Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

September 9, 2025
9:01 a.m. – 1:30 p.m. EDT
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attendance

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

Terry L. Mills Jr., MD, MMM, PTAC Co-Chair (Chief Medical Officer, Aetna Better Health of Oklahoma, and Owner, Strategic Health, LLC)
Soujanya R. Pulluru, MD, PTAC Co-Chair (President, CP Advisory Services, and Co-Founder, My Precious Genes)
Lindsay K. Botsford, MD, MBA (Market Medical Director, One Medical)
Jay S. Feldstein, DO (President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine)
Walter Lin, MD, MBA (Chief Executive Officer, Generation Clinical Partners)
Krishna Ramachandran, MBA, MS (Chief Information Officer, UnitedHealth Group)

PTAC Members in Partial Attendance

Lauran Hardin, MSN, FAAN (Chief Integration Officer, HC^2 Strategies)*
Lawrence R. Kosinski, MD, MBA (Founder and Chief Medical Officer, VOCnomics, LLC)*
Joshua M. Liao, MD, MSc (Professor and Chief, Division of General Internal Medicine, Department of Medicine, The University of Texas Southwestern Medical Center)*

PTAC Members Not in Attendance

Henish Bhansali, MD, FACP (Chief Medical Officer, Medical Home Network)
James Walton, DO, MBA (President, JWalton, LLC)

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

Marsha Clarke, PhD, MBA, COR III, PTAC Designated Federal Officer
Steven Sheingold, PhD

Via Zoom

List of Speakers and Handouts

1. **Session 4: Data-Driven Approaches for Enabling Patients with Chronic Conditions and Enhancing Secondary Prevention**

   Charles R. Senteio, PhD, MBA, LCSW, Associate Professor, Department of Library and Information Science, Rutgers University School of Communication and Information*
   Gianni Neil, MD, Chief Medical Officer, ChenMed*
   Mendel Erlenwein, Founder and Chief Executive Officer, CareCo
   Khue Nguyen, PharmD, Founder, Emprise Health (*Advanced Care Model [ACM] Service Delivery and Advanced Alternative Payment Model* proposal)

   Handouts

   - Session 4 Day 2 Experts' Biographies
   - Session 4 Day 2 Presentation Slides
   - Session 4 Day 2 Facilitation Questions

2. **Session 5: Payment Models and Benefit Design Improvements to Enhance Patient Empowerment**

   Robby Knight, MBA, MS, MSW, Co-Founder and Chief Executive Officer, Soda Health*
   Clay Johnston, MD, PhD, MPH, Co-Founder and Chief Medical Officer, Harbor Health*
   Paul Berggreen, MD, Chief Strategy Officer, GI Alliance, and Founder and President, Arizona Digestive Health*
   Kaitlyn Pauly, MS, RDN, DipACLM, Chief Integration Officer, American College of Lifestyle Medicine*

   Handouts

   - Session 5 Day 2 Experts' Biographies
   - Session 5 Day 2 Presentation Slides
   - Session 5 Day 2 Facilitation Questions

***Via Zoom**

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

Also see copies of the presentation slides, other handouts, and a video recording of the public meeting.

Welcome and Co-Chair Overview

Lee Mills, PTAC Co-Chair, welcomed the Committee members and members of the public to the second day of the September public meeting. He explained that the first day of the public meeting included a number of subject matter expert (SME) presentations on using data and health information technology (health IT) to transparently empower consumers and support providers. Co-Chair Mills then reviewed the agenda for the day, noting that SMEs represent a variety of perspectives, including viewpoints from a previous PTAC proposal submitter. He indicated that a public comment period would be held in the afternoon. Participants must register to provide an oral public comment, and public comments are limited to three minutes.

Co-Chair Mills then invited Committee members to introduce themselves and share their experience with using data and health IT to empower consumers and support providers. Following Committee member introductions, he explained that the discussions, materials, and public comments from the public meeting would inform the report to the Secretary of Health and Human Services (HHS) on using data and health IT to transparently empower consumers and support providers. Co-Chair Mills noted that the Committee was prepared to receive proposals on innovative approaches and solutions related to care delivery, payment, or other policy issues from the public.

Session 4: Data-Driven Approaches for Enabling Patients with Chronic Conditions and Enhancing Secondary Prevention

SMEs

- Charles R. Senteio, PhD, MBA, LCSW, Associate Professor, Department of Library and Information Science, Rutgers University School of Communication and Information
- Gianni Neil, MD, Chief Medical Officer, ChenMed
- Mendel Erlenwein, Founder and Chief Executive Officer, CareCo

Previous Submitter

- Khue Nguyen, PharmD, Founder, Emprise Health (*Advanced Care Model [ACM] Service Delivery and Advanced Alternative Payment Model* proposal)

Krishna Ramachandran moderated the session with four SMEs on data-driven approaches for enabling patients with chronic conditions and enhancing secondary prevention. Full biographies and presentations are available.

Charles R. Senteio presented on centering lived experience in data-driven care and new tools for chronic disease prevention and management.

- Dr. Senteio described his expertise in understanding and using information about a patient's lived experiences to improve the care process. He also has expertise in understanding how respectful artificial intelligence (AI)-enabled tools can help make information accessible before, during, and after clinical encounters. He noted his background as a health equity researcher, licensed clinician, and information scientist offered an upstream perspective at the point of patient engagement, which complements the perspectives of the other experts in the session, which focus on downstream coordination.
- Dr. Senteio highlighted that clinical care considerations extend beyond clinical diagnoses. Lived experiences are important to consider yet may not be fully captured in electronic health records (EHRs). For example, a patient may not fill a prescription for reasons that cannot be captured in an EHR entry. In a clinical setting, patients with chronic diseases are more likely to disclose lived experiences when they are in respectful, trusted environments.
- Dr. Senteio explained two promising AI tools to support patient information-sharing in trusted environments:
    - Pre-visit AI avatars or chatbots enable private, stigma-free disclosure of sensitive experiences, including in areas of medication adherence or disclosure of trauma. This type of tool has been validated in several care settings, including emergency departments (EDs). Similarly, generative AI tools tailored with social determinants of health (SDOH)-aware prompting, such as in heart failure dialogue models, can enhance the quality of dialogue with patients. Dr. Senteio acknowledged that these tools still lag in replicating human interaction.

    - In-visit AI prompts support clinicians in addressing sensitivity needs during visits. For example, ChatEHR is a conversational, AI-enabled tool that can be integrated into the EHR system. The tool enables clinicians to query patient records and generate summaries. These types of tools complement downstream platforms by enriching the upstream data that care coordinators and other clinicians can act upon.
- Dr. Senteio described that when tools are designed with empathy, dignity, and respect in regard to the language, tone, and appearance used, patients are more likely to engage and disclose sensitive medical information to AI tools. Similarly, when providers use AI tools to receive brief, relevant patient summaries, providers tend to be more confident in tailoring care to the patient. These considerations can lead to better chronic disease management, fewer missed red flags, increased trust, and reduced ED visits.
- Dr. Senteio summarized that to better manage chronic disease, providers must treat more than symptoms; providers must keep people at the center of the conversation. To do so, providers must understand patients' lived experiences. While the data and technology exist to gather this type of information, it is imperative to consider how empathy impacts patients' disclosure of information and how the information is used.
- Dr. Senteio concluded his presentation by noting that respect and technology are not opposing forces; they can be part of a formula that results in better outcomes.

For additional details on Dr. Senteio's presentation, see the presentation slides (pages 2-9), transcript, and meeting recording (7:26-15:23).

Gianni Neil presented on ChenMed's approach to empowering patients and mitigating existing gaps in care using technology.

- Dr. Neil has been affiliated with ChenMed for 12 years, starting as a primary care provider (PCP). Her work is currently focused on care for the aging population across all ChenMed locations. ChenMed employs approximately 4,000 team members and operates 111 centers across 12 states.
- Dr. Neil provided a summary of the underserved patient population served by ChenMed. Patients are medically complex and have, on average, five chronic conditions. Approximately 30% of patients are either partially or fully eligible for both Medicare and Medicaid.
- Dr. Neil described ChenMed's vision to increase the number of good days for patients, including increasing their lifespan and their health span. The organization's model of care includes working with the patient to manage health care costs while also treating the chronic condition. She added that ChenMed's older adult patients are often caregivers and important members of their communities; supporting their health can have a positive impact on their communities.
- Dr. Neil explained that ChenMed aims to increase overall quality of life for patients. ChenMed creates a care team around the patient. The PCP-led care team detects and manages high-risk diseases; coordinates external care management if patients see a provider (e.g., specialists) outside of the center; conducts ongoing patient engagement activities, such as on-site fitness or cooking classes; and addresses social needs, such as barriers to transportation, lack of access to affordable medications, and food insecurity.
- Dr. Neil described a typical patient care journey at ChenMed. She noted that PCPs are assigned a reduced patient panel compared with fee-for-service (FFS) counterparts. PCPs are expected to build trust with patients, such as by providing patients with their cell phone numbers. Care teams conduct robust medical screenings, monitor for changes in health, and provide patients with shelter at the centers when the weather is cold.

- Dr. Neil emphasized that the patient and the PCP act as team members; the PCP is considered a co-pilot through the patient's health care journey as they age. When a patient is referred to outside specialists, ChenMed aims to see the patient within 24 to 48 hours to update and reconcile care plans.
- Dr. Neil described gaps that technology and improvements in communication can address. She described different ways technology can improve care for patients, including using AI tools that support patient communication with the care team; improving electronic medical record (EMR) integration with outside care settings to support data transfer to ChenMed; and increasing access to remote patient monitoring tools.

For additional details on Dr. Neil's presentation, see the presentation slides (pages 10-44), transcript, and meeting recording (15:23-29:50).

Mendel Erlenwein presented on AI infrastructure for care teams.

- Mr. Erlenwein is the Chief Executive Officer (CEO) of CareCo. He described his passion for care coordination and explained that when care coordination is conducted correctly, it serves as a foundation for a patient's experience with health care and helps build trust between the provider and the patient.
- Mr. Erlenwein indicated that successful care coordination is critical to providing value-based care. He explained that generative AI tools are currently used in the forms of AI-based chatbots to communicate management and education with patients. Mr. Erlenwein indicated that chatbots may not be effective in improving trust with patients in the care coordination process.
- Mr. Erlenwein explained that generative AI should be used in areas where it provides advantages and has shown success. People, on the other hand, should oversee work in areas where humans have been more successful relative to AI. Mr. Erlenwein expressed that AI excels at analyzing a large sum of data and surfacing insights. People, in contrast, tend to be better than AI with delivering care and empathy. Mr. Erlenwein explained that this notion inspired the motto for CareCo, "build the brain to amplify the heart." He explained that under this motto, AI conducts tasks such as pre-call preparation, post-call documentation, task creation and management, and communication. Leveraging AI provides care team members more capacity to provide patient care.
- Mr. Erlenwein summarized CareCo's platform. The platform launched in January 2025 and has conducted over 45,000 patient conversations as of August 2025. The platform includes a telephone-based care coordination system, text and video integration, and an in-person ambient recorder. The platform consolidates all forms of patient communication into one platform to capture the entire patient interaction for use in developing patient call guides. He noted that while ambient recorders are used in many doctors' offices, only a small percentage of the communication is saved in patients' charts.
- Mr. Erlenwein explained that CareCo is using an AI-developed call guide that provides care coordinators tailored discussion points to cover during a patient's visit and includes a citation back to the source data input from the patient's chart.
- Mr. Erlenwein described how a post-call record is presented to the care team through CareCo's portal. The record includes a fully formatted transcript, clinical documentation, tasks to be completed, and follow-up communications required, such as physician and patient follow-up email templates.
- Mr. Erlenwein concluded his presentation by encouraging health systems to use AI tools to support care and care team processes.

For additional details on Mr. Erlenwein's presentation, see the presentation slides (pages 45-52), transcript, and meeting recording (29:50-39:28).

Khue Nguyen presented on transforming care with practical AI.

- Dr. Nguyen summarized the Alternative Payment Model (APM) proposal previously submitted to PTAC for consideration. The proposed model was a high-touch, person-centered approach for the high-needs population. In Dr. Nguyen's tenure, she has experienced opportunities and challenges in making care coordination effective, scalable, and sustainable. Dr. Nguyen's perspectives are informed by her experiences at the provider level and from designing payer strategies.
- Dr. Nguyen outlined progress in AI tools over the past decade, including EHR, interoperability, dashboard, risk score, registry, and team-based resources. She noted that advancements in AI have been too slow and incremental and indicated that the industry has reached its limit with the current set of tools available. Dr. Nguyen added that despite the large amount of data available in the current systems (e.g., EHRs, claims data, patient registries), insights are uncovered too late in the care journey. Dr. Nguyen indicated that these systems look backward when the systems should look forward and be predictive. She explained that this difference is what divides data from impact.
- Dr. Nguyen noted that care managers are the backbone of care coordination; however, they are burdened by administrative tasks such as searching through EHR systems, reviewing claims, and contacting patients. She explained that care managers do not have time to synthesize information meaningfully or connect with patients. Dr. Nguyen acknowledged that the current process is not sustainable and often leads to burnout.
- Dr. Nguyen shared that AI is creating technological breakthroughs in the health care industry. AI is capable of creating real-time, adaptive, personalized support for patients and physicians; continuously learning and anticipating patients' needs; synthesizing complex medical data; supporting care plan workflows; and achieving the delivery of higher quality care with lower costs.
- Dr. Nguyen underscored that the industry can either continue to iterate on existing tools and approaches or embrace AI.

For additional details on Dr. Nguyen's presentation, see the presentation slides (pages 53-60), transcript, and meeting recording (39:28-45:59).

Following the presentations, Committee members asked questions of the experts. For more details on this discussion, see the transcript and meeting recording (45:59-1:41:21).

Dr. Neil discussed how ChenMed leverages technology in curbside specialty consultations. She also described outcomes the organization has measured following the implementation of these processes.

- ChenMed conducts curbside consultations with both a small set of employed specialists and with a third-party consulting firm. The organization receives video recordings of sessions conducted by the consultants and reviews outcomes with the patient. ChenMed also uses a technology platform similar to a texting device to engage curbside specialists in real time during PCP visits. The organization intends to engage more specialists with expertise in value-based care to gather recommendations on cost-effective improvements for the care team.

- ChenMed has found a 50% reduction in cardiology queries when specialists are engaged with PCPs, including reductions in requests sent to outside cardiology providers or hospitals and reductions in unnecessary tests conducted on patients.

Mr. Erlenwein discussed CareCo's business model.

- CareCo gives its Software as a Service (SaaS)-built platform to Accountable Care Organizations (ACOs), payers, and health systems already conducting care coordination. The platform is also licensed to third-party care coordination companies. Pricing models are for per-user or per-active patient.

Experts discussed which disciplines, such as physicians, nurses, pharmacists, social workers, and community health workers (CHWs), are most successful at conducting care coordination.

- One expert explained that successful care coordination depends on available resources. Each discipline offers its own resources, and having a well-rounded team is important. Typically, a nurse or social worker may best serve as the quarterback. It is important to leverage other disciplines based on each patient's needs.
- Multiple specialties use care coordination tools currently. There are tools that serve as a single hub to analyze all forms of communication across care teams.

Experts discussed differences in competencies among care teams relative to AI tools when delivering anticipatory disease management.

- Complex cases are often assigned to care coordination teams. Patients receive quality care from experienced physicians, but the physicians may not be familiar with technology. Technology can help ensure that all patients receive care with respect and dignity 100% of the time.
- AI empowers the patient and the PCP to be advocates across the health span and identify a worsening disease state before it is too late. For example, AI tools have helped one expert's organization identify patients at risk of needing dialysis to proactively intervene before dialysis was needed. Additionally, AI tools can scan medical records at every interaction with the care team to identify changes in health patterns.
- Until incentives are aligned, the implementation of AI tools will not be widespread.
- Although patients may not care who they speak with at a physician's office when they contact the office with a need, a human interaction with a physician is needed to drive change.

Experts provided examples of how their organizations measure the impact of successful care coordination and discussed how measures can be used to justify the cost of purchasing an AI tool.

- One expert indicated that there is an opportunity within PTAC and the Center for Medicare and Medicaid Innovation (CMS Innovation Center) to foster innovation. The next steps to transform the health care system are to provide incentives and develop new payment models that target AI-based value-based care. Having those features in place will allow one to measure the impact of the model.
- Currently, there are discrete rates. If the use of AI is increased throughout the workflow, AI might improve standard outcomes, such as readmission rates or team capacity.
- It is challenging to show upstream outcomes before the outcomes (e.g., all-cause readmissions) can be observed in the data. One expert indicated that they measure metrics such as missed medication fills or administration of urgent care-level medications. Caution is needed when implementing AI to ensure that insights are robust before investing in a tool that the team cannot manage.

Experts discussed the ways in which their organizations use AI to anticipate patient needs rather than react to care events that have already occurred.

- Generally, AI is still reactive; however, there are current efforts to improve the anticipatory capabilities of AI tools. One example of a potential form of reimbursement for AI tools includes the measurement of the success rate for accomplishing the care plan objectives. AI tools can provide the source from the patient record to justify the outcomes of those measures.
- The tools exist but financial incentives need to be established to encourage uptake of the tools. For example, to ensure that patients can attend their visits, AI is currently being tested to conduct outreach to high-risk patients with transportation needs and coordinate transportation on behalf of the patient.
- One expert developed an outreach tool that allows care teams to detect and quickly address subtle changes in a patient. AI can now support these efforts.
- Vulnerable patients tend to have episodic care events. These events tend to require a dynamic approach to care, including having a provider conduct home visits to gather information and identify gaps in care. AI can collect and analyze data to identify patterns and understand where and when care is needed. AI relies on providers' ability to connect with patients to understand the dynamic scenarios in which they live.

Experts discussed how AI is used to train and educate staff.

- Current AI tools offer motivational learning techniques to educate staff. The next step is to integrate behavioral health factors to personalize techniques used to have discussions with a specific patient.
- AI can be used to upscale the physician to improve communication practices with patients.
- Providers and patients can share lived experiences, which naturally improves their communication, understanding, and trust. That connection may not be possible with AI; however, it may be close enough. Similarly, some patients may seek different types of relationships with their providers. When patients and providers do not have similar backgrounds, AI could help a provider bridge gaps in understanding a patient to improve care.

Experts discussed potential waivers or financial changes to support the use of technology to conduct chronic care management.

- One expert recommended removing copays from effective preventive care services and restructuring incentives to promote the use of successful care coordination strategies.
- The Centers for Medicare & Medicaid Services (CMS) should consider making a statement that gives the industry permission to incorporate AI in value-based strategies or other FFS care management services as long as a human is involved in the care plan.
- CMS should consider testing an AI-native APM that includes humans to measure the full potential of incorporating AI tools into care coordination.
- Incentives have worked to increase use of EHRs through Meaningful Use. Similarly, CMS can consider creating incentives for responsible uses of AI to improve patient care and health outcomes.

Experts discussed whether they have observed times when AI-interactions alone were sufficient without the involvement of a human from the care team. Experts also discussed whether different considerations should be given when using AI among high-needs patients.

- Approaches differ when a patient reaches out to the care coordination team versus when the care coordinator reaches out to the patient. For example, when a patient contacts a care coordinator to make a request, addressing the patient's needs using AI may be sufficient. The quality of the AI involvement is dependent on the number of patients seen in a month and the care team's capacity to handle all patients.
- The approach to development is a key difference between AI-native versus non-AI-native approaches. A non-AI-native approach could incorporate AI into the current workflows in place of a human. An AI-native approach could consider both challenges and available resources to support a process. Both non-AI-native and AI-native approaches should involve humans in the process.
- Although AI can support high-needs patients, using AI for these patients can be more challenging because of the high-touch care required for these patients. For example, AI can conduct phone conversations with high-needs patients.
- One expert recommended studying how unsupervised AI is handled in other industries before allowing unsupervised AI to operate in health care.

Session 5: Payment Models and Benefit Design Improvements to Enhance Patient Empowerment

SMEs

- Robby Knight, MBA, MS, MSW, Co-Founder and Chief Executive Officer, Soda Health
- Clay Johnston, MD, PhD, MPH, Co-Founder and Chief Medical Officer, Harbor Health
- Paul Berggreen, MD, Chief Strategy Officer, GI Alliance, and Founder and President, Arizona Digestive Health
- Kaitlyn Pauly, MS, RDN, DipACLM, Chief Integration Officer, American College of Lifestyle Medicine

Walter Lin moderated the session with four SMEs on payment models and benefit design improvements to enhance patient empowerment. Full biographies and presentations are available.

Robby Knight presented on cost sharing strategies and supplemental benefits for enhancing patient empowerment.

- Mr. Knight introduced Soda Health, a technology company focused on reimagining government benefits to work better for everyone. The company uses smart cards that restrict purchases to the level of the stock keeping unit (SKU). The cards are used primarily by Medicare and Medicaid plans to administer benefits such as transportation, utility assistance, over-the-counter (OTC) items, and food. Mr. Knight noted that Soda Health has been operating for over five years and emphasized the company's best-in-class technology for enabling precise SKU benefit control.
- Mr. Knight highlighted the company's perspective that supplemental benefits—currently treated as marketing costs—should instead be viewed and managed as medical benefits given their inclusion in medical loss ratios. He advocated for closer partnerships with providers to reduce the overall cost of care.
- Mr. Knight described how beneficiaries receive cards and engage through digital tools such as apps, call centers, and text messages. Soda Health encourages care gap closures (e.g., A1C tests, health risk assessments) at local pharmacies and makes it easy for patients to understand and access eligible care. He shared results from a pilot with a Medicaid plan, noting nearly 60% completion of A1C tests within six weeks. Results were driven by a multi-modal approach of engaging both patients, through rewards and incentives, and providers, who in this case were pharmacists.

- Mr. Knight concluded by emphasizing the importance of simplicity, especially for beneficiaries managing complex life circumstances. He explained that Soda Health aims to make it easy for members to understand what benefits are available to them and understand how to drive value for everyone. He noted that confusion about supplemental benefits is a major source of member inquiries. Mr. Knight shared that 30-40% of calls to health plans typically relate to questions about benefits. However, only about 2.5% of calls to Soda Health relate to questions about benefits, which he attributed to the experience Soda Health has built.

For additional details on Mr. Knight's presentation, see the presentation slides (pages 2-7), transcript, and meeting recording (0:00-4:30).

Clay Johnston presented on aligning member incentives.

- Dr. Johnston shared his professional journey that led to the founding of Harbor Health. A stroke neurologist by training, he described his early frustration with the limitation of the health care system in supporting innovation and addressing key problems. He established the Dell Medical School at University of Texas (UT) at Austin, where he and his team rebuilt care models around specific conditions using human-centered design and technology with a focus on improving outcomes, experience, and reducing cost. These redesigned models lowered costs for conditions such as musculoskeletal issues, bipolar disorder, and breast cancer—sometimes by as much as 30-80%. However, he noted that payment reform remained a major barrier, as bundled payments were difficult to implement and most payers were resistant. Dr. Johnston noted that only one insurer, Bind (now Surest), showed interest in his team's approach. When that opportunity did not materialize in Texas, he partnered with Bind's former CEO, Tony Miller, to launch Harbor Health.
- Dr. Johnston emphasized that meaningful reform requires control over health care dollars. Without that control, it is impossible to design the ideal care model. He argued that incumbent systems are optimized to maximize profit and resist change, which is why Harbor Health was designed as a "payvider"—a hybrid payer-provider model that controls the insurance premium, regardless of whether it acts as the insurer.
- Dr. Johnston explained that Harbor Health's model is designed around people and organized around health journeys and conditions, which Dr. Johnston described as both intuitive to patients and actional for care redesign. The organization uses a mix of providers, coaches, and technologies, and subsidizes actions to encourage people to do the right thing—whether that is choosing a provider or engaging in health promotion activities.
- Dr. Johnston emphasized the importance of surrounding members with the support they need and recognizing that much of what affects health happens outside of office visits. Harbor Health's system is designed to be responsive both inside and outside clinical settings, using people and technology to meet patients where they are.
- Dr. Johnston suggested that a key part of Harbor Health's approach includes organizing around conditions rather than service categories. The data systems are built to track condition-specific outcomes, prioritize needs, and optimize care pathways.
- Dr. Johnston explained that Harbor Health does not own hospitals or specialists. Instead, the organization uses data to guide patients to high-value providers. He provided an example using real data from a local HCA Healthcare hospital system, noting that patients often rely on Healthgrades—an online resource that provides comprehensive information about providers and hospitals—to evaluate providers. While Healthgrades reflects patient satisfaction, Harbor Health supplements this with extensive claims data—ingesting 60% of commercial claims and

100% of Medicare data across Texas—to assess provider quality and total cost of care (TCOC). He emphasized that higher cost does not correlate with higher quality, and Harbor Health uses this insight to align benefits with care pathways that reduce waste and improve coordination.

- Harbor Health allows members to select providers of their choice; however, Harbor Health removed copays for patients who see high-value providers to align benefits with care models that promote efficiency and quality. Dr. Johnston noted that incentives can be applied at multiple points along the care journey—not solely referrals—and that timing and appropriateness of care are key considerations. He highlighted large cost variations for similar procedures with minimal differences in quality.
- Dr. Johnston concluded his presentation by acknowledging other innovative Texas-based models such as Curative, which offers zero deductibles after an initial onboarding visit, and Everly, which uses rewards cards to encourage healthy behaviors. He emphasized that Harbor Health is part of a broader movement pursuing these types of reform.

For additional details on Dr. Johnson's presentation, see the presentation slides (pages 8-21), transcript, and meeting recording (4:30-12:16).

Paul Berggreen presented on using provider payment models and performance measures to enhance patient empowerment.

- Dr. Berggreen noted that he is a gastroenterologist in Phoenix and the Chief Strategy Officer of The Specialty Alliance. He stated that his focus was not solely on designing a payment model, but also on improving the clinical value delivered to populations of patients.
- Dr. Berggreen described a model where a population of patients is surrounded by traditional care, such as office visits and procedures, and emphasized the importance of wrapping additional services around that core. Starting with physician leadership across gastroenterology and urology (nearly 1,600 physicians), he explained that experts have developed care pathways for all relevant disease states. These pathways feed into a population health dashboard, which is vital for enabling quality improvement projects and transitioning to a population health management system across the organization.
- Dr. Berggreen indicated that the dashboard serves as a research patient finder tool and supports real-world evidence data projects, which help shape the direction of care. The dashboard powers the model's chronic care management program, which currently manages approximately 50,000 patients monthly nationwide, including remote patient monitoring. Importantly, the dashboard enables the delivery of services that are not typically covered by Medicare or commercial insurance, such as nutrition counseling, behavioral health, and pharmacy technology support for patients with polypharmacy.
- Dr. Berggreen explained that once such services are wrapped around the ecosystem, practices are well-positioned to engage in value-based contracts. The model also works with FFS arrangements.
- Dr. Berggreen showed the dashboard and indicated that data are aggregated nightly from five million patients across gastroenterology and urology. The dashboard is stratified by disease state and allows filtering by physician, office, and patient population. Using inflammatory bowel disease (IBD) as an example, Dr. Berggreen demonstrated how granular filters allow users to isolate patient populations down to the individual physician, office, and patient. He emphasized that this granularity is key to powering the program. Metrics derived from care pathways allow the organization to measure physician and patient performance across five million patients. For

IBD, the organization set a national baseline for how well physicians help patients adhere to care plans—a baseline that correlates with better outcomes and lower system-wide costs.
- Dr. Berggreen explained that in a six-month pilot program across six offices, the organization identified over 900 patients who had fallen out of adherence. With a focused effort, the organization re-engaged nearly half of these patients, resulting in additional labs, office visits, procedures, and changes in medications—especially biologics. He noted that biologics are expensive and should be used appropriately. The program helped identify patients who were not responding to treatment or who could benefit from biologics but were not yet on them.
- Dr. Berggreen emphasized that better information is essential to designing effective programs. He argued that models must start with the patient but be built around the practice or the entity delivering care.
- Dr. Berggreen concluded his presentation by emphasizing that any model must work in both risk-based and FFS environments and noted that this model supports both.

For additional details on Dr. Berggreen's presentation, see the presentation slides (pages 22-31), transcript, and meeting recording (12:16-18:32).

Kaitlyn Pauly presented on payment innovation and benefit design for patient empowerment.
- Ms. Pauly noted that she is the Chief Integration Officer at the American College of Lifestyle Medicine (ACLM). She highlighted the unsustainable epidemic of chronic disease in the U.S., noting that 90% of health care costs are tied to chronic diseases, and 80% of those costs are driven by lifestyle factors.
- Ms. Pauly emphasized that the health care system should be designed to address root causes of disease and not solely manage disease symptoms. She noted that lifestyle-related chronic conditions are not adequately addressed in medical education, and that the current fragmented, one-to-one, short visit model of care delivery often lacks the time and resources needed to address lifestyle factors in clinical settings. She explained that the system remains focused on disease and symptom management, reinforced by unsustainable payment and reward systems that do not support root-cause care. In some cases, the systems penalize health restoration, disease remission, and medication de-escalation.
- Ms. Pauly explained that ACLM was founded to educate and equip clinicians to treat root causes of chronic disease and to advocate for systemic change. Lifestyle medicine is a medical specialty that uses therapeutic lifestyle interventions to restore health and reignite clinicians' joy in practice. The six pillars of lifestyle medicine are optimal nutrition; physical activity; stress management; restorative sleep; avoidance of risky substances; and connectedness. The lifestyle framework and care delivery approaches are evidence-based. Lifestyle change is listed as a first-line treatment in clinical guidelines for most chronic diseases.
- Ms. Pauly described a vision for benefit design that enables patient awareness, empowerment, and control of health that is supported by trained clinical care teams. She proposed expanding coverage for therapeutic lifestyle interventions, reducing cost-sharing, covering services beyond the clinical setting, and supporting tools and services that address barriers to lifestyle change.
- Ms. Pauly also called for aligned payment incentives and quality measures that reward root-cause treatment. She provided examples of current misalignments in incentives, such as clinicians being penalized on medication adherence metrics when patients improve through lifestyle-only interventions, or risk scores decreasing when patients enter remission.
- Ms. Pauly proposed payment innovations, including fair compensation for lifestyle interventions; hybrid payment models; support for group visits; expanded digital tool coverage; and incentives

for disease remission and medication de-escalation. She emphasized the use of metrics such as lifestyle improvement, patient activation, and quality of life to measure and reward success.
- She concluded her presentation by encouraging support for physician-led pilot programs, removal of systemic barriers, and collaboration across the health care ecosystem. She emphasized that health care alone cannot solve the chronic disease crisis; stakeholders across society must work together to make healthier choices easier for all Americans.

For additional details on Ms. Pauly's presentation, see the presentation slides (pages 32-45), transcript, and meeting recording (18:32-26:50).

Following the presentations, Committee members asked questions of the experts. For more details on this discussion, see the transcript and meeting recording (26:50-1:07:20).

Experts discussed returns on investment (ROIs) from care models, including improvements in financial and non-financial outcomes.

- Value can be delivered in any payment model. The more relevant goal for physician practices is to deliver better outcomes for patients and to change dynamics that lead to poor outcomes. Some of those dynamics can be prevented. Gaps in care, patients falling through the cracks, and incomplete tasks due to system limitations should always be preventable.
- Value-based care programs have encouraged innovation; however, the programs have relied on annual performance metrics, which can discourage investment in interventions such as lifestyle changes that do not yield benefits within the same year. Frequent switching between plans compounds this issue. Success in these programs—whether Medicare Advantage (MA), ACO REACH, or others—is more based on risk coding than on achieving better outcomes or reducing waste. Some organizations have become their own insurers to avoid being subjugated to external rules and misaligned incentives.

Experts discussed design improvements needed for supplemental benefits to drive value to the system.

- Supplemental benefits have grown from an average value of $155 per member in 2019 to roughly $1,500 per member in 2024, with utilization doubling. This growth has resulted in a 20-fold increase in overall cost for health plans, which now face tradeoffs such as funding cancer care versus OTC vitamins. These benefits, funded through medical loss ratio (MLR) spend, are currently used more for member acquisition than for driving real ROI or cost-of-care improvements. To create value, the model should center providers in benefit design, allowing physicians and pharmacists to prescribe targeted interventions based on member conditions. Beneficiary engagement with the Smart Benefits platform is strong, with over 70% monthly active users—compared to typical digital health engagement of 4-5% annually—which presents an opportunity to identify challenges in members' lives and drive cost-of-care improvement. A national pilot with a large payer is already showing promising results, with nearly 50% of participants completing A1C tests as the stage gate for additional benefits. Given the scale of MA spending relative to its savings, the industry should consider redesigning the model on what truly drives value and engaging other ecosystem players, such as retailers, to support that shift.
- Value-based payment depends on delivering high-value care. Redesigning care delivery is essential to meet patient expectations for engaged, high-quality interactions with clinical teams. Patients increasingly desire care that is both high-value and engaging. Clinicians are enthusiastic about working with lifestyle medicine providers who focus on upstream drivers of health, lifestyle, and patient empowerment.

- Supplemental benefits are primarily used as a marketing tool to attract a certain type of person—often healthier individuals—into plans. These individuals are risk-coded to appear sicker, which contributes to perceived cost savings. Instead of offering free products, these benefits could instead support evidence-based interventions that lead to healthier individuals. Member engagement remains a major challenge, and benefits should be designed to enhance engagement.
- From a practice standpoint, delivering better value at scale and affecting outcomes requires having systems in place that enable global care for patient populations. Care should not be segmented by plan design; practices deliver the best quality care to every patient, so any model must serve the entire practice. Building these programs is difficult and resource-intensive. Although specialty practices are prepared for risk-based models, adoption has been underwhelming or nonexistent, requiring practices to proceed in both FFS and risk-based approaches.

Experts discussed what they have done in their practices to promote more accurate coding to ensure readiness for risk-based contracts.

- In the beginning, one expert's practice recognized coding as an issue but chose to focus on improving outcomes and reducing waste in care. Over time, the practice realized that poor coding was creating hardship and needed to shift direction. Catching up can be difficult, particularly in models such as ACO REACH where risk adjustment factor (RAF) score increases are limited to 3% annually. Current efforts include educating clinicians on the importance of coding—emphasizing coding to the appropriate level, not over-coding—and implementing IT systems that flag prior-year Hierarchical Condition Category (HCC) codes and identify coding opportunities based on record review. These recommendations are surfaced at the time of visit and responded to in real time.
- From a private practice standpoint, correct coding is a priority—not because of risk-based models, but to ensure compliance and appropriate payment in an FFS model. One expert's practice has a robust compliance department dedicated to validating coding. However, private practices are under pressure from commercial insurers; for example, recent Cigna and Aetna policies are automatically down-coding level 4 and level 5 visits. Correct coding is not a challenge; the challenge involves managing a mixed constituency of payers.
- In a risk-based model with the current coding structure, there is no incentive for having a healthier patient population. Providers who focus on delivering better health outcomes face lower payment.

Experts discussed their experiences working with payers to minimize patient copays for chronic care management (CCM) services.

- Copays discourage health care use. One expert recommended that copays should be used to encourage the right behaviors, and in some cases, should be negative to subsidize actions in a patient's best interest. The ACO REACH Model has allowed providers to remove copays for certain services such as CCM. MA plans have not been as flexible about removing copays for services such as CCM. MA plans should be required to cover CCM without a copay, which could drive the right behavior and response from practices.
- The CCM program has been beneficial and has a modest copay—as little as $8 per month and not necessarily each month. During the public health emergency (PHE), copays were waived, which led to remarkable enrollment in the program; after the PHE ended, enrollment decreased, and it has taken years to rebuild. Charging a nominal fee for a low-cost, high-value service does

not make sense. Some commercial payers, including Cigna and the Blue Cross Blue Shield Association, do not cover CCM services, which is counterproductive to their goal of delivering quality, longitudinal care.

- One approach has involved working with health plans to manage an overall pool of dollars. A specific example is the C06 Healthcare Effectiveness Data and Information Set (HEDIS) measure for medication review and reconciliation, which costs CMS approximately $124 on average, while retail pharmacies can provide the same service at roughly half the cost. From this perspective, pharmacy is a highly efficient site of care. If the goal is to drive value and outcomes, care should be shifted to the most efficient site of care—such as a pharmacy—to generate savings that can then be reinvested. A key challenge is the need to provide better information and data back to the PCP. More broadly, there is a belief that the current system is not working and that there must be ways to unlock savings—given the scale of health care spending—and reinvest those dollars more effectively. With experience across over 50,000 pharmacy locations, optimizing the site of care by leveraging the pharmacy is a critical strategy.
- While CCM is a valuable model used by many clinicians, there is also significant use of intensive, therapeutic lifestyle change programs delivered through shared medical appointments or group visits. The copay has been a barrier, particularly for patients who cannot afford to pay multiple copays over a series of weeks or months. This has led to attrition, with patients often participating in only the first few visits before discontinuing due to cost.

Experts discussed the lifestyle changes and supplemental benefits that have the largest ROI in terms of spending.

- Food and transportation were identified as having the highest ROI. Transportation is the largest barrier to beneficiaries accessing appointments, including visits with dieticians or A1C performance interventions. Food is also identified as a key driver of outcomes. There is substantial literature supporting the impact of programs such as Supplemental Nutrition Assistance Program (SNAP) on reducing the overall cost of care. It is essential to first serve patients' first order needs. One challenge is the lack of coordination between CMS and the Department of Agriculture, particularly around programs such as Electronic Benefits Transfer (EBT), Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and SNAP; however, this appears to be changing.
- One expert agreed that food and nutrition offer the most substantial cost benefits. Nutrition is described as the primary way patients can achieve disease remission and improvements in health outcomes. When a disease goes into remission, the cost of care decreases over time. Wraparound care is also essential. Programs such as medically tailored meals and produce prescription programs can be effective acute interventions, but without the ability to maintain nutritious dietary patterns following the intervention, patients may return to their previous health status. Nutrition and culinary education and access to healthy food are viewed as critical for achieving long-term outcomes from food-based interventions.
- It is important to identify the barriers to complying with a treatment plan. These barriers can include lack of transportation, financial constraints, or other life circumstances. A system where the practice takes some responsibility for helping patients follow the physician's treatment plan is part of the solution.

Experts discussed whether and how to make patients responsible for their outcomes and how to measure patient empowerment and patient engagement.

- Patients are responsible for how healthy they are; ignoring that reality overlooks their critical role in making care work. Outcomes are shaped by a combination of patient actions, provider actions, and chance. For example, some conditions such as IBD may not be preventable. It is important not to penalize people for bad luck. The focus is on how to engage members in taking the right steps in their care. Of note is the use of "members" rather than "patients." People do not want to be patients—they want to be healthy. One tool used to support engagement is the copay, which creates an expectation that members are contributing to their care. The copay serves as a form of subsidization for doing the right thing. It is also on the system to clearly define expectations so that benefits can accrue to members if they take the right steps in their care. At the same time, there is an effort to build a parallel incentive structure for clinicians—moving away from relative value units (RVUs) and toward rewarding actions that improve outcomes or reduce waste. Being both the payer and the provider makes it possible to build such systems in parallel, aligning incentives for both members and clinicians.
- Building on the earlier point about focusing on the treatment plan, the opportunity is to realign benefits and solutions around the individual patient. Currently, people receive an OTC benefit with a substantial dollar amount. Drawing from prior experience at Walmart, it was observed that some members, limited by fixed incomes, would use their OTC benefit to purchase items such as vitamins and resell them because they did not need the item and instead needed the money. Benefits should not be one-size-fits-all but instead personalized based on what the member and the provider determine is the best course of action for the individual's care. Rather than using benefits as a marketing tool, the goal should be to center the benefits on the treatment plan developed between the member and the physician. This approach supports personalized benefits that reflect what the member needs to improve their health outcomes.
- A key challenge is identifying what leads to positive versus negative outcomes. Using IBD as an example, there are published guidelines for care, but measuring adherence to those guidelines across patient populations or at a national level has not been done. Establishing a national baseline for care in a given disease state is one way to understand a measurement. Without that baseline, it can be difficult to know what to reward or penalize. Although similar efforts are underway in some specialties, not all practices have the level of sophistication to support this type of measurement. As a result, the goalposts may be unclear.
- There is a strong effort underway to capture more lifestyle-related factors through lifestyle assessments. If providers do not know what a patient is doing outside the clinic, it is difficult to address what may contribute to worsening chronic conditions. Incorporating additional types of measurements—both patient self-reported data and data from digital technologies such as wearables—is important. These inputs can be used to make better decisions and support patient education about how behaviors influence health outcomes.

Experts discussed innovative approaches to incentivizing patients to use digital health tools in value-based payment models.

- One organization subsidizes the cost of digital health tools when possible. A particular area of focus is blood pressure management. Remote blood pressure cuffs are subsidized for members in risk-based plans.
- In gastroenterology, a key area of focus is managing fatty liver and obesity, which can lead to chronic liver disease. Remote patient monitoring is used with digital scales, which are provided to patients free of charge. If patients use the scale at least twice per month—ideally 16 times per month—the costs of the device can eventually be recouped. The digital scale is the only wearable device applicable in gastroenterology right now.

- Cuffs, scales, remote patient monitors, and continuous glucose monitors have been effective for some patients.
- There is not enough low-hanging fruit in other areas to find extra dollars or value to provide these tools to members.

Public Comment Period

Soujanya Pulluru, PTAC Co-Chair, opened the floor for public comments. There were no public commenters.

Committee Discussion

Co-Chair Pulluru opened the floor to Committee members to reflect on the day's presentations and discussions. The Committee members discussed the topics noted below. For additional details, please see the transcript and meeting recording (1:03-22:18).

- Care teams (e.g., nurses, social workers, care managers) work in the middle layer between the patient and physician to provide care coordination management. The care team is an important part in the process.
- AI should be made more human in value-based care. AI could make anticipatory care management more automated and less labor-intensive.
- Communication between care coordinators and managers with providers remains a challenge. There is an opportunity to leverage ambient recording to generate AI solutions to support care management.
- There are opportunities to improve practices' coding for risk. Many practices are uncertain about the value they will receive from risk coding.
- Proactive care solutions should be considered first dollar coverage and not incur a copay, potentially through a waiver for the CCM and transitional care management (TCM) codes.
- One Committee member expressed interest in the AI applications possible in physician reimbursement models. More exploration is needed to understand the possibilities of using non-traditional providers to develop AI models.
- Some barriers that can be relatively simple to address continue to hinder value-based care and patient empowerment and engagement. The Committee members should consider identifying these barriers and discussing solutions to address the barriers, such as through waivers or benefit design improvements.
- There are opportunities to responsibly test and incentivize AI to improve care coordination and create more capacity for the health care system.
- In the context of new tools and AI, there are cost sharing and co-insurance barriers for care coordination. There may be opportunities for waivers and existing programs to remove these barriers.
- Many tools and a large amount of data are about to be introduced in health care. There is a need to determine how to measure success without introducing more process measures that would add to the burden related to reporting and documentation. Consideration should be given to ensure that payment aligns with the volume of data that PCPs will need to manage. While the goal is to shift toward TCOC payment models, interim solutions are needed to avoid overburdening the primary care workforce with data. It will be important to involve more team members and leverage AI to support care coordination.
- Guardrails will be needed to ensure that data are not used to deny payment or suggest that a metric was not made.

- There is potential to improve the use of data to better support providers. AI has demonstrated how rapidly technology is changing the practice of medicine.
- Organizations such as Harbor Health use data to help patients make the right choices, such as directing patients to higher quality and more efficient providers through the use of low or no copays.
- Empowering and activating patients without making them accountable in their own health care might be insufficient in the transition to TCOC models. There is little evidence showing that empowering patients impacts outcomes, particularly in the Medicare population and the seriously ill population that drives a large amount of Medicare spending. Additional research is needed to develop an evidence base showing that patient empowerment and engagement improve quality and cost outcomes. There may be opportunities for the CMS Innovation Center to embed these technologies into payment models to achieve desired outcomes.
- Innovation should be purpose-driven. Data and technology must serve the public interest. Value for taxpayers, beneficiaries, and public programs should take precedence over enriching private interest.
- Personalization must be balanced with speed, safety, novelty, and equity.
- Additional work is needed to identify real, scalable solutions.
- There is the potential of prediction in AI. However, at an aggregate level, some use case benefits may be overstated, monitoring is often limited, and there are potential unintended consequences of the technology.
- There are economics of change. Silos are not only technical, but they also reflect business models and structures. Breaking down these silos has consequences that should be managed.
- Not everything in every program needs direct payment. For example, in Medicare, most services are covered under bundled services (e.g., Inpatient Prospective Payment System [IPPS], outpatient system). Every service or activity is not parceled into a code or discrete service. Additional work is needed to identify areas where changes to payment are not needed.
- The CCM, TCM, and Psychiatric Collaborative Care Management (CoCM) codes provide an opportunity for CMS—through waivers or model design—to remove barriers to achieving higher value care.
- Regarding supplemental benefits in Medicaid and MA, one Committee member recommended emphasizing the benefits that lead to improved health outcomes and systematically removing the benefits that are focused on marketing. Supplemental benefits should add value. For example, food, transportation, and hearing aid benefits are important but almost never included in Medicaid programs.
- Innovations in AI are advancing at a pace that regulatory compliance and legal frameworks cannot keep up with. There are opportunities for CMS—through regulatory powers, waivers, and/or model design—to offer safe harbors for use of AI tools that drive value and lower costs, potentially through the Medicare Shared Savings Program. If a tool increases value and quality of care, the tool should become the expectation.
- AI holds the most promise in health care because it has the computational power necessary to tie in datasets. AI has the ability for personalization, such as through care management platforms. Personalization allows for the delivery of human-based care.
- Identity management allows for patient consent that is seamless through multiple environments. This technology works and can be adopted today.
- There is a need to build guardrails into the system to ensure that disparities are not created in benefits or outcomes or used to deny payment for activities that deserve payment.

- When reflecting on the stagnation of reimbursement for physicians and copays for CCM, one Committee member noted that it is important to remember that increasing payment also increases burden for patients, taxpayers, and beneficiaries.
- In an ideal world, insurers would stop paying for certain services and begin paying for other services. The Committee members should consider what partners at the CMS Innovation Center and others are doing to promote cost savings with stable quality or stable cost with increased quality. Additional data on these topics are needed. Solving one problem could create issues in another. For example, addressing challenges with copays could impact coverage determinations.

Co-Chair Pulluru inquired whether ASPE staff had any clarifying questions. Dr. Steve Sheingold noted that the information discussed during the public meeting, within the context of the patient empowerment framework described during the PCDT presentation, will inform the report to the Secretary.

Closing Remarks

Co-Chair Pulluru announced that the public meeting is Jim Walton's final public meeting as a Committee member as his term is ending. Co-Chair Pulluru adjourned the meeting.

The public meeting adjourned at 1:30 p.m. EDT.

Approved and certified by:

//Marsha Clarke//
_____
Marsha Clarke, PhD, MBA, COR III
Designated Federal Officer
Physician-Focused Payment Model Technical Advisory Committee

11/17/2025
_____
Date

//Terry Mills//
_____
Terry L. Mills Jr., MD, MMM, Co-Chair
Physician-Focused Payment Model Technical Advisory Committee

11/7/2025
_____
Date

//Soujanya Pulluru//
_____
Soujanya R. Pulluru, MD, Co-Chair
Physician-Focused Payment Model Technical Advisory Committee

11/7/2025
_____
Date