# PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

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## PUBLIC MEETING

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

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Tuesday, June 16, 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*
LAWRENCE R. KOSINSKI, MD, MBA*
KRISHNA RAMACHANDRAN, MBA, MS
DAVID C. TYSON, MA

PTAC MEMBERS NOT PRESENT

HENISH BHANSALI, MD, FACP
JAY S. FELDSTEIN, DO
JOSHUA M. LIAO, MD, MSc
WALTER LIN, MD, MBA

STAFF PRESENT

MARSHA CLARKE, PhD, MBA, COR III, Designated Federal Officer (DFO), Office of the Assistant Secretary for Planning and Evaluation (ASPE)
STEVEN SHEINGOLD, PhD, ASPE

*Via Zoom

A-G-E-N-D-A

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

9:02 a.m.

*** Welcome and Co-Chair Overview - Targeting Improvements in Patient Safety Through Alternative Payment Models 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, the PTAC. My name is 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 perspective and expertise on targeting improvements in patient safety through Alternative Payment Models. Today, we have a great lineup of experts for our last expert session that will focus on payment mechanisms and financial incentives to encourage patient safety in Alternative Payment Models.

The Committee has made considerable effort to include a 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 this meeting topic. As a reminder, public comments will be limited to three minutes each. If you've not registered to give an oral public comment and would like to do so, please email ptacregistration@norc.org prior to the public comment period today at 10:50 Eastern Time. Again, that's ptacregistration@norc.org.

Then, the Committee will discuss our comments and recommendations for the Secretary of HHS[1].

*** PTAC Member Introductions**

CO-CHAIR MILLS: Because we might have some folks here today who weren't able to join yesterday, I would like the Committee members to introduce themselves and share just your backgrounds, your areas of expertise, and any experience you have with the topic.

And we'll go to each person in turn. I'll start. I'm Dr. Lee Mills. I'm a family physician. I have worked most of my career in medical group and integrated health system operations, clinical informatics, quality improvement. I have the privilege of have led

1 Health and Human Services

or shared leadership in about six different CMMI[2] pilot models over the years. Currently, I'm Chief Medical Officer of Aetna Better Health of Oklahoma, one of the state's contracted managed Medicaid plans.

And next, I'll turn to Chinni.

CO-CHAIR PULLURU: Hi there. Chinni Pulluru. I'm a family physician by trade. I'm the founding Chief Medical Officer of Agentic Healthcare, which is a vertically integrated health tech company supported by the Cures Gateway to deliver on individual access to patients to have agency over their record and deploy AI[3] agents to take action on behalf of them and their families.

Prior to that, I was a Chief Clinical Executive at Walmart Health which entailed, for a period of time, running Walmart's COVID response, but also managing the patient safety organization for all the 5,000 pharmacies in Walmart Health. And prior to that, I was at DuPage Medical Group where I ran risk management for the group. Thank you.

MR. TYSON: Hi. Good morning.

2 Center for Medicare and Medicaid Innovation
3 Artificial intelligence

David Tyson. I am the Senior Director of Policy and Regulatory Affairs at Novant Health, which is an integrated delivery network across the Carolinas that has about 600,000 patients in value-based care arrangements in one form or another. I sort of help the health system navigate all federal rules and regulations and programs related to quality, safety, and value-based care.

DR. BOTSFORD: Good morning. I'm Lindsay Botsford. I'm a practicing family physician in Houston, Texas, where I also serve as the Regional Medical Director for the Midwest and Texas with One Medical, part of the Amazon Health Services family. I currently chair the governing body of our ACO[4] REACH entity with Iora Health Network, and over the last 10 years prior, worked in large health systems and medical education serving in a variety of VBC[5] models, including PCMH[6] and MSSP[7].

MR. RAMACHANDRAN: Thanks, Lindsay. Krishna Ramachandran, Chief Information Officer

4 Accountable Care Organization
5 Value-based care
6 Patient-Centered Medical Home
7 Medicare Shared Savings Program

for United Health Care Operations and Experience. I've been in health care for 24 years, technology, providers, and the payer perspectives working on a range of value-based care models from MMSP, patients in medical home to commercial ACUs[8] and MA[9] plans as well.

CO-CHAIR MILLS: Thank you. Now we'll turn to our virtual members. First, Larry. Okay, Lauran.

MS. HARDIN: Good morning. I'm Lauran Hardin, a nurse by training and Chief Integration Officer for $HC^2$ Strategies. $HC^2$ stands for Healthy Connected Communities, and we work with multiple partners across the country in building connected approaches for complex populations. I have a 20-year history of leading care coordination, quality, and safety initiatives in multiple populations and multiple ACOs and Alternative Payment Models. I was part of the team that established the National Center for Complex Health and Social Needs and worked with community, states, payers, providers across the country in developing models.

8 Ambulatory Care Units
9 Medicare Advantage

I'm looking forward to the meeting today.

CO-CHAIR MILLS: Thank you, all. Four of our Committee members, Dr. Henish Bhansali, Dr. Jay Feldstein, Dr. Josh Liao, and Dr. Walter Lin are unable to join us for Day 2 of the June meeting, but we wanted to certainly acknowledge their contributions and great work.

For today's agenda, we'll be exploring a range of topics on targeting improvement in patient safety through Alternative Payment Models. The background material for this public meeting, including an environmental scan, can be found on the public meeting registration site and will be posted online on the ASPE PTAC website meeting page.

The discussion materials and public comments from this public meeting will inform a report to the Secretary of HHS on our topic targeting improvements in patient safety through APMs[10]. I would like to note as always that the Committee stands ready to receive proposals on possible innovative approaches and solutions related to care delivery, payment, or

10 Alternative Payment Models

other policy issues from the public on a rolling basis.

We offer two proposal submission tracts for submitters allowing flexibility depending on the level of detail of the payment methodology. You can find information about submitting these proposals on the PTAC website.

And now, we're excited to hand this over to Lindsay to welcome and facilitate our first session of the day. Lindsay?

*** Session 4: Payment Mechanisms and Financial Incentives to Encourage Patient Safety in Alternative Payment Models**

DR. BOTSFORD: Thanks, Lee. All right. Well, welcome to Session 4 on payment mechanisms and financial incentives to encourage patient safety and Alternative Payment Models. I'm Lindsay Botsford. I'm one of the PTAC members and I get to walk you through the session today.

We have four esteemed experts in this session to discuss their perspectives on payment mechanisms and financial incentives to encourage patient safety. Their full

biographies and slides are posted on the ASPE PTAC website.

Welcome to our in-person session participants, and for our 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 robust conversation.

So presenting first, we are pleased to welcome Dr. John Hollingsworth, who is a urologist and professor at the University of Florida College of Medicine and Chief Quality Officer at UF Health. John, welcome.

DR. HOLLINGSWORTH: Thank you. It says here that my video is disabled by the host, so I apologize. I can't seem to bring that up, though. There we go. I appreciate the Committee's time. Thank you for the opportunity to talk a bit about an academic health system's perspective on this topic. Amy, if you would advance the slide, please? Thank you.

All right. So 25 years ago, *To Err is Human* fundamentally changed how we think

about patient safety. It moved us away from the idea that harm was primarily the result of individual negligence and toward the recognition that harm is often the consequence of system design. And that shift mattered. It accelerated transparency, reporting, and accountability and catalyzed the modern patient safety movement as we know it, and it led to real progress across health care.

We've seen reductions in selected health care-associated infections. We've seen the widespread adoption of checklists and standardized workflows. We've seen greater organizational attention to safety culture in the development of national measurement and reporting infrastructures that didn't exist prior to its release. But despite that progress, preventable harm remains common. Improvement has been uneven, and some domains have plateaued or even worsened following the COVID pandemic.

And perhaps most importantly, patient safety, in my opinion, no longer occupies quite the same space in health care policy discourse as it once did. My

perspective is that the first chapter of the patient safety movement succeeded in changing awareness, and the next challenge is transforming system capability.

Amy, if you could advance to the next slide, please?

I don't think we've abandoned patient safety, but I do think we have experienced something that might be described as safety drift or perhaps fatigue. Over the last decade, health care organizations have faced extraordinary competing priorities. There was the pandemic. We are dealing with workforce shortages and burnout, financial instability, access and throughput pressures, digital transformation, and all of those deserve attention, but collectively, they crowded out the space that patient safety once occupied.

At the same time, safety work itself has increasingly become fragmented into compliance programs, dashboards, regulatory reporting, and isolated performance metrics. Those tools matter. They create accountability. They operationalize

improvement, but over time, there is a risk that safety becomes defined by what is easiest to observe and report rather than by the full spectrum of patient harm and system vulnerability.

I think one of the central challenges facing us today is just that. On the next slide, I would just highlight that the modern patient safety enterprise was largely built around harms that are observable, codable, and extractable from administrative data and surveillance systems. Examples include health care-associated infections, falls, pressure injuries, health care-acquired conditions, but while these measure are important, they do represent real patient harm. They have helped to improve transparency and drive accountability and increase organizational attention.

They do have a limitation. They're built on our national safety measurement architecture around what we can measure at scale. What we see on the surface of the iceberg is important, but it is not the entire safety landscape. Below the surface are risks

that are even more consequential but substantially harder for us to observe.

Those include things like diagnostic error, communication breakdowns, care fragmentation, cognitive overload, operational fragility. They're often distributed across time, people, and care settings, and because they are difficult to measure, they are often less -- less attention is being paid to them.

Please advance the slide. Many of the most important consequential patient safety threats don't get picked up with -- as traditional adverse events. Diagnostic delay, failure to recognize deterioration, fragmented transitions of care, communication failures, delayed follow-up of abnormal results, inbox overload, digital workflow hazards, operational strain, and staffing instability.

These are harms that are longitudinal and contextual. They emerge through a series of small failures rather than a single catastrophic event, and they frequently cross organization and care-setting boundaries. As a result, they are poorly captured through claims data, surveillance

system, or traditional quality reporting infrastructures.

And one of the messages that I hope to leave the Committee with today is that the absence of measurable harm is not necessarily the presence of safety.

Please advance the slide. Historically, many of the risks that we're talking about were simply too difficult to detect at scale. And that's beginning to change. Advances in analytics, machine learning, artificial intelligence are creating new opportunities to identify risks that were previously invisible such as diagnostic delays, communication failures, unsafe operational conditions, delayed follow-up, handoff failures, early signals of clinical deterioration, weak signals distributed across fragmented systems.

For the first time, we may be able to move from retrospective defect counting toward continuous system risk sensing. I think that's a profound shift, not because artificial intelligence is the solution itself, but because it may provide the enabling

infrastructure necessary to identify risk earlier and intervene even before harm happens.

Next slide, please. The second thread on which I want to pull relates to incentives. Many of the current safety-focused payment programs were important and necessary. CMS[11]' non-payment policies, hospital-acquired condition reduction programs, readmission penalties. These initiatives elevated safety nationally and established accountability, but fundamentally, they share a common architecture: detect harm, assign accountability, and pose a financial consequence.

They are retrospective, they are defect-oriented, and they are primarily punitive. While those approaches have value, they largely finance around failures states rather than around safety capability.

Please advance the slide. The next era of patient safety should increasingly reward organizations that prevent harm before it reaches the patient. Organizations that identify risk early, strengthen communication

11 Centers for Medicare & Medicaid Services

and reliability, reduce operational fragility, improve care transitions, detect deterioration proactively, build learning systems, and continuously adapt.

There's an opportunity here to complement traditional lagging indicators with leading indicators of safety and resilience. Examples would include diagnostic safety infrastructure, closed-loop communication systems, predictive deterioration surveillance, transition of care reliability, near miss learning systems, interoperability and data integration, and AI-enabled risk identification. In other words, shifting from measuring whether harm occurred to measuring whether an organization possesses the capability to prevent it.

Please advance the slide. And I think that the CMS Patient Safety Structural Measure is an important signal in that regard. Historically, safety policy focused on adverse events. This structural measure asks a different question. Does the organization possess the infrastructure necessary to support safe care? Do leaders prioritize safety? Are

learning systems present? Is there accountability? Is there meaningful patient engagement?

This reflects an important conceptual shift from asking did harm occur to asking does the organization possess the capabilities necessary to reliably prevent harm? I believe that distinction will become increasingly important in future payment policy.

Please advance the slide. And the third thread on which I want to pull concerns participation itself. Many federal APMs remain voluntary, and voluntary participation introduces important limitations. Organizations that are well-resourced, highly organized, and already aligned with models are more likely to participate in them. Lower-performing organizations often opt out. As a result, improvement observed within APMs often reflects not delivery system transformation, but rather participation bias.

Organizations are responding rationally to incentives, but the reality complicates our ability to understand the true

effects of these models.

On the next slide, let me just highlight some empirical work that we've done demonstrating this phenomenon. We evaluated the Medicare Shared Savings Program, and when we accounted for non-random clinician exit, apparent savings were substantially attenuated with the MSSP. Higher-cost clinicians were more likely to leave participating organizations. And the lesson was not that ACOs failed. The lesson was that organizations respond strategically to incentives.

That's what incentives are designed to do, but it reminds us that observed improvement may reflect both delivery system transformation, as well as compositional change, and those aren't the same thing. This becomes particularly important when we think about generalized ability and policy design.

On the next slide, one reason that mandatory models deserve serious consideration is that they reduce selection bias. It generates more generalizable evidence, it forces operational redesign, it exposes real implementation barriers, and it creates broader

accountability.

Programs like CJR[12] and the TEAM[13] Model are valuable examples of that. The central point is that if patient safety is a foundational expectation of health care delivery, we should increasingly think about safety-oriented payment reform as core infrastructure, not optional participation.

On the next slide, I just want to close with bringing those three threads together. Over the last 25 years, we've built a first generation patient safety architecture that was grounded in what we could measure, structured around retrospective accountability, and often implemented through voluntary participation models. That architecture delivered important gains, but it also has limitations.

The opportunity ahead is to build the next layer, a safety architecture that is more predictive, more proactive, more system-aware, and more aligned with how care is actually delivered today, one that incorporates diagnostic safety, longitudinal care

12 Comprehensive Care for Joint Replacement
13 Transforming Episode Accountability Model

coordination, operational resilience, continuous learning systems, and advanced analytics capability for identifying risk before harm occurs.

Twenty-five years after *To Err is Human*, the patient safety movement is not over, but I do think it's ready for its next chapter, and thoughtfully designed payment models can help us get there. I thank you for the time of the Committee.

DR. BOTSFORD: Thank you, John. As a reminder, we're saving all Committee questions until the end of all presentations.

All right. So next we are thrilled to welcome back one of our very own past PTAC members, Dr. Jennifer Wiler, who is a Professor in the Department of Emergency Medicine at the University of Colorado School of Medicine. She's the Co-Founder of UCHealth's CARE Innovation Center, and the Chief Executive Officer of Minerva Partners.

Jen, welcome back and please go ahead.

DR. WILER: Good morning. Thank you so much for the privilege of speaking to the

group. I was asked to talk about the provider perspective. Next slide.

What I'd like to do is summarize briefly metric selection considerations, briefly review the types of financial models that exist and those within health care, think about the alignment of safety performance and payment, and then ultimately, the unintended consequences and considerations for the Committee.

Next slide. So first, let's talk about metric selection and considerations. Over the last two days, the Committee has heard much about where there are opportunities from a patient safety perspective. And the question is when thinking about financial incentives to encourage safety improvements, should the focus be on the highest harm areas, or those that touch the most patients, or those that have ultimately the highest impact with regards to morbidity or mortality or to a specific patient population, or maybe to cost?

Next slide. The next consideration is around maybe focusing on areas where there's greatest variability. There are many areas

that show nationally, depending on the publicly reported quality measurement, there's a huge variability in the top performers' performance and those of the bottom performance.

So the question is should payment models incent decreasing this variability, or specifically, should they focus on bringing the bottom up, or what about maintaining high performance? And should payment models look the same for each of those different groups?

Next slide. Maybe metrics should focus on avoidability.

Next slide. You might have already heard about the common rubric around medical errors occurring, some of which are deemed to be avoidable, and some of which touch patients. And then there's bubble where harm is considered a never event. There's also, the Committee reviewed, preventable sentinel events.

So maybe payment models should focus on these areas of highest harm where there's basically no disagreement that the event was avoidable and that it should have never happened.

Next slide. Another consideration is around the availability to capture the data. Much has been spoken about, including in Dr. Hollingsworth's last presentation, about data and data capture in our history. Currently much of our data that's publicly reported is from structure data. But just being able to capture data, I want to call out that there is still variability.

For instance, in surgical site infections, there's still debate about what's the definition of an infection. And I don't know about other organizations, but in my organization, sometimes we even have to discuss the case with NHSN[14] to decide if something should be called a surgical site infection or not. So there's -- it's still, although we think something that is very straightforward, it can actually be something where there continues to be variability and interpretation.

Next slide. And last but not least, one other thought around metric selection consideration and payment models is should there be a focus on one model, or should there

14 National Healthcare Safety Network

be a focus on holistic improvement of the system? So really, what is the impact on drivers of harm because we know that holistic improvement is what is ideal, but then how do we actually execute on that vision from a payment perspective?

Next slide. So there have been discussed many strategies to improve patient safety and to decrease harm. Those include standardization and training, the use of technology, the use of checklists like the surgical safety bundle checklist, or two-nurse medication verification. But when you look through this list of strategies to improve patient safety and think about how to crosswalk those to a financial reward or disincentive, that's where this gets challenging.

Next slide. So next I want to talk about different types of payment incentives for performance. This is not an exhaustive list, many of which of these types of programs are already available within both the fee schedule and also within other Medicare and CMMI programs. These include gainsharing or incentives or grants.

Next slide. And again, this is not an exhaustive list, but many different types of programs have been piloted or used as financial incentives to change behaviors. These strategies have been modified and expanded for use in health care in many different programs, and I won't walk through the incentives in the description and the purpose for which they were implemented, but much discussion has been talked about their success over the last few days, or lack of success.

Next slide. Actually, sorry. Can we go back? But the one thing I did want to say is but that this is a pretty exhaustive list of what are our options. So if we're thinking about current opportunities from a safety perspective, number two, what are the financial incentives that could be put in place to change behavior, we start getting down to actually on the financial incentives side, a much smaller list.

Next slide. So next, let's think about that alignment between safety, performance, and improvement, and payment. So if we walk backwards from the goal, I think we

can all agree that we want to eliminate avoidable harm, especially these never events or high-harm events. Ideally, we want to reduce those events that happen within our in-patient facilities because we know there are high volumes, so reduce hospital-acquired conditions as Dr. Hollingworth just talked about.

However, there are many other areas where we know there is opportunity that we should be mindful of, including timeliness of care, so diagnosis to implementation of a treatment plan; improved reliability, so actual adherence to that treatment plan; improving access to care. In my own community, we have dismal access to mental health and addiction resources, for instance, which we know is a co-founder in overall health and outcomes or poor outcomes; creating learning systems to make organizations more safe, but also, we should consider reducing the cost of harm to patients, both financial and to our care teams and moral and ultimately want to impact the most patients possible, I would think.

Next slide. So when we think about

what should be financially incentive, I think there's a couple of different domains. One is around data. Data is power, and not only having access to it, being able to then leverage it to change performance is important. And the Medicare programs have done this for a long time around pay-for-reporting. So should the consideration be around access to data and data sharing, because much of this safety data sits within proprietary databases within deliveries organizations?

The next is should we pay for process? Dr. Hollingsworth talked about this a lot, and so I won't go into that too much, but when thinking even about evaluating potential near-harm events from an event review perspective, should we actually pay for action? There's an opportunity identified by a system, a delivery system or care teams. Should financial models pay to change and improve their care delivery system, so actually action? And should we pay more if a system moves fast, or should we pay less if a system moves slow?

And what should this look like for high-performers who already do a great job of

improving care delivery to patients, and should payment look different for the low-performers who haven't yet achieved those types of outcomes? And last but not least, should the repayment for outcomes only?

Next slide. The last consideration I wanted to highlight is that when we think about payment, there's also different ways to slice and dice groups. So should payment be based on site of service? Should payment be based on a population or a disease or condition? Should payment be based on a provider's specialty? Should it be based on payer source? Should it be based, we say all care is local, on geo-location or geo-zip code, or should it be based on a patient?

I think if we look at where are there highest opportunities, again, thinking about payment models, then another really important consideration is then how is there a -- what area of focus for performance and then payment these programs should be based on.

Next slide. And finally, last but not least, when we think about behavioral economics, which was a term that was created at

the University of Chicago that combines elements of economics and psychology to understand how and why people behave the way that they do in the real world -- next slide -- we need to think about what are the unintended consequences of financial incentives in health care?

Again, this is not an exhaustive list. It is representative, but some of those unintended consequences include overtreatment or undertreatment, a disproportionate focus on short-term outcomes, and risk avoidance. Dr. Hollingsworth just uses the word, I wrote this down, I loved it, strategic response to incentives, and I'd add financial pressures.

And that's exactly right. It is behavioral economics, and it is a predictable and strategic response; however, it can be unintended in terms of impacting outcomes.

Next slide. And to go even further, there are literally examples currently within our payment systems where perverse incentives currently exist. Again, this is a representative list, not an exhaustive list, but of perverse financial incentives, their

description, an example in health care, and their potential consequence. This could include patient selection or cherry-picking. This could include data manipulation or gaming. I think we all know, but to say it explicitly, there's a lot of time spent in trying to remove patients from denominators in publicly reported measures to improve performance.

There's an overreliance on metrics, which -- this is what I would actually really like to highlight, I think in organizations where quality is judged only by the current publicly reported measurable indicators, it doesn't actually focus on creating these true learning systems that Dr. Hollingsworth was just talking about, but rather, especially in organizations maybe that are early on in their safety journey or maybe low-performing, or may not have the financial reserves, there is a simple focus on the publicly reported measures and not actually trying to improve the safety culture and focus on eliminating avoidable harm to patients.

And then last but not least I think the most perverse incentive that most are aware

about is defensive medicine and the fear of penalties which encourage excessive cautions, which again, can lead to over (audio interference).

Next slide. So from the provider perspective, I just wanted to highlight a couple of things. In general, right, the provider community, we want to do the right thing for our patients. We do not want to cause harm, physical, emotional, or financial to our patients. That said, we cannot be perfect. We cannot have 100 percent sensitivity and specificity from a diagnostic or treatment perspective.

We also do not want to be sued. We'd like to be paid fairly, and what's most challenging is that most individual providers or even teams don't feel like they're in control of the systems that they work in, and that's at the macro level and feel like many of these outcomes are actually out of their control.

So with that, I want to thank you for the opportunity to highlight some of these challenges around how to pay for performance

from the provider perspective.

DR. BOTSFORD: Thank you, Jen. Next, we're excited to welcome Mr. Jimmy Blanton, Deputy Director of Quality and Program Improvement for Medicaid and CHIP[15] Services at Texas Health and Human Services. Welcome, Jimmy.

MR. BLANTON: Thank you. And good morning, everyone. It is truly an honor to be invited to be part of such a distinguished panel. I'm already learning from our first two presentations on many things I can take back to our state, which is really the perspective that I'm here to give you today, the perspective of a government agency that oversees 16 managed care payers in our Medicaid program, and is also responsible for ensuring the safety, the well-being of our beneficiaries and that they're receiving the highest-quality services at the best value.

I've been involved in our state's efforts to transform, transition Medicaid from to a value-based model for over 15 years. It's a long process to move from fee-for-service to

15 Children's Health Insurance Program

value-based care. But patient safety's always been a critical priority of these efforts and, you know, that reflects some of the influence from Dr. Kenneth Shine who was the president of the IOM[16] when *To Err is Human* was published and brought his expertise to our state and leadership capacities at the University of Texas System and with the Texas medical community. So we do want to live up to his example in the work that we do in our state.

But that work, if you go to the next slide, you can see is really shaped by the complexity of our programs, and this is typical probably for larger states. Smaller states may not have the same kind of structure, but we are one of the larger Medicaid programs, obviously, in the country serving about four and a half million people. We do it through 13 regions and within each of these regions, we have up to six -- we have six programs that stratify our different Medicaid populations, including into products that serve individuals with disabilities. And so we have our 16, currently 16 managed care organizations who are

16 Institute of Medicine

working in a sort of what I'd call a managed competition model. And they're the ones who are administering it. And so we have a very delegated system in our state. One-size-fits-all isn't something that we're able to do often.

We do have levers that we operate, including policy levers and oversight levers that are in our contract. We have a very extensive contract, of course, with managed care organizations. And we have incentive payment programs as well. And so that's the approach we take. Our state is highly urbanized. It's a very diverse state. It's highly urbanized with 80 percent of our 254 counties are rural, and our provider community is similarly diverse. We have a lot of rural hospitals.

We have among, I think, the largest rates of small and independent practices among physicians. And so we are -- we have to be -- that leads us to take a certain approach in our state that I hope is considered when, you know, when the CMMI and others come out with models and that we might be able to use and adapt in

our state.

If we go to the next slide. So the question is how do we keep patient safety front and center? Well, we start with, you know, one of our chief opportunities at the Medicaid leadership level is to provide the goals and the objectives for our program, and we do this in Medicaid managed care through a quality strategy that's required by CMS, but we are able to shape that to fit our state. And you can see here highlighted that keeping patients free from harm is one of our foundational strategies that we have within our Medicaid program and has been that way going back for many years.

And we carry this through into the next slide and to the way we form our objectives. We have objectives for each of our strategies. These are the ones we currently have for keeping patients free from harm. They focus on reducing avoidable complications and adverse health care events in all settings, but there's really a particular focus on hospitals and nursing facilities and that you'll see by way of us being a Medicaid agency, and we cover

over 50 percent of the births in our state, and there's a lot of emphasis in our state on maternal safety, and so reducing severe maternal morbidity, C-sections, you know, these are areas that are of great interest to a Medicaid program because we cover so many births.

Next slide, please. Just to get more of a sense of how we operationalize this kind of work in our state, so then we move to our initiatives and our measures, which are mapped out in our quality strategy, and you see those here for our patient safety initiative. The goals -- all of the goals and objectives are operationalized through initiatives like this and through these kinds of measures. They include a lot of the traditional measures that we have heard about already from the first two presenters. And we also use -- we also look at potentially preventable complications.

We have software that we use for many of our programs that looks at I think 60 different potentially preventable complications, and we use that in different ways. And then we also do have some beginnings

here of trying to encourage certain cultures of practice for quality improvement by promoting the adoption of maternal morbidity safety bundles through Texas AIM. That's the Alliance for Innovation on Maternal Health.

And so that's the kind of thing maybe that we would want to look at more I think going forward in our state is how to bring these evidence-based bundles into our facilities and into our practices. So if you go to the next slide, we, you know, I think the first presentation really kind of lined up the way a state might handle this.

So we track all of these measures. This is one initiative through one of our directed payment programs, our comprehensive hospital increased reimbursement program. Our hospitals can earn bonuses, can earn payments for improvement and for reporting and for various activities that promote our quality goals. And this is for our patient safety goal for CHIRP[17], and you can see we track different metrics across the system and we see that, you know, at least in our directed payment programs

17 Comprehensive Hospital Increase Reimbursement Program

that we're seeing, you know, positive results in terms of what we want to see and that there's improvement on some of these core patient safety metrics.

But we also have many other dashboards in our state. We have one -- we have a core managed care quality program website for MCOs[18] which has a lot of interactive capabilities, and you can track not only patient safety but really probably up to about 100 measures. And there are different dashboards.

We have incentive programs and the metrics are reported on this dashboard, like Pay for Quality, where our MCOs have -- can earn capitation or be penalized based on their performance on key quality measures. We have five-star ratings for our managed care organizations. We have other incentives and requirements, you know, contract oversight that we do, and the data is reported through different public sites. And so that's very important for us, and that shows that as a state with 16 MCOs, we're really managing this

18 Managed care organizations

on a high level, which brings us to Alternative Payment Models, which is our next slide.

Alternative Payment Models are really, for us, a way for our managed care organizations to push down some of the accountability to their provider networks. We do not specifically direct these models. They're not directed payment programs, but we do have some requirements in them in terms of priorities that they may need to meet. And since 2018, we've been tracking uptake of models, and we've had requirements on managed care organizations to organize a progressively higher share of their reimbursement to providers through an Alternative Payment Model which connects payment to an incentive to a metric or metrics for performance for quality and efficiency.

And we've seen over the years, if you go to the next slide, some really, you know, what we want to see in terms of growth and Alternative Payment Models, just generally that, you know, they've nearly doubled in terms of their, you know, their use in our state. And so we have a lot of our dollars that are

connected, at least in some ways, to a metric, and this is helping the system become acclimated to being paid and providers to being paid and managed care organizations to paying in this way and not just a straight fee-for-service.

But there's still challenges to go to deepen the program from just trying to, you know, have dollars that are kind of nominally connected to an Alternative Payment Model. So let's go to the next slide, please. So there is one exception to our rule around the delegation of our Alternative Payment Models, which is really -- it's our hospital quality-based payment program which is our chief patient safety APM within Medicaid. And it looks at rates of potentially preventable complications and potentially preventable readmissions in Medicaid at the hospital level.

We use software from Solventum, formally 3M, a health information system. We adjust hospital scores essentially for risk, for clinical risk, and then what we do at the state level is we run their actual to expected rankings, and we provide that information to

our managed care organizations and to the hospitals. We also provide registries of members so that there's information for MCOs and hospitals that they can use for their internal quality improvement purposes.

And then our managed care organizations implement -- they have -- this is where they do have some flexibility on how they operate Alternative Payment Models. We're essentially, at the state level, we're doing the math, and we have a standardized approach, and then our managed care organizations are incorporating this into their Alternative Payment Models. So we do a little bit -- we have a little more of a direct role within our payment safety, our hospital quality-based payment program.

So if we go to Slide 11, you know, even with programs like this, we find that making progress with readmissions and, in this case, with complications, it's challenging. We have seen some improvements over the years around potentially preventable complications, the rates, anyway.

And then, you know, there was a

little bit during the public health emergency, there was some volatility, and we think that maybe the rates are coming back down. We'll see when we see our 2025 data, but these are challenging metrics to move, these complication rates. Readmission rates, even more so, and so we are always looking for things that we can do to help supplement this model to really move us forward in our state, and that's why I think the work that this Committee is doing will be so important to us.

So next slide. And we do also have other Alternative Payment Models that our MCOs have adopted. They tend to adopt models that can push down incentives that maybe we have on them through our accountability programs. And so they'll have PPCs[19] or potentially preventable events embedded in other models. And you can see some examples here. These are really just buckets. In some cases, patient safety may be the purpose of the model. In other cases, it's part of a model, like a total cost of care model.

You may have patient safety metrics

19 Potentially preventable complications

built into those kinds of models. It really kind of depends on where these managed care organizations are working in the state. They're trying to meet our providers where they can, and to bring the state along so that we get more -- we're able to have more participation in a value-based care.

So if we go to I think my final slide just to wrap all of this up, I think some of the -- you know, the main point that I really wanted to make is really around how we approach it from a pretty high level in our state by setting, you know, our -- what we try to do is set goals, set objectives. We try to provide some technical assistance and maybe some standardization where we can.

We are leaving it up to our payers with oversight from us to implement this across the state in different ways depending on the health care systems that they're dealing with, the providers that are in those different parts of the state. And so we don't have a one-size-fits-all program, but we are trying to kind of move this along in a way that is really beneficial for our members and which lowers

risks of something that's not working right or that could really create a problem with our providers, with our provider networks.

So again, thank you for having me. I look forward to the discussion today.

DR. BOTSFORD: Thank you, Jimmy. Last, we are happy to welcome back for the second day in a row Ms. Sue Sheridan, President and Chief Executive Officer at Patients for Patient Safety US. Please go ahead, Sue.

MS. SHERIDAN: Great. Thank you. I feel very special to have given the first and the last presentation at the PTAC, so thank you to the organizers. I want to just share a few reflections from yesterday, and then I'll jump into our earn-back model that I kind of teased you with yesterday.

I do want to agree with John, our first speaker this morning about, you know, in listening to the conversation yesterday and knowing the magnitude of harm in the United States from patient diagnostic errors, it really strikes me that payment models are voluntary. I simply don't understand why they're not mandatory, like John. And I say

this with a good heart, you know, I know this is kind of painful for clinicians to hear, but something I didn't say yesterday is that, you know, I shared that my husband died. I was a single mom for 15 years, but I did get remarried, and of all professions, I married a doctor.

So I have profound respect, and I honor the clinicians, and I know the hard work that you do, and I know that the systems that you're working really aren't designed to optimize your outcomes either. So I say we need mandatory payment models, but I want to shift into the earn-back model because it is not a punitive type of model. It is, I think, an exciting model. Now, this was created by various minds. Many of the minds are patients who have experienced losses or family members who have experienced losses.

And like I said yesterday, the first thing we want when there is harm to ourselves or a family member is that it never happens again. And so many of the payment models that I've read about, really they're not about learning. And so I want to walk through --

now, yesterday, for those who didn't hear me speak yesterday, you know, I focused yesterday on the importance of collecting and learning from patient-reported outcome and experience measure or patient-reported safety measures. We simply are not capturing those, and it is a very rich layer of data that quite frankly other developed countries do collect.

And yesterday I talked about, you know, what are the values of patient-reported outcome and experience measures, known as PROMs and PREMs. The value, it measures what matters most to patients. Transparency, it makes hidden harms and near misses visible, measurable, and actionable. Preventive, real-time patient reporting, the measures can identify safety risks, and harm can be prevented.

It contributes to a learning health care network, a real-time learning network and a much faster learning network where we don't have to wait for claims data that we know can take months. Accountability, PROMs, and PREMs create C-suite accountability for patient and diagnostic safety. And the last element of

value of patient-reported outcomes is integrity. These are harder to game.

So I just wanted to say that that was what I covered yesterday. You know, yesterday you also talked about should it be -- should we embed patient safety as add-ons to several models, or should we have on big gestalt, and I think, Leo, it was you who said, yes, and, and so I'm going to talk about some of that yes, and today.

Yesterday I presented kind of a short-term approach where we could package some of these patient-reported outcomes and, quite frankly, other safety measures into current ACO models because we've got that infrastructure. So what I'm going to do today is talk about the next generation payment model. Now, this could be an add-on, a module add-on to other programs. I don't know if we would aspire to do one big safety stand-alone model.

Now, we're calling it the PIVOT[20] Earn-Back Model. That is just because it is based on the PIVOT questions, the patient-reported experience measures and outcome

20 Patients Involved in deVeloping Outcomes Together

measures that are currently getting validated. This could be a patient safety earn-back model. We're not wedded to the title, but, you know, we patients had the opportunity to kind of blue sky, and the beauty of patients blue skying about a payment model is we don't see barriers. We're not in it. You know, like a lot of people, we see opportunities.

So that's what I want to present today. So you can see here the, you know, with our next generation, I'm just going to call it the PIVOT Patient Safety Earn-Back Model. I'll call it the Earn-Back Model. It directly measures what matters to patients. It measures failures in diagnostic and safety delays, communication breakdowns, and prevented harm.

It allows a second chance, and we're going to walk through this, but it allows health care systems a second chance to reinvest and recover performance losses through demonstrated safety improvement. It rewards measurable improvement rather a one-time penalty cycle. It encourages transparency and learning rather than fear and hiding harms. It is technology-enabled that I'll walk through as

we go through this. And we believe it will achieve better outcomes and lower costs.

I also want to address, now, when we created this model, it was actually a couple months ago when we were refining it, and John made me think of this. You know, should we also include the Patient Safety Structural Measure in a model like this? Now, the Patient Safety Structural Measure is the gateway to safety. Yesterday we talked about this as being kind of the foundation of culture and leadership. Is there a way, and I'm asking you to kind of blue sky this with me. Is there a way that we could build in the PSSM[21] into a patient safety earn-back model?

So first, just a high-level overview of the PIVOT Earn-Back Model. Okay. It's a two-sided risk. We do believe that there's got to be some skin in the game, that organizations can share in the savings, but they are accountable for performance. When they don't meet their benchmarks, and again, we were playing with some numbers and percentages. We are not wedded to all this, but we think there

21 Patient Safety Structural Measure

has to be a higher weight to safety, that performance, if they don't meet their measures, it goes into a reserve. They have the opportunity to earn that back. They're using patient reporters as some of the measures along with others, and there will be a digital AI component to this.

So the PIVOT Earn-Back Model, as you can see on the left-hand side, I don't know if you can read it, but for those who weren't here yesterday, on the far left are what we call the PIVOT questions. These are patient-reported outcome and experience measures that matter to patients. We went through a very rigorous process over the last couple years, but patients want to be able to report unexpected physical, emotional, financial harms. We want to report if we were told how to report our concerns. We want to report if our or our family members' concerns were dismissed. This was ECRI[22]'s number one safety issue two years ago.

We want to report delays in diagnosis, treatment, and responses in clinical

22 Emergency Care Research Institute

care. We want to report at discharge were we ready and did we feel safe when we went home, and we want to report our overall perception of safety. Did we feel safe in the hospital? Now, what if we were asking patients this, you know, every day while they're in the hospital with some chatbot or something? You know, think of the data that we would collect.

Now, to the right of that, we've got three domains. Now, maybe we need a fourth, but this shows clinical outcomes, and we heard a lot about ways to collect clinical outcomes with trigger tools and other ways. We have patient-reported outcomes at 30 percent, and then we have the cost efficiency. Now, maybe here we need to add another domain that is structural, a structural domain, and fit the Patient Safety Structure Measure in that. Again, just kind of thinking of pulling in all the levers that we have at our fingertips already at CMS to really make a comprehensive payment model.

Now, another thing that I really want to stress is the payment model lives within a much larger ecosystem. So we need to

remember that CMS has levers, AHRQ[23] has levers, and so how do we pull these into this payment model?

So the next domain that I'm going to talk about is just the technology-enabled learning and burden reduction. We envision, at least for the patient-reported measures, that these will all be measured automatically. Think about again if a patient is in a hospital or after a visit that they have an app or their portal, and they're asked the patient-reported questions. It goes straight into, you know, the AI can collect it. It can analyze it. It can triage it and then actually embed it right in the revenue cycle.

So we're really trying to think how do we reduce burden? You know, other ways, well, you can just read that, but it really simplifies, you know, using technology in many ways. We believe that also if it's simpler and more automated, we'll have higher patient responses. And so we really see this model implementing AI in automation across the board to reduce burden.

23 Agency for Healthcare Research and Quality

Now, this is the earn-back cycle, and this is what gets kind of fun. So this is -- whoops, sorry. I've got the wrong page.

So just to walk you through this, for step one, if a performance measure is missed, now of course, we'd have to know what are those performance measures and the scores and that, but if it is missed, the organization misses a benchmark, and a portion of payment is withheld. Now, Sam, you said yesterday it's their money. So think about this, if they take their own money and put it, let's say, in an escrow, for lack of a better word, and that -- and it's put into this reserve and that they have at their own opportunity to show that they've improved in certain areas, and then they can -- if so, they can earn a percentage of that back.

Now, think about, again, those levers that we have at CMS and other places at that improvement implementations. Think about utilizing the QIOs, the quality improvement organizations that already exist that are free consultants to health care systems. We might look to see if AHRQ has already created patient

safety tools that can address that tool, or are they identifying problems that could spark new patient safety research at AHRQ?

So I liked, Sam, yesterday when you said, and this is exactly what we're envisioning here, now if they take their own money, and they set it aside, and they can earn it back, and they choose not to, they're choosing not to earn back their own money, you know, with the PSSM now with board and C-suite now involved in patient safety, I don't think the boards would like that. So I think there is a great incentive to use this kind of earn-back model now that we have the PSSM to really ensure they don't leave money sitting on the table.

So we created something. Yesterday, this language was used -- oops, I'm sorry. I'm going too fast. The economic flywheel. And, you know, it just, in my mind, in our minds, it makes sense that the more you invest in safety, that you're going to reduce harms and costs. You're going to earn back your returns. Those returns create capacity to invest even more, driving a continuous cycle of improvement and

value.

So again, this is kind of the constant learning, constant investing cycle that patients want to see. We don't want to see a one-and-done with some of the payment models that penalize and then they're done. In the current payment models, I question what we're learning. We're learning how to reduce utilization and reduce costs. In this type of model, this is a patient safety continuous learning model.

So I'll just skip over that. So I want to close with this quote. It's by Sir Liam Donaldson. He was the Chief Medical Officer of the United Kingdom. He also was an international leader in patient safety with the WHO[24], and he said, "To err is human, to cover up is unforgivable, and to fail to learn is inexcusable."

So I would say one of the greatest risks to patient safety is -- in our current payment models is the status quo. This will take courage. And I want to go back to yesterday when I talked about Pat, my husband

24 World Health Organization

who died from the failure to communicate a malignant pathology.

When Pat was dying of his cancer, and he had about 10 days to live, you know, he got really silent when we knew he had 10 days to live, and he looked at me and he said, "Sue, I want to go to Disney World, and I want to take my kids to Disney World and let them have the time of their lives." At this time, Pat was paralyzed from C5[25] down.

So within three days, 53 of us, including his four big brothers who carried him, we went to Disney World. And while we're at Disney World, it was soon before he died, but Pat and I had a chance to have -- of course, we had some very precious conversations. And Pat said to me, he said, "Brown" -- that was my maiden name -- he said, "Brown," he said, "Whatever you do, he said, don't give up on patient safety." That was 20-some years ago.

So PTAC, I ask the same of you. Do not give up on patient safety. We have a lot of work to do, and it will take courage. I

25 Fifth cervical vertebra

could say the patient community is relying on you to raise the bar in patient safety and payment models, and we've -- several of us have given you ideas.

So in honor of Briana, of Pat, of Cal, and all the patients who don't have voices around patient safety, we are calling on your courage and your wisdom to move the needle. Thank you.

DR. BOTSFORD: Thank you, Sue. Thank you to all of our experts for the conversation and those wonderful presentations to kick it off.

DR. BOTSFORD: At this point, we get to move to questions. So for any PTAC members with questions to start it off, please go ahead and flip your name card up, or for our virtual Committee members, feel free to raise your hand on Zoom.

I'll also give permission to any of our presenters to ask questions of each other. We do encourage all of our experts to give -- keep responses to a few minutes so we can encourage a broad conversation.

Okay. So with that, let me go ahead

to Krishna to start.

MR. RAMACHANDRAN: I'll kick us off there. So I've been reflecting the last two days. Clearly like the patient safety needs focus, and we've not made more progress, and so that's like very resoundingly clear, I think, from talking to folks here as well. I think the part, the tension that I am sort of like wrestling with is does it need a focus payment model or not? Is it embedded in existing models? Does it need a dedicated model? That's the sort of tension that is in sort of my head swirling there.

I guess -- each of them, of course, have their own pros and cons, right? And I'd love maybe the panelists' perspectives on I guess dedicated payment model or not I think would be helpful. So it sounds like you might be in the dedicated payment model camp, mandated payment model camp, it sounds like, but I'd love maybe others as well to see where folks land.

MS. SHERIDAN: Yeah. Well, and you heard the tension in my own mind. You know, what I want is what's best for patient

outcomes, and so right now, like I said yesterday, maybe for now, we embed it as an add-on onto current payment models. We want this to be treated with urgency. This is an urgent matter, and so I would say can we consider it like a stepwise approach?

Do we right now embed it in current payment models and see what happens? You know, is it effective, and kind of pilot it at -- like that and maybe eventually, I mean if we're not moving the needle in patient safety, which we have not, I mean, yes, there's been pockets, but I think we need something very robust.

I don't know the answer, if it's an add-on, and, you know, that's what CMMI said yesterday, you know, not sure about a dedicated payment model. So I don't know the answer to that, but the answer is whatever makes patients safest.

MR. RAMACHANDRAN: The other panelists, any perspectives?

DR. WILER: Sure. I'll jump in. I think the answer is what sounds like someone gave yesterday, and it's both. I think when we think across the current programs, there's an

opportunity to put the safety lens and say is there avoidable harm or potential harm, right, we want to move upstream in that potential space, where if we shined a light on it in a model that focuses on primary care, model that focuses on cancer care, timeliness, you know, untoward events related to, you know, medication reactions, non-adherence to treatment protocols, et cetera, could we create a measure in those specialty spaces? We should do that immediately.

I also think that you've heard a lot about safety being considered a core infrastructure, not only focus, but also from a payment perspective, and I know when I had the pleasure of serving on the Committee, we talked a lot about the cost of capital for infrastructure. That's real money. Not every organization is in the same place with regards to their, you know, integration of data or in how to leverage that to do improvement work. And so I think there's some wonderful suggestions that were just given by Sue around thinking about what a stand-alone model would look like.

But we've never tried it before in this space, and I think it's -- this is a big enough problem that has not been improved over a significant amount of time and focus, as John was talking about, and it deserves, and our patients deserve, a stand-alone model for us, even if it's just to create infrastructure that puts this on an above-the-line strategic focus from our, you know, large organization -- delivery side organizations that we should do it.

DR. BOTSFORD: Jimmy?

MR. BLANTON: Thank you. And, you know, on the question of whether we need a single stand-alone model, I mean, I'd be a little bit skeptical about something like that over a nation as vast as the U.S., but I think that what we really need more than anything is a better data infrastructure. We need to make our electronic health information, you know, the HIEs[26] work better. We need TEFCA[27] to work. We need access to better data if we want to really take the next steps to -- not just for patient safety, but for all of our quality work

26 Health Information Exchanges
27 Trusted Exchange Framework and Common Agreement

across states.

I think we do the best we can with claims data. Even that could be improved, I think, but we need to be able to track these events better, track patients a little bit better in terms of, you know, having more visibility on where these kinds of safety issues are emerging and where the accountability lies. So I think we just have a lot of -- some data gaps we still need to fill.

And then we need also, I think, better evidence-based practices that could be incorporated in that are being adopted. So I think those are areas more so than just having a single model that would be more -- that would move the needle, but, you know, that's where I would come down on that.

DR. BOTSFORD: Thanks, Jimmy. John?

DR. HOLLINGSWORTH: Yeah. So first off, the presentations this morning have been -- I've learned so much from the speakers on this panel. In particular, Sue, your presentation was just simply amazing, and the work that you're doing is to be celebrated.

I would come down on this particular

question of do we need a dedicated program or do we leverage existing programs, I see it as like a continuum, and we should, you know, take advantage of what is there now that we can piggyback off of building towards having a stand-alone APM focused on patient safety.

And I really think the focus, and I think Jimmy made comments to this, is moving away from what is easy to measure and really recognizing that capability of the learning system that we hope to see in each of our communities to protect our patients from harm.

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

CO-CHAIR PULLURU: So my question is for all the panelists, but starting out with Jimmy and maybe John. When we talk about these, you know, I saw 2 percent, 2.5, 3 percent as far as at being at risk, right, the unintended consequence of some of this is that patients have less access because people will just opt not to play. And I've seen that happen, you know, when multiple groups have said well, we're just going to stop taking Medicare because we can't make it work anymore,

and there's just way too many burdensome administrative stuff.

And I guess, Jimmy, you've done this in Texas, you know, a very small state with Medicaid which is a very difficult place to get access anyway. So I'd love to hear, you know, did you see a bunch of people just say you know what, we're not going to take Medicaid anymore because now there's another 2 percent that you're holding?

MR. BLANTON: Yeah. I think that -- so in Texas, we did not see that. It may be difficult for hospital systems not to take Medicaid in our state, and so that is part of it. And that program is really directed towards hospitals. Now, we do have some safeguards in around the size of the hospitals. So you have to have a certain number of events, and so where there's -- you know, so some of the really small rural hospitals may not be subject to the penalty because of that in a given year.

We try to risk-adjust the results as best we can clinically, and so that, I think, provides some sense of fairness, although

there's still always, you know, a lot of engagement that's necessary with our hospital systems about how we're approaching this and, you know, how we're measuring this. But it is really a mandatory, it's -- it's a mandatory model that actually the legislature authorized back over a decade ago before we were even in managed care as much, and so we used to apply it in our fee-for-service system, and then it has moved into our managed care system.

So we have not seen, with those levels of risk, you know, hospitals that are not contracting with our managed care organizations.

DR. BOTSFORD: John?

DR. HOLLINGSWORTH: Yeah. No, I would -- that's a fantastic question, and, you know, one way to get around it, I think, is the obvious one, all-payer models. And, you know, those aren't set up, obviously, but that would help to address the potential concern that you could intentionally exclude populations of patients based off of payer.

Moreover, you know, there's a lot of compelling empirical work that would suggest

when you do have payer-specific models that the other -- the hope would be that there would be spillovers to those other populations of patients that aren't maybe targeted by a value-based program, but we have evidence that suggests that that doesn't happen, and that sometimes organizations will specifically target interventions based off of the program.

So if we could move to all-payer models for these types of things, I think that that would be the -- address the concern that's raised, because I think it's a very legitimate one for sure.

DR. BOTSFORD: All right. I'm going to go on to the next question and Lauran.

MS. HARDIN: Wonderful. The presentations have been excellent. This question is directed to Dr. Wiler, and, Jen, it's great to see you again, but I'll also open it up to the entire panel. So you called out on your slides a really interesting point that we haven't heard a lot about, which is mental health and substance use disorder as a confounder to patient safety and also cost and complexity in the populations.

I wondered if you would have recommendations around metrics, practices, or incentives for that population and what you've seen with that, if you could speak to that?

DR. WILER: Thank you for the question. So great to see you. I would say that I'm not an expert in this area, but as a practicing emergency physician, I think the simplest measure is access. Does the patient have a need, and do they have somewhere within the community to engage, if that's for their addiction services, for their behavioral health services?

I think we underestimate how simple access to care is in terms of a measurable metric that we already collect within our data systems. Again, I'm oversimplifying here, you know, back to the comments that Jimmy made. But that said, that timeliness of care and connection is so important. That's been shown in studies over and over, so that's one that I would suggest, but also throw it out to the rest of the group for suggestions.

MS. HARDIN: I would love to hear from the other panelists, especially Jimmy with

Medicaid and anyone else if they have comments about that.

MR. BLANTON: Do you mind repeating the question again, make sure I understood the question?

MS. HARDIN: Sure. So having been involved with the National Academy of Medicine high-costs, high-needs consortium and really looking at patient safety and quality, we know mental health and substance use disorder conditions really can be confounders, as Jen had said, and also a really important area of safety, so we haven't heard a lot about measures, patient safety related to that. I'm just curious if you tapped into that with the Medicaid population?

MR. BLANTON: Yeah. I would say that when we look at like preventable events, that we do often, like, those are categories which have the highest numbers. There's clearly a strong relationship. I think in terms of the way we do our metrics, we try to account for that through the risk adjustment, which is important so that, you know, you're not having a -- like an unintended consequence

that was just brought up where those individuals might find it harder to get treatment for some reason.

So you do have to build it into your risk adjustment, I think, models to start with. I mean, that's kind of a technical answer. We do have within our APM structure what we've done, and it's something we need to look at; we were just focused on the numbers for many years. Are you getting half of your dollars into an arrangement that has quality metrics as part of the payment?

And then we went back and thought we needed to really deepen this, and so we added some priorities into our APMs for our managed care organizations that they needed. They didn't have to, but the way that it's scored, it would be beneficial for them to try to address behavioral health needs specifically to have models that address behavioral health needs. Integrated behavioral health, in particular, has been a priority within our state that we're trying to address in a number of ways in Medicaid.

And, you know, we have the sister

program that we work with on that as well, so, yeah, it is -- what you say is absolutely true. We have to risk-adjust for it, and then we need to have models that are really focused on improving care for members who have behavioral health needs.

DR. BOTSFORD: All right. To John for comment?

DR. HOLLINGSWORTH: Yeah. No, I -- yes to everything that's been said. Clearly we have a national crisis when it comes to behavioral health and access to it. There just aren't enough behavioral health professionals to care for the population that needs that care. And this is separate from our discussion on patient safety today, but I do see that this is where there's a real opportunity for some of our AI solutions, agentic AI and whatnot, to really help with cover some of those gaps that we have in access.

But to Jimmy and Jen's points around, you know, measurement and the fact that those patients of ours who have behavioral health issues, that does confound a lot of our measurement, and being able to account for that

in a thoughtful way is something that any program that comes as a recommendation from this group we need to account for.

DR. BOTSFORD: All right. I'm going to go next to Larry, then Sam.

DR. KOSINSKI: I have to first open up by saying Sue's passion is compelling. And that's what we need. We certainly have interest from CMS. Sam's been here two days sitting here with us. We heard yesterday from the technical side that this is all doable. This is all measurable. So, you know, what do we need? We need to change the culture. And how do we change that culture?

And I go back to, I think it was 2001, when Katie Couric's husband died of colon cancer, and it was a non-physician, non-government official, a celebrity -- okay, I'll give her that, but it moved an industry. It moved us to do something that we had the ability to do before, but we just weren't compelled enough.

And I think, you know, sometimes -- I'm an old guy. I've been doing this a long time. Sometimes it's like pushing on a noodle

to try to move things forward, but if we can get a pull strategy maybe from both the patient space, as well as the governmental space, and I also would bring in here the payer space because they're paying for, and the employers are paying for, the disasters that occur from a lack of focus on quality and outcome.

But I want to close by saying I'm opposed to a stand-alone safety-based measure because as Lee said yesterday, I can't separate the quality from the safety, the safety from the quality, the safety from the quality and the cost. They're all intertwined, and we need to use our technology to push our data, but I think a pull, a strong pull from the public and from CMS would help move this forward.

Sue, you're welcome here any time.

MS. SHERIDAN: I'll keep coming. Thank you. Just about the passion and how do we go forward, just really quickly, what I didn't say yesterday, you know, you know my son has a condition called kernicterus. It's brain damage from jaundice. When Cal suffered that, so were many, many, many other babies in our nation. This is in the 1990s. They all fell

through the cracks. And so seven moms got together, including me, and we called together all the HHS agencies.

We were told, I was told, that I was Pollyanna to think that we could change the standard of care. I am so glad they called me Pollyanna because, guess what, that lit us on fire, and we collaborated with every HHS agency, including Joint Commission, and we changed the standard of care. It is now required that all babies get a bilirubin.

My point is, we started out, we moms, believing that we were going to make a difference. We started out believing we were going to be successful, so that's what I want us to do is believe in something that might be out of the box. It is going to be different, and we will get pushback, but we have to start believing and then just put every ounce of energy into what we believe.

DR. BOTSFORD: Sam?

MR. WATTERS: Thank you. And thank you for everyone's perspective on this. I want to weigh in on the stand-alone model side. I think clearly I am biased. I've been biased,

though. In the first administration, I worked at the Agency for Healthcare Research and Quality. I helped push the talking point that we have 21st Century Cures, now we need 21st century care.

I saw us put out research that was proven to save lives and move the needle, and then it would not be adopted. That is a problem that can't be solved by just adding elements of patient safety randomly in small models as a check the box or an afterthought.

My failures to move the needle on patient safety in the first administration unfortunately haunt me by the fact that the love of my life, I can't even say died. She's still alive in a vegetative state, and I have to live with that every single day because we have not taken the steps that we should as a country.

So I want to offer four reasons why I think we really should consider a stand-alone model. First, I'd never actually heard the full quote from Sir Liam Donaldson, “to err is human.” The, to cover up is unforgivable, to fail to learn is inexcusable, piece, I think,

is really important to the point of needing a stand-alone model.

To cover up what happens when we're less punitive, we know from two countries, New Zealand and Sweden, that when you offer a sort of national compensation fund, which I am not advocating for, but when you do that, reporting of patient harm goes up significantly, and that's not because of an increase of patient harm. That's because hospitals no longer feel compelled to hide. And we know that hiding exists.

We know -- I know that it happened in my personal experience because the doctor that gave too much lidocaine to Briana told the hospital that it was not lidocaine toxicity, and it was. And it clearly was. So we know that there's something broken fundamentally about the systems that we have, and just adding patient safety as a side element is not going to solve that.

Number two, we know that hospitals are experiencing significant downward cost pressures. Do we really think that tighter budgets are going to lead to the type of

investments that we need to save lives? Personally, I'm concerned that if we lose focus on patient safety, that those investments become secondary, or they get lost altogether.

Third, and a very obvious one, is that we have been talking about this for at least 27 years. Okay, we had Lucian Leape, was a godfather of this. We had John Eisenberg, was a pioneer of this. We've had multiple waves of national outcry from different high-profile people suffering these types of accidents, and yet they continue to just recur over and over again. I think it's time that we recognize that we have to have something dedicated to figuring out how we can get it right, and then we can build those learning -- those lessons learned into everything and make that integral to everything that we do.

And then four is sort of the obvious one with the emergence of so many impressive technologies and an administration that is willing to embrace that type of change. I mean, I'm here for two days because I want to see something move in this space because I'm committed to it and because I've had the

permission to clear my calendar to sit down here and try to figure something out.

We should take advantage of that opportunity, and we should understand that if we don't commit ourselves to figuring out what the next wave of change that is coming in our health care system looks like, that there will be gaps. There will be cracks, and now is a pretty good time to commit ourselves to figuring out how we can integrate safety into the next generation of care. Twenty-six years in, I don't think we have 21st-century care. I think we have something that maybe looks like a marginally increased version with new technologies of 20th-century care.

I know that's a pretty bold statement, but I would really like to see us think about what we can do to learn a lesson nationally so that it becomes -- so that we're not third, fourth, fifth, sixth, whatever we are in patient safety because we're not first. I would like us to be first. So thank you.

DR. BOTSFORD: All right. Any response from our presenters or comments?

MS. SHERIDAN: I'll just add one

more thing and, you know, it's -- I don't know if I should say this in a government-recorded event, but, you know, I shared what Pat said to me when he was dying to never give up on patient safety. He went on to say something else, and that was, he said, "Brown, go out and kick some ass."

You know, honestly, I don't think I have enough, and so I'm sending that message to you as well. We have this opportunity.

DR. BOTSFORD: I'll end with a question. Well, probably close to ending, maybe there's time for one more, but as we think about, you know, over the many years that folks have been talking about the inability to move the needle, we have tried various strategies. We've tried penalties. We've tried quality measure reporting. We've tried some quality measures that border on safety. We can -- that's a separate conversation, I suppose.

One of my skepticisms is whether we think 2 percent, 3 percent around the margins is going to move the needle, and I'm curious around outside of thinking about withholds or

small amounts around the margin, what types of more bold funding mechanisms or prospective payment could we think about that might move the needle? And so curious for Jen and John in particular, but we can also get the Texas Medicaid perspective as well, too.

What do we think would really be needed to materially create the systems or purchase the emerging technologies for a system that wanted to make these changes? Because I suspect it's not only just will, but there's real financial barriers in this case that I'm curious if the will alone is enough.

DR. HOLLINGSWORTH: Jen, do you want me to go first? No, I mean, that's -- and I think Jen said this in her presentation. I sincerely believe that all providers, physicians, advanced practice providers, non-physician clinicians are striving to deliver the safest care that they can. And to your point, you know, one of the challenges that we have, I think, to take that next step, we do have to start to embrace technology that is coming online, and there have to be mechanisms that incent that.

A former mentor of mine once said the way you herd cats is by moving the milk, and so we do have to create ways in which we can incent that behavior for systems and, you know, I think that there are paths forward for doing that, but to get people to do what we need them to do to evolve from a punitive retroactive program around safety to something that is proactive and identifying all of these harms before they reach the patient.

So I completely agree that we need to incent systems to do the right thing.

DR. WILER: Thank you for the question, and I have to say, Sam, any person who creates a list of numbers, which the Committee knows I love to use to do, I am just -- I am so excited to hear your list and fully support it.

Lindsay, my comment would be I think, you know, over the years I had the privilege of serving on PTAC. Again, we heard over and over about the challenges regarding infrastructure, and I think when we look back over the last two decades of meaningful change and what were those levers that made a

difference in delivery of care, acknowledging that there are barriers to infrastructure and solving for those problems made a big difference.

Moving from paper to electronic records, not that there's not many issues that we've heard over the years around well, how do we actually now integrate those EHRs[28], for instance, but just that pivot from paper to electronic had a huge cascading impact on patient safety, even if we just focus on medication safety, for instance.

But we think about the biggest opportunities around care. It's around communication and care delivery and coordination. So what is preventing us from being able to do that? It's this, you know, infrastructure around communication. So acknowledging that and paying for that absolutely I think is something that these models need to consider and again, why I think there should be a stand-alone model, just as Sam was describing, to acknowledge that.

And again, we heard these same

28 Electronic health records

issues when we heard about rural care models, for instance. So we'd be checking off a couple of different boxes. And then next, I think considering paying for information. Again, if we see what's the time from diagnosis of cancer to delivery of care, and is it different for patients with mental health issues or patients who live in certain communities or patients, you know, who are of a certain ethnicity, that data then really helps us to identify where there are gaps to solve. And maybe that's where then really paying to solve those problems at a local level is where I personally think are the biggest, you know, opportunities.

As a Chief Quality Officer, you know, we try to tackle metric performance, but it's when we put our unit-based teams together who are looking at care and saying how can we do it better, and they were doing their own problem-solving, did we actually improve care delivery for many patients, not just one patient population? So in thinking about doing that at scale, there have to be big dollars to create that infrastructure and then create the process, and then I think we will see the

outcomes.

DR. BOTSFORD: Okay. John?

DR. HOLLINGSWORTH: Yeah. I just wanted to piggyback off of Jen's first comment.

I think meaningful use is a great example of how there was a technology out there that had been -- adoption of which was slow, the electronic health record, and that was something that really galvanized the medical community. And there are very few practices today that aren't on an electronic health record. As Jen said, there still are challenges with interoperability, but some sort of push from a group like this to create, you know, that sort of program could really accelerate that infrastructure build out that's needed to get at some of those latent safety issues that right now we're just not addressing with our current programs.

DR. BOTSFORD: All right. Thank you, all. We're in our rapid-fire close, so I'll -- for all of our presenters, if you have any final comments, it's your speed round for 30 seconds or less for any closing comments.

MS. SHERIDAN: I'll start. Just

going back to the potential of an earn-back model, I want us to really seriously consider something like that. It is a completely a different psychology than the compliance and penalty model. So I think if we think about this really proactively, it could psychologically change how hospitals think about patient safety and process improvement, and like I said yesterday, the earn-back model is a learning health care system within a payment model where I think there could be so much learning across health care systems to really ramp everything up.

DR. BOTSFORD: All right. Well, thank you. Final one, John.

DR. HOLLINGSWORTH: Yeah. See, I would just end by saying I suspect the future safety-oriented APMs will look more like investments in organizational capability than traditional pay-for-performance programs. The aspiration should be to create payment models that encourage organizations to become better at sensing risk, learning, and adapting rather than just avoiding penalties. So I'll just end on that.

DR. BOTSFORD: Jimmy?

MR. BLANTON: Yeah. And just as you're doing this work, I would say not to forget about, you know, a lot of hospital -- I mean, not all of this care is delivered through, you know, these large integrated health care systems that have massive capabilities. There's a lot of smaller hospitals that are serving a lot of people, particularly in a state like us -- like ours. So please consider that, too, and have some flexibility in the way that you're moving forward.

DR. BOTSFORD: Thank you, all. So big thanks to all of our four experts for your time and your presentations here. We appreciate your insights. You are welcome to stay and listen for our final closing.

At this time, we will have a break until 10:50 Eastern Time. Then, you can join us as we welcome public stakeholders to share their comments on the meeting topic. And then our day will conclude with a final Committee discussion. On break until 10:50.

(Whereupon, the above-entitled

matter went off the record at 10:43 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 have signed up to give a public comment. I will announce your name and your organization. If you're here in person, please come up to the microphone and begin your three-minute comment period. If you've dialed in, our moderator will unmute your line so you can deliver your three-minute comment.

I would like to open it up to Dr. Divvy Upadhyay, who leads diagnostic safety efforts at Geisinger. Divvy, please come up to the microphone and proceed with your comment.

DR. UPADHYAY: Thank you, Dr. Pulluru. And just to clarify, I no longer have that affiliation. I worked for over a decade on diagnostic safety, so just a correction. And I apologize that I'm not there in person. I appreciate the ability to share my comments remotely.

Please let me know when I can start.

CO-CHAIR PULLURU: Go ahead and start.

DR. UPADHYAY: Oh, thank you. I appreciate it. So Chair, members of the PTAC, and officers at the federal partner agencies, good morning. Please allow me to express my gratitude for convening on such a critical, sensitive, and complex subject as patient safety. It sort of breaks my heart to learn that yet another person exposure and lived experience to patient harm had some part to play in the efforts that led to the organization of this event. I pray that God gives strength and love needed to Mr. Watters and his loved ones to live through this unspeakable pain and really thank him for sharing his story.

You see, no clinician, and I'm preaching to the choir here, so no clinician really enters a clinical hospital wanting to make a mistake, yet they happen. No system wants to live with these errors, yet they happen. They happen sometimes because humans inevitably falter. They do their best. They spend years doing diligent hard work, but yet

they can falter when it comes to these things because of things they don't know, things they assume they know, or mental shortcuts they take owing to habit or time pressures.

That's unavoidable. To add to that, organizations that have not paid attention to safe design or patient-centered goals complicate the matter. I bring this up to give you context from my own lived experience over the last 10 to 15 years because I think, you know, as a conclusion to a lot of exposure that I've had in the field in the trenches out there, I think payment methods are a very strong influence on health systems.

I've spent a decade -- half a decade studying payment models in depth. Actually, coincidentally I used to very briefly be a senior associate for a contractor for PTAC many, many years ago. I spent some time, almost a decade in the trenches, for patient safety, you know, simultaneously researching it and operationalizing it.

How I've seen things are that health systems with billion-dollar revenues often traditionally look at safety as a non-revenue-

generating cost center. They don't have the time or the bandwidth to encourage reporting or, for that matter, create an environment to proactively address potential safety issues. I think the point I'm trying to get at is we're in a crisis. I say this respectfully, and I don't take this lightly. And for this crisis, I think we need government intervention.

A reason I think that a mandate is needed because I think hospitals are ready to do anything that CMS wants them to do. You know, all hospitals have people in charge of length of stay, readmissions, infection -- Anything CMS wants, it gets done. And so I don't, you know, want this to be seen as something over the top, but I urge you, the PTAC, to consider strongly recommending to the Secretary to mandate some basic safety infrastructure, and I have faith that the current administration does not shy away from unpopular opinions or complex policies that might especially be in the larger interest of U.S. citizens.

Prior administrations have tried but could not execute. Here, in my view, we have a

strong executive, and I propose, and I say this very respectfully, an executive order on patient safety. I propose it to be called the TRUMP Act of Trump's Action Plan where T stands for transparency, R stands for reform, U stands for unprecedented, M stands for medical, and P stands for patient safety. So the Transparency and Reform for Unprecedented Medical Patient Safety Act, or action plan if it's an executive order, can urgently convene through HHS, a national office, or task force of patient safety.

Strengthened with their experienced personnel experts and strategists. I mean, let's say Mr. Watters and colleagues can lead this right now from the government, and I don't mean to sound punitive. The idea here is that this mandate may be backed by CMS conditions of participation that we've written about many times could possibly give the right nudge to health systems who are still struggling after 30 years to find the right ROI[29] to invest in patient safety. It could ask for things like closed loop systems.

29 Return on investment

You know, once and for all, align the hundred-plus patient safety organizations to feed data into a national database. And if it is CMS money, taxpayer money, why don't hospitals and health systems publicly report the annual spending on medical claims and settlements? There are a number of initiatives that experts put together in a room can come up with, and it could be executed in the interest of something that has been recognized as a problem, but it appears that nothing has been done from a policy perspective.

You'll see we're a country where an x-ray can cost you $800 at a hospital and right across the street, it is $68. We have been debating site neutral payments for a decade with the best intents and yet, not able to execute it. So that is why in this urgency I have less faith in maybe some, you know, that it might be the right time for payment models or policy from the traditional sense. And that's the reason I'm proposing an executive order that sort of streamlines things and puts, you know, things in order because health systems are struggling with ROI --

CO-CHAIR PULLURU: Thank you, Divvy.

DR. UPADHYAY: Yup, thank you. Appreciate it.

CO-CHAIR PULLURU: You're at your allotted time for your comment. Thank you so much for your passion and your comment and ideas.

DR. UPADHYAY: Thank you.

CO-CHAIR PULLURU: Next, we have Dr. Linda Hayes Bennett, who is a doctoral candidate at George Mason University. Welcome to the microphone, Dr. Bennett.

DR. BENNETT: Thank you. Oh, is it on? Is it on? It is now. Hello. I am Dr. Linda Hayes Bennett, and I'm so happy to be here. This has been a fascinating event. I attended all day yesterday as well. I am on my second doctorate, health services research and policy, as well as data analytics.

I started my career as a cognitive behavioral neuroscientist during the decade of the brain, studying transition metals in animal models of plaque formation in the hippocampus. Iron, copper, and my favorite, manganese. So how that plays into our health at the

mitochondrial level and bottom up, what I call terrain health.

I followed my degree and another master's at Johns Hopkins in aging and gerontology, mental health as well. Etiology. Etiology is what I learned at Hopkins, and I'm 25 years into this journey, and I quip that I'm doing my third doctorate on LinkedIn because there's a lot of things I'm not allowed to talk about such as music as medicine, ageism, et cetera.

So what a journey. Disclaimer, my first career, highest-level opera singer, six-figure salary, 15 years, dozen times featured soloist at the Kennedy Center, and you've got to be healthy to be an opera singer. So I do study health and what that means. So my questions are at this intersection of preserving human function and resilience before decline occurs. How do we map onto what's going on in patients' lives months, years, even decades before they even arrive at the hospital?

So in studying all these systems, I'm interested in upstream interventions,

sleep, hydration, oxygenation, activity levels, social connection, spirituality. Let's look at that. Let's define that medically. Music as medicine, physiological triangulation of music, caregiver support that influence physiology long before disease becomes irreversible. So these modern models focus on procedural errors, falls, medication events, documentation failures, but how does PTAC envision upstream physiological and environmental contributors to patient deterioration?

Mainly, dehydration is a big one, and delirium risk, but a hypoxia, chronic progressive hypoxia, lack of activation. So in the evolutionary sense, we evolved. We're the survivors of evolution. So how do we look at these upstream modifiable factors, patient monitoring, so that our problem when they eventually arrive at the hospital is lessened, and we have triumphant outcomes when patients really need medical intervention. Thank you so much.

CO-CHAIR PULLURU: Thank you, Dr. Bennett. Next we have Ms. Gina Hoxie, who is a Director at the American Society for Clinical

Oncology, or ASCO. Welcome to the microphone, Ms. Hoxie.

MS. HOXIE: Good morning. Thank you all very much. Thank you, Co-Chairs and members of the Committee. I'm Gina Hoxie. I'm our Director of Payment and Access at the American Society of Clinical Oncology. We are a national organization representing more than 50,000 physicians and other health care professionals that specialize in cancer treatment, diagnosis, and prevention. We are dedicated to conducting research that leads to improved patient outcomes, and we are committed to ensuring that evidence-based practices for the treatment, diagnosis, and prevention of cancer are available to all Americans.

ASCO really appreciates the PTAC's focus on enhancing patient safety through APMs. As you all work to advance APMs and specialty care models, we strongly encourage you to collaborate directly with medical specialty societies that have already developed rigorous evidence-based standards, measures, and certification programs for safety.

Medical specialty societies are

uniquely positioned to define what safe, high-quality care looks like in practice. CMMI should streamline its efforts and leverage existing clinician-led certification programs rather than creating duplicative or fragmented APMs. One example that we currently have up and running is called ASCO Certified, which certifies practices. They must -- sorry -- one example is ASCO Certified Program which certifies oncology practices that meet strict benchmarks for patient safety, care coordination, and evidence-based treatment delivery. When APMs incorporate professional society-led programs, they are more likely to achieve three critical goals. One, they accelerate safety adoption. Practices that are engaged in established certified programs have already built the workflows and the infrastructure that's needed to ensure patient safety and to improve outcomes.

Second, they avoid compounding administrative burdens. We know that this is a huge problem, especially in practices right now, so aligning APM requirements with trusted certified programs means clinicians and

practices spend less time navigating redundant reporting frameworks and more time on direct patient care.

Finally, they foster stakeholder alignment, so when society-led programs are integrated into federal models, this naturally encourages multiple payers and providers to align around the same high standards of safety. If you need more information on anything, happy to answer. ASCO urges the PTAC to recommend that CMS and APM developers integrate professional society standards and certifications for safety within model designs.

Thank you very much for your time, your commitment to transforming care delivery. Thank you.

CO-CHAIR PULLURU: Thank you, Ms. Hoxie. Next, we have Dr. Patrick Romano, a Professor of the Divisions of General Medicine and General Pediatrics at the University of California, Davis, and a presenter in yesterday's Session 2 on measuring patient safety in value-based care. Welcome to the microphone, Dr. Romano.

DR. ROMANO: Thank you. Good

morning. I won't reintroduce myself since I presented yesterday, but I just wanted to offer six kind of summary thoughts after listening through the last day and a half of amazing presentations.

First, I want to advocate for really safety in every APM. Safety is a core value. It has clearly been underattended to over the past 25 years, and some safety measures should be incorporated into every APM. And I encourage you to think about the Pygmalion effect, this idea that if we expect patient safety to improve, if we anticipate and motivate organizations to improve safety, then they will do so. Pygmalion effect.

Second, a balanced approach is necessary across multiple measures. Really incorporating the idea that any single measure can be gamed, and we need to perhaps focus on measures that may be most sensitive to the financial incentives built into the program. So if the program incents reduced use of post-acute care in patient rehabilitation care, for example, then we have to look specifically for harms that may result from underuse of that

care. So a balanced approach to measures.

Third, how much to put at stake. Well, I would suggest the Goldilocks principle, not too much, not too little. It should be a graded incentive, not an all or nothing approach, but an amount that seems commensurate to the magnitude of harm.

Fourth, we want to promote innovation in infrastructure and measurement, so we've heard a lot about the potential of real-time measures, whether we call them eCQMs[30] or dQMs[31]. We've heard about AI tools. We've heard about the need to incorporate patient perspectives, measures focused on diagnostic delay or diagnostic miscommunication. So let's promote innovation in the infrastructure and in measurement. Fourth point.

Fifth point is to ensure that providers are engaged from the bottom up, really aligning actionability with accountability so that when providers are accountable, they also have the ability to act, aligning those intrinsic motivations that we all have as professionals with the extrinsic

30 Electronic clinical quality measures
31 Digital quality measures

motivation. And here, I would keep in mind the Sisyphus principle. We don't want to feel like we're always pushing the rock uphill.

We want to feel like we're making progress and that we can achieve the goals that are set out for us.

And final sixth point is always consider and measure the unintended effects, whether it's voluntary withdrawal, underreporting, risk avoidance, gaming. These effects have to be anticipated from behavioral economics, have to be incorporated and measured.

So six final points, safety in every APM, Pygmalion effect, a balanced approach with multiple measures, the Goldilocks principle, not too much, not too little, promoting innovation in infrastructure and measurement, ensuring that providers are engaged, the Sisyphus principle, and finally, always measuring and considering unintended effects.

So thank you for the opportunity to join.

CO-CHAIR PULLURU: Thank you, Dr. Romano. With that, I'll check with the host

before we move on. Are there any other people who've signed up to give a public comment?

I believe Sue? Great, thank you.

Hearing none, that's the end of the public comment period.

*** Committee Discussion**

CO-CHAIR PULLURU: Now, the Committee will discuss everything we learned yesterday and today based on this public meeting. PTAC will submit a report to the Secretary of HHS with our comments and recommendations on targeting improvements in patient safety through Alternative Payment Models.

Committee members, please refer to the potential topics for deliberation document during this discussion. If you have a comment, please flip your name, or for our virtual Committee members, please raise your hand in Zoom. Who would like to start?

I might just start calling on people. No, I'm just kidding.

DR. BOTSFORD: Chinni, I can go.

CO-CHAIR PULLURU: Go ahead.

DR. BOTSFORD: All right. Building

a little bit on our conversations from the last two days, I mean, I think there's lots of compelling reasons why the issue needs attention and why the issue needs payment. I think there were clear arguments made for why innovation is needed and why there may be technologies that exist or are being developed that could materially change things, especially as you think about the role of AI and early detection and warning systems.

I think I was struck by the fact that there's probably some ways in existing models, as folks talked about, to shine the spotlight on safety, perhaps choosing existing quality measures that touch on safety. And I think we heard from that from Susannah yesterday talking about some of the focus on medication reconciliation measures and how that would promote avoidance of errors.

I do think overall something mandatory is needed. I think the question is, is it -- you know, where does that payment come from? I heard the thing that would be the most helpful is the idea of payment to invest in the infrastructure itself, the data, the tech, and

the capability for safety as opposed to penalties for current unsafe environments.

I think I heard two strategies around prospective payment and potentially regulatory intervention. I still haven't really heard a concrete payment model, although there's hope that there could be a payment model which makes me think there's more development needed before moving forward.

I would acknowledge, though, I think as our previous commenter just shared, you know, we really need to think about the administrative burden, the cognitive overload, and the operational fragility of the system we're working with when we talk about adding on just one more thing, even if it is a very noble cause. And I would also say that when we think about delays in payment or withholds, for many systems, those are in fact a penalty.

So with all of the comments about needing to think beyond penalties, I think we need to be cautious with saying that a withhold is not a penalty. And then I think just maybe echoing the commenter most recently, there do seem like there's options for aligning APMs

with existing certification programs that are out there as opposed to designing things that are entirely new, which would be an interesting place to start.

CO-CHAIR PULLURU: Next? Krishna?

MR. RAMACHANDRAN: Yes. I guess my reflections the last two days, for me, like insofar as the payment models are as a manifestation of our priorities. Essentially it's a way for us to align incentives to what we as a society want our care delivery systems to focus on. To me, I think figuring out how to reintroduce this focus on patient safety makes sense to me. So, I mean it sounds like we've had a -- we've tried to do this the last 25 years. It's not working, and so reintegrating, refocusing feels like a very logical outcome after the two days of discussions.

Of course, how we do it, how much, how wide, you know, how punitive, not punitive, is it mandatory, is it not, those are all mechanics of any payment model that we have to sort of work through in the process. For me, as I reflect, sort of the yes and approach

feels logical, like figuring out how to introduce patient safety sort of parsimoniously in existing models. Obviously, if you need to reduce the burden by minimizing some other measures that exist, fantastic. That's a path for us to take.

And then if that doesn't work or doesn't have the effect at scale that we were hoping to have, how do we create a sort of focused attention on dedicated patient safety models is a logical path for me. And certainly, amping up the intensity, whether it's the mandate, withhold, I mean those are all further sort of levers we can pull broadly.

So anyway, so my broad takeaway was we need to do something. It just feels like this is a problem that we've not made enough traction as a country, and then starting with sort of the chassis we have approach and then evolving into a more dedicated focus would be logical sort of path for us to convert this sort of energy and passion into action and improving the system.

CO-CHAIR PULLURU: Lee?

CO-CHAIR MILLS: Sure. Appreciate

those comments and agree. I guess I've got some things I've heard that I want to emphasize. Some other things that I've put thoughts together, but I guess in my notes I'm seeing that I really did find it compelling that perhaps the only way to make a mistake here is to not try something.

We see the reality of the system that we've built today, and we're deciding that status quo is not acceptable. And so while there is risk in trying something new, I think there's equal or worse risk to not trying something new. Right? And so the path, though painful, though complicated, though there will be unintended positive and negative effects of a trial, I think to improve anything, we must change something. And so I think I'm in the state of being predisposed to action and trying to do better. Right? Status quo is the only wrong choice.

I do think we heard pretty compelling arguments that the policy tools and the legal framework exist that something could be tried, and that was a position we're not often in, so that's great. I do think I've

heard compelling discussion that we probably need to make something mandatory in some fashion. Right? And that's -- there's kind of a new willingness to consider that.

I wonder if we use mandatory-ness as a policy tool in and of itself. Perhaps it's, you know, you do get more flies with honey than with vinegar, and yet people will simply opt out if it's too challenging or they have too far journey to go, so perhaps it's mandatory for any new APM. It would be mandatory for -- making this up -- the bottom quartile of patient safety mechanisms, and then it's a, you know, bonus incentive for those that are already at the median or doing better. Right? We can pull those levers independently. It doesn't have to be mandatory for the universe necessarily. Right?

I do wonder about kind of a two-tailed model, like I was saying, where it's almost an upside bonus for those already doing okay at patient safety, median or above, while it's a downside risk, loss prevention mechanism for those that are doing the worstest. Right? Those incentives might hit differently.

I think we've heard some pretty good conversation about we do want it to be of a magnitude that it's sufficient enough that it can't be ignored. Right? The pain of taking -- - the pain of just taking the fear, the penalty, is worse than not trying, and so that would have to be graded in a developing model.

We've heard some information about, you know, care coordination and transitions of care are probably the single largest safety domain that we have plenty of evidence base and plenty of PTAC conversation about what constitutes good care coordination and transition of care. And yet, those aren't typically built in as required or mandatory metrics in CMS and CMMI's, you know, panoply of potential models. And so that those might be specific measures to consider featuring prominently.

And I guess I appreciate Dr. Romano's, you know, six actionable steps, and I'm very happy those were read into the record. I guess I'll just end it in a lot of conversation about, again, this is not technical, and it's not data; it's really more

about culture. And having done a few culture change projects in operations at health systems over my career, culture change is slow, measured in years, and incremental, always.

And so I think we have to think about that both in baking safety into every existing model, as well as any unique specific model that we have to have a multiyear time horizon to this project and have the incentives, either upside or downside, you know, gradually step up in both bonus or severity over that time period. It's never going to be a one-year act. So thank you.

CO-CHAIR PULLURU: Larry, and then Lauran.

DR. KOSINSKI: Let me get off of mute there. Well, my comments are going to be somewhat similar to what we've heard, but I have to open by saying I appreciate the passion that was expressed by both Sue, as well as Sam. And having the patient and the administration spaces as a pull on the system represent maybe a unique opportunity for us. But as we have said, safety's not a stand-alone issue. It most often results from system failures.

We heard a lot of anecdotal examples of what can occur, when are these failures, but they reflect a tip of the iceberg of systems failure. What we also heard very clearly is that we are at a technological revolution. The advances in AI may be creating an inflection point for us in the implementation of care redesign. The elephant in the room is culture.

Culture needs to change not only on an individual but on a team basis. I like the concept that patient safety needs to be part of every value-based care model, but we know that EHI[32] integration needs to be part of every model. Patient engagement has to be part of every model. Care coordination has to be part of every model. Payment models have to be structured correctly. This is not a one-issue problem.

And maybe my major conclusion I've come to from this meeting is that PTAC is at an opportunity in its roadmap that it's developing for September, and maybe our major focus at this point should be to take all the work we've done and craft the correct structure of a

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value-based care model so that it includes all of these things that we have learned through the course of our sessions over the last few years so that we can present the Secretary with a structure that brings in all of these components instead of focusing on one.

CO-CHAIR PULLURU: Lauran?

MS. HARDIN: I'm going to add on to some of the comments that have been made. So we've heard really important stories about harms that have happened. I have experienced that in my own family, and we also heard really strong data about how harm is continuing to happen in the health care system.

So it's really clear that this level of harm is unacceptable. There's no clinicians who want it to be this way. Individually, we don't want it to be this way, but we are in a dichotomy where we are up against -- and I'm going to quote one of the speakers -- safety as a non-revenue-generating cost center. That's significant in light of the economics of our health systems today with some of the changes going on.

So in order to overcome that

dichotomy, we've heard very clearly that this is about cultural change. It's really important to expand this across the ambulatory space. It's not only hospitals. It's not only in the primary care office. It's across multiple services, and that we have to attend to the real challenges in the workforce itself with administrative burden, stress, and really having the right information at the point of care to make decisions.

We've heard core components of doing this while in patient safety as longitudinal care coordination, interdisciplinary team engagement. Also, a thread of the integration and attention to behavioral health, mental health, and substance use populations, and the core components of design that result and change our learning systems and a focus on safe system design like aviation has done deeply.

So some of the real opportunities I heard in the presenters during the two-day session was real-time patient reporting. What's different that we have now compared to previous safety initiatives is the integration of AI and expansion of technology and the

ability to potentially put in place prospective systems and continuous risk assessment.

It's clear there needs to be rewards rather than penalty as part of the system in order to move change. And one of the great examples someone brought up is the investments and meaningful use resulted in huge transformation and integration of electronic health records. So I think we have an opportunity to look at what investment will motivate change across the states.

CO-CHAIR PULLURU: Thank you. I'll end with my quote that struck me today besides the one that, you know, from Sue, is that absence of measurable harm is not necessarily the presence of safety. And when I think about what I feel we've learned over the last two days is that this is a -- we have a very complex huge country, very varied and very hard to move. We've tried to move this for 20-some years.

And I believe the movement has to come both bottom up and top down. And when you think about bottom up, it really entails do we have the right measurement, and really studying

that and making sure we do. I think multiple speakers spoke about alternative ways to measure. Speaks about data and how interoperable real-time, predictive, prospective data can exist.

Our stakeholders are patients. Listening to what patients can give us and using the power of AI to really synthesize and syndicate that data to make it actionable, and then thinking about training. I really liked what one of our public commenters spoke about, Ms. Hoxie, about using current mechanisms for training providers, as well as physicians in various specialties and hospitals, current certification mechanisms and making sure we have that already a little bit, but putting a focus on it to train.

To me, that's sort of the bottom up. And embedding it into current APMs to some degree. And then I think about the top down, and everyone's spoken about strategy. And one of my favorite quotes is a strategy eats -- or culture eats strategy for breakfast. And if you don't have a top-down initiative that comes from CMS, the Director, and all of the

leadership, I do believe that this gets lost, and there's not national attention on it. And that top down from our Committee's perspective is really setting up, in my mind, a framework for what Lee mentioned yesterday, you know, and/or.

Is there a way that we can embed this into multiple levels on the bottom up and what already exists as chassis, and then is there a new initiative, new model similar to the health tech ecosystem that gave birth to the pledge for, you know, kill the clipboard?

So I think there is a top-down way that we really need to be bold about and address and not accept the status quo. And that would be my, you know, my take on the last two days.

Lauran, did you want to say something?

MS. HARDIN: I forgot one thing in my comments that I think is really important that Sue brought up. So an opportunity that we have not traditionally thought about and really deeply included is to design the systems that capture at the point of care the patient voice

and family voice to identify risk in the moment and make identifying risk and elevating it safe for patients and families so that when things are noticed and can proactively be identified, that that doesn't result in abandonment from the system or being labeled by the system. The patient voice and family voice is really, really critical in this dialogue.

CO-CHAIR PULLURU: Anybody else?

*** Closing Remarks**

CO-CHAIR PULLURU: Thank you to all the Committee members for sharing your very valuable comments from across our two-day meeting. Before closing, I would like to check with the ASPE staff to see if there are any clarifying questions for us? Marsha, Steve, do you have any questions?

I want to thank everyone for participating today, our session experts, my PTAC colleagues, and those who have joined us in-person and online to listen in. We explored many different topics regarding targeting improvements in patient safety through Alternative Payment Models. Special thanks to my colleagues on PTAC. There's a lot

of information packed into these two days, and I appreciate your active participation and thoughtful comments.

*** Adjourn**

The Committee will work to issue a report to the Secretary of HHS with our recommendations from this public meeting. And with that, one final thank you to the Committee and session experts for joining us to make this a memorable and informative PTAC public meeting. This meeting is now adjourned.

(Whereupon, the above-entitled matter went off the record at 11:33 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: 06-16-26

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

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Court Reporter