30 days or readmission or whatever of so and so. In some ways, I think we have to experiment with that. I don't exactly know whether that will work and whether it's feasible in an environment if you can't then articulate what the measures are and you're just saying, we're using this AI system to tell us, you know, truly get at what the risk of a large population of patients is, but it's a black box.

I think that's going to be very tricky, but it feels like the right direction. It feels like the direction that we've taken, which is we have to have a demonstrable set of measures that can be transparent and therefore are gameable. You know, everybody's going to focus on the coding to get to the right place, you know, a set of measures that may be less transparent, and we can't articulate what they are, but demonstrably are far more reliable in predicting the outcomes of a large population of patients. I think we have to experiment to see what that looks like.

And as, as you know, as he said, you're talking about huge amounts of money moving one direction or the other, so it's going to have to

be able to withstand a lot of political pushback if people don't know what the measures are. But the current system, I think, is not working, and it's certainly not credible to clinicians. I think clinicians feel like these -- I'm being measured on these things, and they get at a tiny sliver of the true quality of care that I'm delivering and either at the physician level or at the system level.

MR. BOUTIN: I think at the end of the day, we're talking about the outcome measures focused on the clinicians, which clearly the subject matter of what this group is supposed to do. However, they're all about the outcomes for patients and families. And patients are in your offices for a very, very small percentage of their time, and so much of their care is happening outside of your office. We don't have patient- and family-centered outcome measures integrated into this. So, we're trying to account for their outcomes through measures for physicians that are a tiny bit of what's actually happening in their lives, and that tiny bit has now been structured to make it difficult for them to access.

We need to flip it on its head. We need to think about what are those true outcome measures for families and patients. They need to be integrated into the health care system. The health care system needs to be paid for that. It needs to be a sustainable business model. It needs to be one that you can't adversely select out. That is where you're going to get to see the greatest change, the fastest. And when I look at some of the recommendations, some of the specific things, in Recommendations 5 and 6, you talk about long-term predictability for payers, health plans, and Accountable Care Organizations. What about patients and families? They could benefit from some predictability over the long term.

Recommendations 10 and 11, performance measures and patient experience and patient-reported outcomes and experience. All sounds good, but patient engagement has a fairly recognized definition everywhere outside of the delivery of health care, which typically is about, what did you think of my conversation with you? That's not true patient engagement, and it

doesn't get you to patient and whole-family outcome measures, which are going to allow patients to actually engage with you and the health care system to get the outcomes we're trying to hold you to account for.

Recommendations 18 and 19, we talk about usable patient data to promote patient engagement, structuring out-of-pocket payments in ways that incentivize patient engagement. But, again, who is defining that patient engagement? Because when I speak with the patient community, they don't feel like they're being engaged in any of these policy discussions. And they have a lot of really great insights on what will work and what will not work for them.

The reality is, they have the lived experience, and they can tell you what is going to help them navigate this. And you'll be surprised. When we bring patients in and we bring their corresponding physicians in and ask them about how they're experiencing care, the overlap is usually only about 50 percent. And when we send them back, and we ask them to prioritize which are the most important elements, and then we bring them back, the patient

community usually has their top three. You're lucky if you get one from the physicians. And that is because of all the life experiences they have when they're not in that 0.1 percent of the time with you and facing all the systemic burdens to try and get in there. We've got to relieve that if you truly want to get impact with the outcomes here and these value-based design models.

DR. LIN: Before I go back to Chinni, let me just follow up on that, Marc. So, when you asked us to reimagine the system, you named financial health and caregiver well-being as dimensions of value. And, frankly, neither appears anywhere in our white paper. What kind of specific recommendations do you think we should add to the white paper? I think you gave some examples, but are there kind of specific recommendations that we should include?

MR. BOUTIN: Some of the clear issues are, the impact on your mental/emotional health but also the impact on financial toxicity, as well as time considerations. At IVI, we've done work in a variety of these spaces, and you start to see that the time impacts can be huge. We

don't have good data on what that does to people's care, but we do see many people opting out. We see huge implications for families where children don't go to college, or they choose a community college, rather than an Ivy League that they got into, because they need to care for an ailing parent. All of those things have huge implications downstream.

When you start to look at value in the context of medicines, some really interesting emerging work where you may have an innovation that gives you some time back. But the innovation and the administrative burden and the time burden of taking that means you actually lose more time with your loved ones. And then in other situations, we're seeing some innovations that, whether it be surgical or pharmaceutical, where you will get substantial time back because you're not in the health care system, you're actually at home healthy and functioning, and yet we don't award that or treat that as high-value.

We've got to start to take a step back and truly understand what are those outcomes that patients want. You know, one of the examples I've used in the past is, when you look at end of

life, we're so designed to throw everything at people, and the reality is, most people don't want that care because it takes them away from their loved ones. It takes them away from what they want to do.

Now, I have a parent who was treated extensively for cancer, told at the beginning he had about two years to live, went through rounds of chemo and radiation and surgery. He lived two years. He also lost the dexterity in his hands, and his livelihood was repairing antique clocks. If we sat back and looked again at the outcomes that matter to patients as a whole and then at an individual level and held our system accountable for that, you're going to get a different kind of integration in the system.

DR. LIN: Thank you. Chinni.

CO-CHAIR PULLURU: This is for Dr. Duseja and the rest of the panel. You know, as you think about Oracle and, you know, you guys are obviously a massive HR vendor but also have been doing a lot of work with AI within workflow.

This is a two-part question. First is, how would you think about compensating for various aspects of technology, whether it be AI

or remote monitoring of certain things brought in within a value-based system? Or should it just be outcomes, like Sean had mentioned? And two, you know, one of the things that we often don't see besides alerts that none of us docs like is a real intentional implementation of safety within workflow from a technology perspective. So I guess, how do you think about those things?

DR. DUSEJA: Well, thanks for both of those questions. So for the first one, I would say, and I have in the appendix some thoughts around this, around AI implementation, that I do think that there is a risk of promoting AI adoption without actually having it tightly linked to outcomes. I think it's actually critical. There is a lot of training and adoption to use these AI tools responsibly. I think there needs to be safeguards with those.

So, the way that Oracle has approached it is, we put the human in the loop. So, there needs to be a source whenever there's, like, an AI-generated summary, for example. And that allows for almost the ability to say, well, do I trust this information if I'm going to use it in clinical decision-making or not? And so that

governance piece is really key, not only from the technology company but also for those that are implementing the technology. So, I think that I would say that first.

Second, with regard to the compensation, I firmly believe that we should be really monitoring this based on outcomes. So, AI is an accelerator, but we really want to be looking at how is AI actually, in the looking at total costs, improving the total outcomes for the patient panel or the population.

With regard to intentional workflow or not, I think we're seeing kind of two things happen in the health system right now. When you're seeing AI tools being used by providers or system administrators, if it's done on a fragmented platform, I think it can create harm. And so, I think there's an opportunity also to really think about the underpinnings of the platform itself and why there is true importance of having that unified platform.

Once that is achieved and you have more of that connectivity, then we can start looking at using these tools into the embedding this of

the workflow. And that actually, I think, is going to be what's going to signify success in this journey of AI. We can't have another workflow that is just another window where, you know, a provider has to, like, turn from what they're doing to be able to access the AI tool. And that's been our, you know, strategic position that it needs to be embedded into the workflow.

DR. LIN: Anyone else? If not, Lee.

CO-CHAIR MILLS: I'm diving into a little bit deeper series of thoughts that, Marc, frankly, something you said about, you know, the only system in the industrialized world that specifically chose to use friction at every layer of the system as a cost-control strategy, it was really insightful. Never thought about it quite like that before, despite having had a career focusing on reducing the friction for, you know, providers and plans and everything.

So I guess let's dive into that a little bit, and, you know, I'd love just from each of you if PTAC can be a little bit more tactical and more specifically focused on ways that an APM[24] or a physician-focused model or ACOs

24 Alternative Payment Model

can reduce friction to improve outcomes for our society. So, what would be your favorite or least favorite, depending on how you look at it, source of friction, and what would you advise we recommend to reduce friction?

MR. BOUTIN: So, I think we need to start with defining what are the outcome measures that we want to use. And we've done some work on outcome measures that look at burden and friction for patients and families, but it's still pretty new. There's a lot more work that needs to be done. So, I think as a starting point, it's what would those outcome measures look like? And then, how would they be applied across health care systems?

Again, the challenge we have here is, in the United States, we have a multiplicity of systems, and we need to make sure that we can create a sustainable business model. And I'm looking at your face, and I want to be clear I understood the question because I've really severe hearing loss, and my hearing aids are in the shop. So, I'm only getting about 25 percent of the conversation. So, did I get your question correct?

CO-CHAIR MILLS: Well, yeah, absolutely. I guess as, as specific as you can be lets us be more specific in our -- so, you know, is there a specific point? Is it enrollment? Is it risk adjustment? Is it metrics? Just what, what can we do in the system for value-based care to reduce friction and for every participant?

MR. BOUTIN: Yeah. I think it's start with our outcome measures, but the outcome measures need to be the measures that address the friction points that are most important to patients and families. And those friction points are going to be: How do they access care? How do they pay for care? How much time does it take to navigate it? How much utilization management processes are they having to go through? Understanding how an insurance product applies to them.

We all think back. Many of you are younger than I am, but insurance used to be quite simple. And for our health care providers, navigating that with us was relatively easy. And that has evolved over the last 40, 50 years quite dramatically. And for me, coming back to the

U.S. just in the last five years to see how much it has shifted further, where trying to get insurance is challenging. Once you have the insurance, trying to get providers that are covered or in network, trying to deal with getting the appointments, trying to deal with the utilization management just to get to see a specialist, not to mention the medications, it becomes a full-time job. And it's all in a language that we don't understand.

And one additional recommendation I have for you here is, put this report into plain language. You know, there are millions of people that are interested in this, but it's written in a foreign language for them. And the reality is, they're all talking to their policymakers right now, many of whom are in midterms. We'll have a presidential election. And this country, every 12 to 15 years, comes back at health reform. The timing of your report couldn't be better. But let's not just accept where we have ended up. Let's remember where we were not that long ago and where we could be. So, let's start to identify what those burdens are. And the burdens are not the same in rural America. They're not

the same for disparate populations.

We need to take the time to actually understand what those friction points are, generate the outcome measures, and hold ourselves accountable. And the accountability needs to make this sustainable for payers. You know, the days of saying, it's all your fault, it's all your fault, which is what we've done in the health care system for decades now, doesn't work. Every stakeholder is hurting right now. And that gives us an opportunity in the environment to come back and look at this a little bit differently. But we've got to identify the friction points, identify the outcome measures that we want to hold ourselves accountable to.

And again, they're going to focus on time, financial toxicity, and emotional and family well-being, which is something that we've ignored. But the reality is, there are outcome measures that get at that. But families dissolve as a result of these crises. Bankruptcy creates divorce, creates estrangement from family members, and their outcomes just simply go down. And it's not equal across different populations.

MR. CAVANAUGH: Yeah. I really

appreciate the term "friction" because, as Medicare Director at CMS, I felt like I, you know, ran a system of friction. Which is when we created new codes or new services, the first thing we did was say, you can only use it in these circumstances, and we're going to audit you. And, like, it was as much about what you can't do as what you can do. And what I think CMS has been a little slow to is when -- and that's all built because we know without those great governors on this, some providers are going to run amok and bill it like crazy, and we'll have a cost problem, worse cost problem than we have.

However, when an ACO accepts accountability, both clinical and financial, the need for a lot of that friction goes away. And CMS has acknowledged it in very targeted ways. ACOs got flexibility on telehealth long before others did and a couple other areas. But most of those rules still apply even in an ACO context, and they don't make sense. So, you know, we've got a couple that we've shared with CMS about areas where, like hey, the fee-for-service rules should be loosened for ACOs. And I'm sure PTAC,

if you solicited public testimony, could get many more. But I think that's one area of friction that could go away. Hey, someone else is at risk now. We don't have to be as regulatory and friction-oriented as the traditional program. That's one.

The other is, the beneficiary perspective, which you've done a great job of raising. A lot of our practices -- so our practices -- one of our simple strategies is transitional care management. Patient gets discharged from the hospital. We give that notification to our doctor immediately, get that patient in, make sure they understand their new meds, make sure -- manage their transition back to the community. But that patient who just got discharged from hospital, probably paid significant bills, is like, hold on. I think I know what I'm doing, and if I come in, I got a copayment and deductible. But we're like, no, it's the right thing to -- this is good for you. Why when we tell them something that's good for them, they incur a financial liability?

And so this theme of -- and I've been talking to a lot of my friends in the patient

community. There ought to be an agenda of what's in it for the patient. Now, there is a lot in it for the patient. They're going to get better care and so forth. But what tangible removal of friction do the patients get for doing the right thing in accountable care? And I think a lot of it should be is financial. So we have it on annual wellness visits. It’s easy. There's still some friction getting people in for annual wellness visits because they're like, I'm not sick. Why am I coming in? The transitional care visits, chronic care management, a lot of the codes that CMS has created are great, potentially great, don't get great take-up because there's a lot of rules around them because the patient has a liability even when they do the right thing.

DR. LIN: So, we're out of time, but I wanted to give Reena and Dr. Wachter a chance to comment if they wanted to.

DR. DUSEJA: Yeah, go ahead, Bob, and then I'm happy to.

DR. WACHTER: Yeah. I guess the -- sort of hearkening back to what was talked about earlier, I think this has to be a time for experimentation largely around what can AI do to

enable the kinds of changes that you've been seeking and we've all been seeking for a while. I'd say the two areas really are going to be sort of case-mix adjustment and quality measurement. We now have the capacity to take those two areas, which really are fundamental to any revisiting the payment system and moving to a value-based payment, we now have the capacity to do it in a very, very different way than we ever thought possible.

And I don't think we know enough, for example, on this issue of transparency and explainability in the black box. I don't think we know enough to implement the change today, but I think we do know enough to create some large-scale experiments that really tell us, do we now have the ability to do better and more credible case-mix adjustment? Maybe that's less gameable but potentially less transparent in terms of the measures. And do we have the ability to have outcome measures that really reflect, better reflect, the actual outcomes that we and particularly importantly patients and families care about? I think because so much of the data to get at that was embedded in written words in

charts, we couldn't really get at it until we had LLMs[25]. We now have them, and I think we've got to really invest in some research to understand how we could remodel value-based payment with better and more credible measures on both case-mix adjustment and on outcomes.

DR. DUSEJA: So, I agree with all that. I would just add just a couple of things, given time, that, you know, the measuring often right now is based on encounters. And so, we really need longitudinal data. So, that's going to be really important to get to the value that we're all achieving. And then second, I think we need to still -- I'll just take it back to what I said in my presentation, that we need to really assure that we have closed-loop accountability. I think that's really important to help reduce friction, as well.

DR. LIN: Thank you. And I'd like to thank all four experts for joining us this morning to kick off Day 2 with some great discussion and for sharing your valuable insights and perspectives. You're welcome to stay and listen to as much of the meeting as you can. At

25 Large language models

this time, we have a break until 10:50 a.m. Eastern Time. Please join us then as we welcome public stakeholders to share their comments on our meeting's topic. Our day will then conclude with a final Committee discussion.

(Whereupon, the above-entitled matter went off the record at 10:44 a.m. and resumed at 10:54 a.m.)

*** Public Comment Period**

CO-CHAIR PULLURU: Welcome back. At this time, we have our public comment period. At present, we have four people who are signed up to give a public comment. I'll announce your name and your organization, and if you're here in person, please come up to the microphone to begin your three-minute comment. If you have dialed in, our moderator will unmute your line so you can deliver your three-minute comment. So first, I'd like to open it up to Lisa Ard, Managing Director for External Affairs for ChenMed, who's here in person.

MS. ARD: Thanks for the opportunity to provide public comment. It was interesting. I've watched your meetings online but never attended in person. Previously, you invited our

CEO, Dr. Chris Chen, and then, most recently this year, our CMO, Dr. Gianni Neal. So we really appreciate the opportunity and the work that you've done and that we've been able to give previous input to the organization. I added a couple of comments. In three minutes, I'll make it short.

Last week, I was in three of our medical centers. I like to get out in the field. I spend so much time in D.C., and we get in this well-intentioned echo chamber, and sometimes we lose the thread. So it's really important that I always get back in our medical centers. And I'm sure many of you are familiar with ChenMed. We have 200,000 patients. We're in 111 medical centers in 12 states. And the Chen family are one of the original pioneers in value-based care. They took on full risk before the risk adjustment system existed.

And so there's lots of stories from the family about that. So they've seen this really evolve, the ups and downs with it, of the whole system, particularly in Medicare Advantage. One of the things that strikes me when I'm in our medical centers is, we do something every

morning in stand-up: It's called stand-up in each of the medical centers, and they do what's called the ChenMed Way. And the first part of that is the urgent pursuit of more good days.

And they review what's going on, and they'll say the name of a patient and every single worker, and they'll go, oh, because, you know, sometimes you have frequent flyers; sometimes you have patients that have ongoing issues. And I love that the most because I think when you look at your Recommendation 2, that's what ChenMed does. What you're describing the ideal is, I could say it is embodied in the ChenMed way and how we operationalize that. So I added that in because we do genuinely try to keep patients at the center.

But, as you know, we provide all of our care as a provider in the Medicare Advantage program. We do not participate in ACOs. So while I appreciate many of the recommendations, I think they're great recommendations. We're fully supportive of ACOs. ACOs are facing the same types of challenges that full-risk providers and Medicare Advantage are. But I do think that the report -- you know, I'm reconfirming what

Jennifer Podulka and Mike Chernew said yesterday -- I think the report under-indexes on the importance of Medicare Advantage.

I think it should have equal treatment and recognize, you know, we see care-delivery models in traditional fee-for-service, but then you have full-risk ACO models, partial risk, and then you also have partial and full risk in Medicare Advantage. I'd love to see that teased out a little bit more and understand the benefits of each model in your report and understand the challenges and barriers.

And then really the idea of, how do we create incentives? Whether it's in traditional Medicare or Medicare Advantage, to move providers along the value proposition, not payers, providers, you know, because this is where the rubber meets the road.

The secondary thing I wanted to address is quality measures. You know, we talk a little bit differently about quality measures between traditional Medicare and Medicare Advantage. We think that -- but I did hear some similar themes. We think that quality measures need to be radically simplified, and they need to

be directly aligned to outcome-based care. I think was it Dr. Lin yesterday, you said there's only one measure today that even measures outcome-based care, and that measurement really is failure, right?

It's readmit rate, and have we failed or succeeded at it? And so I think there needs to be a discussion of can we tie care directly to -- in our quality measures? Patients certainly need an input, but the facts are the facts. Have we achieved our goal of, under a total cost-of-care model, better managing care? It has to be both.

And then finally, I wanted to address, somebody brought up yesterday, and it's been a raging debate for the last five years that I've been involved in Medicare Advantage, and this will be my final comments, is that someone brought up the difference in cost between traditional Medicare and Medicare Advantage. There's been an ongoing narrative, but I don't think it's settled. Certainly, there is a differential in cost, but I wanted to call out three specific things that have surfaced in the last few months.

MedPAC themselves, in their March 2026 report to Congress, said, oh, when we said there was a 120 percent differential, there's actually a 114 percent differential. So, they, on their own accord, said, "We maybe didn't get it quite right". Number two, CMS officials came out, and they said post V28, there's only about a 2 percent difference between payment traditional Medicare and Medicare Advantage.

And then third, a report was just published about favorable selection, and it says that it's been overstated. Generally, you're seeing in the literature that it's 10 to 15 percent. This report says because of the way that it was estimated by using switchers, that was an inaccurate proxy, and it's more like 3 to 4 percent. So in evaluation of the data, I think it's important that we recognize Medicare Advantage provides a lot of value in addition to what traditional Medicare provides.

Now, you can set aside that debate of whether traditional Medicare and ACO should have access to the same types of benefits. I think that's an important discussion to have, and maybe they should. But I don't think that the

narrative is settled in quite the way, and so it's another reason I think that Medicare Advantage is an important part of this conversation. So thank you for your time. I appreciate it.

CO-CHAIR PULLURU: Thank you, Lisa. Next, we have Ms. Natalia Barolin, who is the Assistant Dean of Health Policy and Advocacy in the Johns Hopkins School of Nursing. Natalia, please share your comment.

MS. BAROLIN: Good morning. Thank you all for the opportunity to comment. I'm speaking today on behalf of myself and my dean, Dr. Sarah Szanton. And we're speaking today as nurse leaders. Our remarks do not reflect the position of Johns Hopkins University or the health system. Prior to this role, I also served as Senior Advisor and Model Lead for the Accountable Health Communities model at the CMS Innovation Center. And as many of you know, Dean Szanton developed the CAPABLE[26] intervention, which has demonstrated a 7-to-1 return on investment for Medicare.

We are now together developing and piloting a new model of care called Neighborhood

26 Community Aging in Place—Advancing Better Living for Elders

Nursing, where we place a registered nurse and a community health worker in neighborhoods block by block to provide integrated clinical and social care. I've been really heartened to hear the conversation this morning around getting more detail and refinement, particularly around measures. And we really want to commend the PTAC for the vision articulated, particularly in Recommendation number 2.

We support that direction wholeheartedly, which really echoes a lot of the work that we've been doing for a long time and that Dean Szanton has been leading. As you all know, decades of evidence, including our own Accountable Health Communities model and the Dean's CAPABLE, have shown that proactive care that addresses the whole person and providing support to address social needs while investing upstream improves outcomes and reduces cost. But as other commenters have said today, the devil is really in the details, and right now the infrastructure to deliver on that vision doesn't exist. The report defines the total cost of care as Medicare Part A and Part B expenditures alone and channels accountability through organizations

bearing risk against a cost-trend benchmark.

That architecture rewards utilization reduction within attributed population over a plan year. And it really isn't built to recognize prevention that pays off over years or value that crosses sectors like housing or education or care delivered really in community-based rural or nurse and CHW[27]-led models that don't fit neatly inside our existing Accountable Care Organizations or health system. The report itself and you all, you know, acknowledge this measurement problem, and that's great to hear.

So we urge you to go a step further than refining the existing measure set but recommend piloting an integrated cross-sector measurement framework, something we refer to as a health unit of value that would allow us to compare health gains per dollar spent across very different models, similar to the way cost savings are compared today. So while one program may overall cost more, it, on the other side, it improves health outcomes much more than another, ultimately reducing costs.

So, for example, this could mean that

27 Community health worker

it intervenes before someone gets sick, like addressing appropriate medication refills and ensuring that somebody has access to nutritious foods, both which we know improve health and prevent acute-care needs and utilization. Using a measure like health units could provide a mechanism to build in credit or value for those outcomes. This could also allow us to translate value from other things like increased worker productivity, educational outcomes, safer neighborhoods, and other things that have a broader societal benefit.

Without this, truly meaningful community-based and prevention-focused models will keep failing to clear the measurement bar. And it's not because we lack impact but because the bar was built to measure something else.

Again, a theme I've heard echoed in the conversation this morning. We'd also like the Committee to consider extending the new pathways concept in Recommendation 8 and the nesting concept in Recommendation 9 to integrate -- that's currently written to integrate specialty care, to really integrate community-based rural and nurse and CHW population health

models.

Right now, there's really no pathway for these models to integrate, and we're really seeing that in our own approach to sustainability for our Neighborhood Nursing model in real time as we try to engage with opportunities under AHEAD[28] and other accountable care models within our state. If we want this vision to be realized, we believe the infrastructure really has to be built, and this report is a good starting point, but, again, need to really refine the details on that. Thank you so much for your time.

CO-CHAIR PULLURU: Thank you, Natalia. Next, we have Robin Goracke, who's the Executive Director for ICARE. Go ahead, Robin.

MS. GORACKE: Hi, my name's Robin Goracke. I am the Executive Director of the Independent Coalition of Advanced Risk Entities, also known as ICARE. We're a relatively new organization. We're a coalition of organizations that take on full risk in Medicare Advantage but are not owned or operated by health plans. So we're bringing a unique perspective to this conversation. We've been following your work at

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PTAC for a while now.

We'll be submitting written comments that will give more detail. But what we really like is your recommendations that are really getting at setting standards for transparency, creating this pathway to financial viability. What we hear a lot from our members is a frustration with this take-it-or-leave-it proposition they often have with payers, where they lack some leverage in building these conversations where they can really have a robust dialogue with the payers.

And I think setting standards in transparency, just basic data transparency, as well as keeping the focus on transparency in pricing. These are two themes that I hear a lot with our members in the Medicare Advantage side, so it's really great to hear that in your recommendations, also keeping the center of this really at the organizations that are taking on the risk, to really see that their work is being recognized and honored, and it's not getting just absorbed in the system. I think a lot of times it's the work you guys can do in the ACO side of things, I think there's a lot of crossover that

could happen in Medicare Advantage.

So we would really like to see some of that standard-building and transparency be crossed over or bridged into the Medicare Advantage side. I think our members really are working hard to stay independent. I think MedPAC's statistic right now is one in five physicians remain in independent practice, which should be alarming to folks. And we really are working hard to create a better environment for independent providers who want to take on full risk and really want to grow in this space.

So we'll, like I said, we'll be submitting written comments that provide more detail but are really pleased with your work, and thank you so much for all that you're doing and this opportunity.

CO-CHAIR PULLURU: Thank you, Robin. We currently don't have any others signed up to give a public comment, so that will be the end of our public comment period. Over to Lee.

*** Committee Discussion**

CO-CHAIR MILLS: Okay, now the Committee will discuss everything we've learned yesterday and heard today. And then based on

this public meeting, PTAC will consider further revisions to the draft white paper, and recommendations will be submitted in our report to the Secretary. Committee members, please refer to the potential topics for deliberation document and your notes. And if you have comments, please flip up your name card. And for the members that are virtual, just raise your hand in Zoom, and we'll call on you in turn. So who would like to start?

DR. BOTSFORD: All right, I can go first. I think I'll group mine into a couple different categories. One are repeats or double-clicks from previous conversations, one are things that were somewhat new, and then maybe a couple that I think need further explanation. I think some of the repeats from yesterday were around exploring more around the themes of a smaller core portfolio. And then I think potentially even just with MSSP as the chassis, potentially, and we heard themes around longer runways needed, and I think longer tenure with plans and PCPs[29] and providers. Opportunity to have longer commitments sounds like a good start

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with some of the models, but at the patient level, the ability to switch year after year is a challenge.

And I think one of the commenters here also mentioned on a theme earlier on not all health improvements improve quality measures, but they may improve health outcomes. And those aren't necessarily measurable within the measurement periods, and some might cost more. So the fundamental challenge of ensuring we're lowering cost or improving quality measures in the near term may be folly. A couple new ones, although not inconsistent with previous conversations, is that rebasing is a fundamental problem to value-based payment.

And I liked the quote in particular from Mr. Cavanaugh around it makes it feel like a bonus instead of a business model, which is, I think, hits to our concerns about predictability and payment for people to really design systems around value-based payment. A cautionary note around AI running the risk of increasing cost if it's used in a fee-for-service world. And then, as it touches on safety in our previous conversation, just maybe this is not so new as a

reinforcement that we don't want to penalize for those that are better at finding harm.

So thinking about with caution, including safety in payment models. I think for ideas that need future exploration, I think risk adjustments; I think that's come up certainly in many of our theme meetings in the past but probably needs its own conversation around opportunities, especially with the advent of AI. Some themes around patient costs and high-cost care and waste and maybe models that help to reduce costs for the beneficiary are worth exploring.

And then I think we heard this yesterday, but maybe a stronger effort around using fee-for-service as an experimentation payment model and adopting some of the lessons from MA and that being an innovative payment model of itself. Thanks.

CO-CHAIR MILLS: Thank you, Lindsay. Who's next?

MR. RAMACHANDRAN: I thought that was fantastic. So plus one to Lindsay. I -- so I think the friction point that came up, which I thought was an interesting addition from today's

theme there, which I thought was an interesting way to think about what are we doing, how are we aligning incentives to reduce friction as well, I think is another important sort of topic to explore, as well. And then I thought I got more clarity, particularly in the role of AI, pay-for-AI piece. So that was good.

Good discussion this morning, as well. Going to use it as a sort of yet another tool, as opposed to trying to sort of nuance payments for it. So those were two big sort of additions I had from today's discussion. So --

CO-CHAIR MILLS: Thank you, Krishna. Lauran.

MS. HARDIN: In addition to the comments I made yesterday, there were some really striking themes today that I think are very helpful and inform the next phase for PTAC. So one of the strongest themes is, there's a real opportunity for a version two with more specificity with some of the things we learned from the comments here. Definitely a very strong theme about the importance of integrating patient-reported outcome measures and really integrated approaches, bringing a stronger theme

into this report about the role of patients, families, and really a whole-person, whole-family care approach.

One of the themes that we've repeatedly heard throughout our work is the importance of longitudinal care, longitudinal relationship, longitudinal data, and opportunity to go a click deeper on that. One of the statements from today that I -- that resonates very strongly for me is, in the land of AI and all of our opportunity with technology, connectivity is not coordination. And I think that's a very important theme to go a click deeper on, as well.

We've talked about interprofessional teams and workforce and team-based care, but we also have heard some really strong opportunities to take that another layer deeper about what does that actually mean? The technology is not going to make the relationships improve the outcomes specifically or make that continuity of care across settings. We've got to also have a deep investment in how we're looking at the people delivering the care, and I think Natalia's statements and comments at the end are very

striking to take that another level and start to think about how other disciplines have an opportunity. And we have an opportunity to articulate more clearly how that can be nested in models as an opportunity with workforce holistic delivery and really thinking deeply about community-based care and the integration of all of that.

I think that one of the things I'm left with, since this is the end of my tenure with PTAC, is what a rich opportunity this is to go further and the opportunity to bring in others to add another layer of specificity. Very valuable day today.

CO-CHAIR MILLS: Thank you, Lauran. Josh, you up?

DR. LIAO: Yep. So, again, another rich conversation this morning, and you know, as I take a half step back, I'll be a little bit longer today because it is also my last public meeting on the Committee. But I think, you know, I feel like we've heard a remarkable range of reactions to the paper. If I was to list out all my comments, it would take too long.

But I would just say at a high level,

you know, we've heard everything from kind of broad questions about what payment policy could and should be to really specific issues, patient vignettes, patient care, AI technology, day-to-day operations. So that range is really helpful.

But I would encourage us, as a Committee, to recognize, I think, while valuable, that breadth also creates a risk, which is that if our white paper tries to do everything, it may actually end up doing very little. And so I think that, you know, it needs a clear point of view, and it needs to be informed by the perspectives that we've heard. But I don't think it can be everyone's point of view.

And I think in that way, I think what I'm taking away from this is that, you know, being realistic about the role of our paper, you know, it's not the first paper to address these issues, and it probably won't be the last, perhaps not even for PTAC itself. And so, I think I would approach this contribution kind of with some ambition but also humility about how we can make kind of a set of points that kind of sharpens the conversation like the ones we've heard over the last day and a half but that gives

subsequent work something kind of to build on.

So I think, you know, taking that step back, I think the discussion I've heard this morning and yesterday really demonstrates that potential. You know, across the speakers' comments, I've heard really several high-level questions. After all this experience and years, we've learned a lot, but what are we doing with that? You know, why do familiar challenges persist? What should come next?

Given that today's arrangements reflect choices from many across the health care system, including the groups represented in these meetings, what responsibility does each group have to carry forward progress? And so I think these are the kinds of, like, conversations that this paper can start. And so I actually think that as we think about success of the paper and us as a Committee, I think trying to trigger those conversations is important, but trying to answer and capture every nook and cranny of that may not be that.

And I would worry that our contribution could be diluted if we try to tailor the content to every part of the stakeholder

community. You know, there are really important things, high-cost, low-cost providers, large and small, integrated or not, new entrants, established participants, rural, urban primary specialty care, et cetera, et cetera. Those differences really matter when I think about everything that I've seen, everything that I've heard the last few days. But accommodating those circumstances, I think, risks leaving the principles without a direction.

And so I know that's very high-level, but that's kind of the aroma that I'm taking from the last two days. So, you know, three things I would leave from this, and I hope the paper really articulates through its recommendations and its preambles, is that no payment approach is perfect, and none operate in isolation. So I've heard from different speakers, you know, fee-for-service, APMs, MA; they each have strengths, limitations, opportunities for gaining -- for improvements.

The incentives also overlap. You know, clinicians in MA can still be rewarded for volume. Our ACOs and bundle payments as we know them are really based on fee-for-service. So I

think, you know, I hope this paper helps look beyond the labels to how incentives actually drive the care. And I hope many of our speakers in this public meeting would agree.

I think the second of the three would be that alignment, in my view, requires kind of what I'm calling disciplined flexibility. You know, plans need product flexibility. States need and face different statutory constraints. You know, meaningful choice is important, and I think in a public interest. Yet, you know, these organizations working across these different groups, you know, alignment is also important. And so how do we preserve meaningful choices while reducing avoidable complexity?

Again, no one said that exactly in those words, but I heard a lot of that at this meeting, and I think that's something that I hope the paper will prompt in conversation and action to come.

And then the final kind of principle is that I think that, you know, while the content of our white paper really should be grounded in what people have called operational reality, including one speaker this morning, I think it's

important to recognize that as a Technical Advisory Committee with the kind of mandate that we have, I don't know if the paper can fully resolve those operational details.

And we've heard compelling examples of that, of aspirations and compelling ones at that, but that once you try to measure those aspirations, be it Patient-Centered Medical Homes or be it population outcomes, when you try to measure and regulate and certify and to make determinations on that, it gets much more complicated. And so I think acknowledging that is something the paper can do. I think completing it is a completely separate thing.

So, in sum, I think, you know, these are kind of the three principles I'm taking from this. I realize I haven't given any specific comments from this morning, but I'm really excited about the paper. I look forward to seeing how it evolves from here. And I think it has and it plays an important role, but it's one role in the broader arc, and I hope we can kind of achieve that point. Thanks.

CO-CHAIR MILLS: Thanks, Josh, for those insightful comments. Walter or David?

Walter?

DR. LIN: Good. Yeah, happy to. This is also my last meeting, so I'm happy to give some suggestions for more work for the Committee. So I'm going to keep my comments forward-facing. Really great two days. Appreciated not only our panelists but also our public commenters and the insights that they've brought.

So from today, you know, I haven't really thought of AI as a value-based care enabler or facilitator, and I think that's just a fascinating idea that could warrant more attention from the Committee going forward. The two areas that Dr. Wachter brought up today around risk adjustment and quality metrics are intriguing. I think that's probably only scratching the surface there.

I also appreciated Marc's comments today about the impact of value-based care on patients. I think patients, families, and caregivers, I think that's an area that we haven't really examined very much. And just hearkening back to yesterday's comments about value-based care having a branding problem with the public, I think, could be also folded into

this future area of examination.

And then, lastly, just from today's two public commenters, specifically around Medicare Advantage and independent provider groups who take full risk under Medicare Advantage, you know, I think there's some debate within the halls of CMS, within even this Committee, whether Medicare Advantage is truly a total cost-of-care program from a provider perspective.

A lot of providers just see Medicare Advantage as a fee-for-service analog because they don't take full risk or they don't take any risk under Medicare Advantage. But there is a subgroup of providers, such as ChenMed, such as those represented by ICARE, that do. And there are probably a lot -- there's a lot that we can learn from that because that is the ultimate kind of total cost-of-care model. You know, working as the Medical Director of a PACE program, I see that as well with complete full risk.

And the decisions that we make in a program like that are very different because of the tremendous flexibilities that we have but also because of the, like, truly, like, two-sided

risk. There are no safety corridors or safety nets, and so we're very conscious, and it changes our care model. So just another rich area of examination going forward.

CO-CHAIR PULLURU: The rest of the Committee members have brought up most of what I had been thinking, and I appreciate that. So I won't repeat anything that you guys articulated way better than me. The only thing I'll add that this day resonated for me the most was around the involvement of the patient. And I do think that was a great call-out and, you know, and sort of holding us to task with our paper is that, you know, policy often does revolve around the actual care delivery. And it revolves around, you know, this Committee has a lot to do with how physicians, providers, and other folks in the health care system are treated.

But I think that any payment reform or any Alternative Payment Model, as well as moving forward in value-based care, sort of misses the mark if we don't find a way to bring that patient in. I don't know what that looks like, but I think it belongs in our paper. And so I think this is for future deliberation on exactly what

that means. So I'll stop there.

CO-CHAIR MILLS: Okay. Two of us left. David, any comments?

MR. TYSON: Yeah. Well, I think most everybody has covered what I would've said and just to sort of immediately follow along with Chinni there. You know, Sean suggested leading off the report with, like, three to four or five core principles, and I think that's a really good point. And I think that what Chinni just highlighted is a strong candidate for one of those principles, and I think Marc touched on that quite a bit.

So, you know, defining value around patients and their whole families to include things like financial health and caregiver well-being, I think is something that is often overlooked, and I think is something that should be called out specifically. Beyond that, another thing that really sort of stood out to me was from Reena, who talked about, you know, the operations gap that we're facing, and how we're sort of still in this model where the patient year is the unit of accountability, but the encounter is the unit of workflow.

So just thought that was an interesting sort of framework of thinking about some of these things. But all in all, the piece that stood out to me most, again, very similar to Chinni, was the patient piece of this. I mentioned this yesterday in some of the comments made at the end is, you know, affordability is the buzzword of 2026. And putting these policies, these programs in a format that actually addresses affordability for patients in a way that they understand in a real-world context, like what does this actually mean for me?, I think will create greater momentum for change because there are a lot of people out there who have a vested interest and a real, you know, active interest in seeing health care reform move forward. But they don't sit around reading, you know, 50-page reports from PTAC.

And so I don't know if there's a way to create a 2.0 or some sort of distilled-down version of these recommendations that is a little bit more public-friendly. I think that that might be a good way to start. Lastly, I'll say, I don't know if it was something I said, but the whole Committee is leaving after I just got here.

So I'll just say that it's very clear that we're losing a lot of really great voices and minds from the Committee, and so hopefully you guys won't go too far, because this has been an excellent discussion today and just in my short time here, so.

CO-CHAIR MILLS: Thank you, David.

MR. RAMACHANDRAN: More guest speakers, so yeah, right?

*** Closing Remarks**

CO-CHAIR MILLS: Yes. There is a tradition of seeing recently tenured PTAC members return as speakers in the future, so. Okay, well, a lot of my comments have been said, but I'm going to kind of summarize just my notes into some themes more than specifics. Just first, on its outset, we didn't hear anyone who spoke against the white paper, the broad organization. We didn't have anybody say that, you know, a given point or recommendation was invalid or poorly considered or should be walked back, right? So that, you know, at its outset, that's positive.

We did heard very consistently that, if anything, we should lean into being sharper,

more focused, more specific, call out very specific things that we would recommend. Some of those themes I -- pretty much all speakers were really aligned or working from the viewpoint that really the total cost-of-care model is the right vision. Again, no speakers talked about it ought to be, you know, a series of infinitely nested episodes. Total cost of care is the right vision, and I think that does link to what Josh and others said about starting with kind of a viewpoint or a perspective or a vision, and we can then double-click on total cost of care is the model in the wrap or however else it's built.

Lot of good themes, and I think a chance for us to get more specific and focused about reducing friction. Really loved the comments today, just focusing on, you know, if you're an ACO or a plan taking total risk in MA, and I was prior CMO[30] of an MA plan that had total capitation to our provider network, why do they have to have some of the regulation or policy stipulations that are used to try to control high utilization in a fee-for-service network, right? They've taken on that risk. Let's free their

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arms to operate, which makes perfect sense.

Certainly heard a lot of comments about, you know, the quality measurement, simpler, smaller, more stripped down, really focus on only the smallest set of measures that really matter and how to define that. Definitely comments about rebasing or action we've been talking about for the entire six-year tenure of us on the Committee that are bowing out now. But I think this white paper is perhaps an opportunity for the Committee to be more specific or perhaps prescriptive about what we want done, which is just remove it, but specifically how to do that, right? You go then to a -- is it a national rebasing every five years? I mean, I'm not sure it can be ever, never rebased. So what does that look like, and how is that done?

Lots of great comments about calling out the value and connection to MA and what role MA plays. And traditionally, MA's not been central to our docket of work in regulation, but I think we've gotten some leeway perhaps to make some more connections or more call-outs there. Specialty involvement: So I think we have got a chance to be a little bit more specific about how

we think specialties can be pulled in.

And really it may be it's only in a total cost-of-care model where the full capitation is going to the accountable organization, and it's up to them to pull in the specialties they need and pay what their market requires payment for. That is really the only way to make it work. But I think we should call that out more. And then, lastly, some interesting comments in one of yesterday's panel about the implications for workforce and training. That despite the best of intentions, if there's not the right workforce or the amount of the workforce needed to operate the models, it's going to all collapse, and so we need to think about the impact of that. And that maybe sets up a future theme-based meeting about workforce and training.

So those are my general comments. And now, just -- you know, point of personal privilege, also my last meeting, and it's just -- really have loved these six years with each of you, you know, treasured colleagues and friends. Some I've known two years, six years, or 25 years. And it's just been great to walk this

journey together and kind of have a chance on a stage bigger than our day-to-day jobs just to focus on the life and health of the country. And that's a privilege I think all of us appreciate or we wouldn't keep showing up.

Special thanks to, of course, the PTAC and ASPE staff who make this so clean and easy and such dedicated civil servants investing your entire careers into the life and health of the country. And we so appreciate that. And then, of course, for the amazing NORC staff and Amy, who has reset my mental standard of what an expert professional logistics facilitator does. My EA[31] does not appreciate that. But well done, and thank you. So any other final comments? Other retiring Committee members, any comments?

DR. LIN: So well said, Lee. Thank you.

MS. HARDIN: It has been a privilege and a great learning journey and amazing work that collectively we have done. And, Steve, I want to specifically recognize you having walked with us and informed us so deeply. We appreciate you.

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CO-CHAIR MILLS: All right. And with that, as my last official act to pound the gavel, the meeting -- oh, I'm sorry, Josh. Go ahead.

DR. LIAO: That's okay. I'm going to jump in right before you gavel and say that I share other Committee members' views. It's been an honor. I think it's also just, as I leave the Committee, I reflect on, like, what a privilege it is, to your point, to add our voices to this conversation. It came long before us. It will continue after. I look forward to being a fan and rooting for the Committee's work as part of the general public, but what a privilege. So really appreciate all the staff, present and past, and all the Committee members that have taught me so much.

*** Adjourn**

CO-CHAIR MILLS: Thank you. And hear, hear. And so with that, I declare this meeting closed.

(Whereupon, the above-entitled matter went off the record at 11:35 a.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: 09-15-26

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