PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

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PUBLIC MEETING

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Virtual Meeting via Zoom

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Tuesday, February 24, 2026

PTAC MEMBERS PRESENT

TERRY L. MILLS, JR., MD, MMM, Co-Chair
HENISH BHANSALI, MD, FACP
LINDSAY K. BOTSFORD, MD, MBA
LAURAN HARDIN, MSN, FAAN
LAWRENCE R. KOSINSKI, MD, MBA
JOSHUA M. LIAO, MD, MSc
WALTER LIN, MD, MBA
KRISHNA RAMACHANDRAN, MBA, MS
DAVID C. TYSON, MA

PTAC MEMBERS NOT PRESENT

SOUJANYA R. PULLURU, MD, Co-Chair
JAY S. FELDSTEIN, DO

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

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 - Improving Multi-Payer Alignment in Value-Based Care Day 2**

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

Yesterday, we had a number of experts share their perspectives on improving multi-payer alignment and value-based care. Today, we have a great lineup of experts for our last session that will focus on addressing challenges to advance multi-payer alignment. The Committee has made considerable effort to include a variety of perspectives throughout this two-day public meeting. Later this morning, we'll have a public comment period and welcome participants to share a comment related to the meeting's topic.

As a reminder, public comments will be limited to three minutes each. If you have not registered to give an oral public comment

but would like to, please email ptacregistration@NORC.org prior to the public comment period at 10:50 Eastern Time. Again, that's ptacregistration@NORC.org. Then the Committee will discuss our comments and recommendations that will inform the report to the Secretary of HHS[1].

Because we have some new folks online who weren't able to join yesterday, I'd like the Committee members to please introduce themselves, share your name, your organization, and if you'd like, tell us about your experience with our topics. And I'll cue each of you in turn.

*** PTAC Member Introductions**

CO-CHAIR MILLS: I'll start. I'm Dr. Lee Mills. I'm a family physician. I have the pleasure to serve as Chief Medical Officer of Aetna Better Health of Oklahoma, one of the state's three managed Medicaid plans. Over my career, I've had the pleasure of practicing and leading five or six different CMMI[2] models over the years from both a health system provider and a payer perspective. Next, let's go to Henish.

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

DR. BHANSALI: Good morning. I'm Henish Bhansali. I'm an internal medicine doctor, primary care practicing by training. I was most recently Chief Medical Officer for Medical Home Network, an enablement entity that worked with Federally Qualified Health Centers across eight states. Prior to that, I was at Duly or DuPage Medical Group as the Senior VP for Medicare Advantage. Duly oversaw or oversees 1.2 million patients in a multidisciplinary fashion. Prior to that, I was at Oak Street and have spent most of my career on value-based care.

CO-CHAIR MILLS: Lindsay?

DR. BOTSFORD: Thanks, Lee. Good morning. I'm Lindsay Botsford. I'm a family physician in Houston, Texas, where I care for patients of all ages, including Medicare beneficiaries as a PCP[3]. I'm also the Regional Medical Director for the Midwest and Texas with Amazon One Medical.

I've got the pleasure of caring for patients and leading in various ACOs[4] and value-based payment models for the last 15 years, including the ACO REACH Model, where I

3 Primary care provider
4 Accountable Care Organizations

currently serve as the Chair of the Governing Body of the Iora Health Network, formerly led by one of today's presenters, which most recently got 37 million in savings for the 2023 performance year. I'll pass it back to you, Lee.

CO-CHAIR MILLS: Wonderful. Lauran?

MS. HARDIN: Morning. I'm Lauran Hardin, Chief Integration Officer for HC2 Strategies and a nurse by training. Our firm is really focused on building cross-sector approaches and multi-payer models; combining and supporting public health, health care, community-based organizations, and states; and coming together to serve complex populations.

My background includes many years in serving and designing care management approaches for complex populations, including in many value-based care models, leading a complex care center model that was recognized by the National Academy of Medicine, as well as the American Academy of Nursing. I was part of the team that initiated the National Center for Complex Health and Social Needs out of the Camden Coalition and partnered with many people across the country designing models for complex

populations.

CO-CHAIR MILLS: Thank you, Lauran. Let's go to Larry.

DR. KOSINSKI: Good morning. I'm Larry Kosinski. I'm a retired gastroenterologist. I had a rich career of 35 years helping to build the largest GI[5] group in Illinois, the Illinois Gastroenterology Group, which submitted one of the very first PTAC proposals called Project Sonar, a value-based care solution for GI conditions. It was recommended for testing by PTAC.

Since then, that project has become a company, SonarMD, a VC[6]-funded company that's now in multiple states across the country with the same program.

I'm also a fractional CMO[7] for a very interesting AI[8]-powered microbiome company called Jona. And my most recent initiative is a company called BioVOC built around an olfactory device, an e-nose that can help people decide on a healthy diet. I've been on the Committee for five years. I'm looking forward to today's meeting.

5 Gastrointestinal
6 Venture capital
7 Chief Medical Officer
8 Artificial intelligence

CO-CHAIR MILLS: Thank you, Larry. Josh?

DR. LIAO: Morning, everyone. Josh Liao, internal medicine physician. I spent many years thinking about the topic that we'll talk about today, physician-focused payment models across different payers and how to drive kind of population health and value-based care both from a clinical practice perspective but also a leadership perspective, holding a number of roles over preceding years.

I also led a portfolio of research on these topics, looking at things like episode-based payment models, accountable care, and population-based payment models as well. Currently, I continue that work. I also kind of have oversight of enterprise programs at Ascension using technology and capabilities within models to address populations like those insured through Medicare and others. Excited for today's conversation.

CO-CHAIR MILLS: All right. Walter?

DR. LIN: Good morning, everyone. I'm Walter Lin, internist based in St. Louis, founder of Generation Clinical Partners. We are a medical practice dedicated to helping

senior living organizations transition successfully into the world of value-based care. I'm also the chief clinical strategy officer for LTC ACO, and our practice has direct experience with other value-based programs, including bundled payments, PACE[9], and home-based medical care.

CO-CHAIR MILLS: Thank you, Walter. Krishna?

MR. RAMACHANDRAN: Thanks, Lee. I'm Krishna Ramachandran, Chief Information Officer in UnitedHealthcare. Twenty-four years in health care in the payer, provider, and health care technology domains, most of it actually furthering value-based care, including efforts on multi-payer alignment. So a topic close to my heart. Thank you.

CO-CHAIR MILLS: Thank you. And David?

MR. TYSON: Yeah, good morning. David Tyson. I'm the Senior Director of Public Policy at Novant Health, which is a integrated delivery network that spans the Carolinas, 25 hospitals over 900 locations. I've been with Novant about 10 years, and that entire time

9 Program of All-Inclusive Care for the Elderly

I've focused on all things public policy, but mostly around navigating value-based payment models to help the system sort of understand and move forward in the early days of MIPS[10] and MACRA[11], the Medicare Shared Savings Program, and have sort of expanded outward from there and focus and reach.

So we currently have about 650,000 patients under value-based arrangements across all payers. So looking forward to the conversation today.

CO-CHAIR MILLS: All right. Thank you, David. For today's agenda, we're going to explore a range of topics on improving multi-payer alignment in value-based care. The background materials for this public meeting, including an environmental scan, will be posted online at the ASPE PTAC website meeting page and the public meeting registration site. Discussion materials, public comments from this meeting will inform our report to Secretary of HHS on improving multi-payer alignment in value-based care.

I'd like to note, as always, that the Committee is ready to receive proposals on

10 Merit-based Incentive Payment System
11 Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act of 2015

possible innovative approaches and solutions related to care delivery, payment, or other policy issues from the public on a rolling basis. We offer two possible submission tracks for presenters, offering flexibility depending on the level of detail about payment methodology. And you can find that information about submitting proposals on the ASPE PTAC website.

Lastly, on behalf of PTAC, I'm pleased to share the Committee is now producing a series of Issue Briefs that summarize the latest information and evidence related to value-based care that the Committee has explored in its public meetings over prior years.

Currently, six Issue Briefs, along with highlights from PTAC's 2020 through 2025 theme-based public meetings, are posted on the ASPE PTAC website. The Committee will be publishing new Issue Briefs on additional topics into the very near future. And now I'm excited for this morning's conversation. I'm going to hand the baton over to Lindsay to welcome and facilitate our first session. Lindsay?

*** Session 4: Addressing Challenges to Advance Multi-Payer Alignment**

DR. BOTSFORD: All right. Thank you, Lee. Good morning. I'm Lindsay Botsford, one of the PTAC members that has the pleasure of facilitating this session. So we have with us four experts to discuss their perspectives on addressing challenges to advance multi-payer alignment. You can find their full biographies and slides posted on the ASPE PTAC website and the public meeting registration site. So at this time, I'll ask our session participants to go ahead and turn on your video if you haven't done so already.

After all experts have presented, the Committee will have plenty of time to ask questions and engage in what we hope will be a robust discussion. So presenting first, we're pleased to welcome Dr. Ben Kornitzer, who is a Senior Vice President and Chief Medical Officer at Aetna, a CVS Health Company. Ben, welcome.

DR. KORNITZER: Great. Thank you so much for having me and glad that I'm out of the blizzard on the east coast that Rushika is dealing with. But I'll be joining you in a few days. I also just want to acknowledge, you

know, what a nice reunion this is, seeing so many friends and colleagues in the past couple of years on this as well.

So for background, I'm a primary care physician, my own practice focused on care for homebound older adults. I started participating in ACO models really quite early on. We're one of the early community-based ACOs. I spent a number of years as a Chief Medical Officer for Mount Sinai's network in New York, including putting together its clinically integrated network. And so significant time thinking through those models as well.

After that, I spent a number of years at agilon, so a senior-focused value-based care enablement organization with largely independent primary care and multi-specialty practices going at risk with different payers around the country. And now the Chief Medical Officer for Aetna, dealing with all lines of business, including our Medicare commercial and Medicaid populations.

If we can go to the next page. So we've already seen my bio, so we can move on. So if we talk about, you know, where we are in

terms of health care in 2026. I think that, you know, this is a slide that should certainly resonate with everyone. But health care is not delivering the quality of care that patients expect that our country deserves. The costs of care are skyrocketing. Trend year over year is, you know, largely unmanageable. And patient out-of-pocket costs are really preventing them from getting the high-quality care that they want.

And so some data that we want to show here. You know, 40 percent of consumers report that they are, you know, delaying care due to that cost of care. And we actually know, and one of the formal precepts of what really good value-based care looks like is it should be longitudinal care, and it should be continuous. And so when people delay that care, that means that their renal disease is worsening. That means that they're at higher risk of having, you know, critical diagnoses, whether they're oncologic or neurologic diseases that could have been prevented. They will miss those opportunities to really intervene.

We also know that from a provider

angle, care isn't working at all. So, you know, 88 percent of physicians report that they want more time to spend with complex patients, but they're unable to do so. You know, we have phrases in medicine where people measure things like pajama time, right?

So the fact that providers are discussing how they're spending their time after hours doing paperwork, not necessarily actually involved in the quality of care and the outcomes, is a major issue. I think it also shows up in the challenges that we have in terms of the access to really high-quality care. And so part of the solution that we need to think through is how do we create that access for those patients, particularly those in most need?

And then finally, from the employer lens. So, you know, we deal with a large number of commercial plan sponsors. And I can tell you that every single one of those conversations, there's two things that they bring up. One is ensuring that they get the highest quality of care for their employees. But two, what can they possibly do to really improve the trend, which is unmanageable and to

a large extent, almost unpredictable? And so these are really major drivers of where we are in health care in 2026.

If we go to the next page. So what's different between fee-for-service and value-based care as we see it through the lens of Aetna, right? So, you know, right now, fee-for-service largely volume-driven. Large number of the costs are really associated with that waste and overutilization, which isn't showing any member benefit whatsoever. But at the same time, we realize that there isn't the quality and value that we want.

So I'll talk a little bit later about how we're making sure that, you know, the relationships that we have really drive those quality and value outcomes, including how we think about our networks and who's participating in those networks. And in fee-for-service models, it's really reactive and episodic. And I think there've been a number of great studies actually showing that, particularly within primary care. It's not just the number of touch points that high-risk members have with their primary care provider, but are those being done proactively?

And we actually see that downstream utilization is much more manageable when providers have a mentality that they have a ongoing relationship with a member, and it's their responsibility to think through almost for the entire year, you know, what are the appropriate screening tests? What are the check-ins that they need to have? What are the conversations? What are their goals of care or other that are really important? And doing so not in a reactive way, but in a proactive way.

That relationship, I think, is absolutely critical. I think two of the biggest gaps we have right now in health care that really pin the right dynamic between payers on a multi-payer model and value-based care for those members is building both trust and long-term relationships. And so I think anything that we do that's going to address better outcomes for members really needs to emphasize that longitudinal nature of that relationship and create that bidirectional trust.

And that's what you finally see come to play in the relationship between providers and health plans. And so, you know, when it's

a fee-for-service model, it's transactional, it's service-driven, it really becomes a zero-sum game. And when we think about what good value-based care looks like, it's a partnership, right? Value-based care is a team sport. And so it's thinking through how do we actually set up providers to do well in these models? How can we share the right sorts of data, the right insights to set them up so that they can continue on and sustain their practices and really get the best outcomes for the patients they're taking care of?

Then we go to the next page. So, you know, historically, there have been some real challenges to adopting value-based care models. So as a primary care doctor, the models are fragmented. So I would have a backpack and go around New York City. I didn't think, well, this is a Medicaid patient, this is a commercial patient, this is a Medicare patient. I thought of my patients as my patients. And so the more that we can reduce that fragmentation and create a seamless experience for providers, I think is absolutely critical.

The operational complexity and

burden, particularly for smaller practices. And so how do we create solutions that are accessible, actionable? How can we share data that can be easily used by different types of providers so that they're really successful? Create new ways of having data interoperability. We think that that's absolutely critical, that that data needs to be bidirectional, that everyone should be participating, whether it's through the HIEs[12], whether it's through aligned ACO networks. I think that's absolutely critical.

You need a certain amount of financial stability to be able to really invest in long-term primary care. And so making sure that those incentives are meaningful enough, and that providers have the economic wherewithal to really go and participate more meaningfully in value-based care is absolutely essential.

And then finally, you need a large population of providers really rallying together. As I mentioned before, value-based care is a team sport. And so one of the things that we see as valuable, for example, coming

12 Health Information Exchanges

from the Aetna lens, is because we participate in essentially all lines of business, commercial, Medicare, Medicaid. We can deal holistically with providers in helping them think through how can they create really successful models of care, rather than just sinking through the silos of those individual programs.

And then finally, I'll just share a little bit about some of the work that we're doing at Aetna. If we can go to the next page. So we really want to transform the relationship that we have with providers from a transactional one to one where it's a real clinical collaboration.

So the way we do that is we work closely with them to make sure that they have access to timely data, that that data is insightful, that they understand where there are opportunities to better manage patients. Whether it's who are their high-risk members, who are people at risk of having readmissions, who are people who haven't been screened for critical conditions, or where we see that they aren't taking important medications.

Again, as I mentioned before, our

ability to understand what it takes to succeed in that environment, make sure that our network reflects who really are those high-value providers, and make it as transparent as possible, I think is really important. We have teams of clinicians, care managers, performance management capabilities that we can really wrap around these relationships to make sure that value-based care providers do well.

We think that the timeliness of data sharing is absolutely critical. I think it's something that, in particular, Aetna has been investing very significantly in, but we also see this across the space. So for example, within Medicare Advantage, we know that our partners who work with us do very, very well when we are able to get them timely information. And we actually see that they improve the quality of that care quite dramatically.

Then I think for everything that we do, building up the knowledge base to say that we understand that value-based care really is moving the needle and what are the particular activities that are most impactful, is an investment that we all need to make together.

I think this is an opportunity where all ships can rise in the harbor together.

Just from our own data within Aetna that we published recently in JAMA[13] Health Forum, evidence that patients in a value-based care model had significantly better blood pressure control, hemoglobin A1C control, lower admissions, readmissions. That's consistent with data that we've seen from peer organizations around the country.

So that gives us conviction to continue to invest in these solutions and make sure that we're giving the opportunity for providers and for our members to get access to what we think is really exceptional high-value care. Thank you.

DR. BOTSFORD: Thank you, Ben. So we're going to save all Committee questions until the end of all presentations. So we'll be back. Next, we're glad to welcome back Dr. Vivek Garg, who's President and Chief Executive Officer at the National Committee for Quality Assurance. Vivek, please go ahead.

DR. GARG: Hey, good morning, everyone. Great to see many of you again and

13 Journal of the American Medical Association

to see the fellow panelists here. It's really a privilege to be here in front of the Committee again. As Lindsay said, I'm now President and CEO of the National Committee for Quality Assurance, but I spent a number of years as a practicing PCP and internist building clinical programs at new entrants like One Medical and Oscar Health.

And then I've spent most of the last decade prior to the NCQA as a CMO in national value-based care groups, supporting complex care models, clinical teams across the country, and trying to move the needle every day on clinical performance and outcomes with organizations like CareMore and CenterWell.

I joined the NCQA at the beginning of this year to focus on exactly issues like the Committee is talking about yesterday and today. How do we align our ecosystem to produce the quality and outcomes that Americans deserve while sustaining our health care professional workforce and addressing the societal cost issue?

For this conversation, I was asked to focus on a challenge many of you see firsthand, why multi-payer alignment is so hard

to achieve in practice, especially in Medicare Advantage. Ultimately, I believe this is really a systems design issue, and a big part of the equation is the quality and outcomes architecture that we deliver through so many different programs and vantage points.

For more than 35 years, the NCQA has worked to define and drive health care quality through accreditation, standards, performance measurement, and expert support. But what this has really been about is to help the ecosystem create clarity. Clarity about what good looks like, how to measure it, and how organizations can improve over time. We're fortunate to sit in a neutral and independent position working across stakeholders to help align expectations and accountability.

If you go on to the next slide. These are some statistics about the reach of our programs and frameworks like UDS[14] measurement. More than 200 million people are covered by health plans that report UDS quality measurement. And almost about 70 percent of Americans are in a NCQA accredited plan, and almost 60,000 clinicians work across more than

14 Uniform Data System

11,000 practices that are recognized by programs such as the patient-centered medical home program. So that means our team sees alignment challenges across plans, care delivery, and programs. Not in isolation, but across a very broad swath of the American population.

If we go on to the next slide. Here are four main issues that we see. I think they really mirror what Dr. Kornitzer just spoke through, but the first is really trust and transparency in data. If you're operating under a value-based framework with a quality focus, you sometimes don't really know who your patients are. You know them as a clinician, but you don't know them systematically.

It can take months to get a full attribution, to have data flow from different plan and policy stakeholder partner programs. And this really drives a lot of fragmentation and incomplete views about clinical utilization and events that are happening, the conditions that people are suffering from, and ultimately, the cost drivers and intervention opportunities that we're all trying to orient around.

Plans aren't always seen as neutral

partners, and there's often a lot of variation in the timeliness, accurateness, and completeness of data that's received. The ultimate result of this gap is that clinicians are held accountable for outcomes that they cannot see fully in time to often influence.

A second gap is really around misalignment between accountability and control. Clinicians and medical groups under risk need to be accountable for costs that they cannot meaningfully influence, including out-of-network leakage, specialty care, high-cost drug utilization, transportation, and other ancillary benefits.

Third, there is a lot of variability across contract terms. Even within Medicare Advantage, which benefits from the uniformity of the Stars framework, performance metrics can vary. Incentives definitely vary. Reporting requirements vary, and rules about what to focus on when and what level of value you can drive from them also vary significantly.

And fourth, which I know the Committee has talked much about already, is the multi-payer complexity. Medical groups simultaneously operate in Medicare Advantage

under Medicare fee-for-service and ACO programs, as well as Medicaid and commercial programs, each with different signals of success. Ultimately, this means that care delivery organizations face fragmented accountability signals across Medicare programs, making alignment very hard in practice.

We go into the next slide. Despite these challenges, we do see opportunities to close the gap. First, like Ben and others have talked about, is to strengthen our investment in primary care to help align delegated risk and payment models with advanced primary care capabilities and the population goals that matter the most. We all know that the U.S. spends single digits of the health care dollar on primary care, and we have so much domestic and global evidence that societies that spend double digits in the mid-teen percent benefit from strongly improved population health outcomes.

Second is to harmonize the quality and outcome signals, even just for seniors as a starting point, to align on a core digital measure set spanning Medicare Advantage and ACO

programs, covering the areas that matter, prevention, clinical outcomes, patient-reported outcomes, avoidable downstream events that no one wants to have happen to their patients, and supported by standardized data exchange expectations, leveraging national contracts like USCDI[15] and FHIR[16] interoperability standards.

The third is to standardize care provider alignment under delegated risk, clarify ownership of risk, unify the data standards, as I mentioned, and make the clinical policy and guidelines more consistent. There's a market gap here where policymakers can step in to really establish the rules of the road. In short, alignment improves when primary care quality and outcomes frameworks and risk ownership are designed to work together.

To give one example, if we could go on to the next slide. Obviously, I've spent almost a decade working in the care of seniors. And if you look at our major value-based programs in Medicare, including Medicare Advantage, we're targeting similar populations

15 United States Core Data for Interoperability
16 Fast Healthcare Interoperability Resources

but have very different measures of success.

MA[17] Stars emphasizes experience, function, plan operations, in addition to clinical outcomes. Under MSSP[18] with APP+[19], there's a more narrow focus on clinical outcomes and utilization, an easier reach in the transition to lead, so far as prioritizing outcomes and utilization with far fewer of those other types of measures.

And the result is that, as we all know, medical groups and clinicians caring for the same types of seniors and populations are asked to focus on and invest against different, sometimes conflicting, signals and rewards of success. It's not just the disharmony and what they focus on. It's also about where they can invest and create standardized programs and clinical management focus areas to drive outcomes.

It's not that the measures are wrong. It's that taken together, they create more noise instead of a coherent measure architecture, especially when it's compounded by different levels of data quality, timeliness, and different incentive frameworks.

17 Medicare Advantage
18 Medicare Shared Savings Program
19 APM (Alternative Payment Model) Performance Pathway Plus

So we really need to think about the shared measurement framework and standardizing so that we can get to this more uniform framework.

If we go into the next slide. I know the Committee has spent a lot of time looking at the success of different multi-payer alignment models. I'll just share one that has stood out to the NCQA team under the State Innovation Model, which is New York's many yearslong effort to standardize the focus on primary care.

As many of you may know, under this SIM model, New York state replaced several different primary care initiatives with a single unified framework, giving one consistent set of expectations, supports, and transformation standards across plans and practices. It aligned on a standard primary care core measure set. It aligned incentives across Medicaid and commercial plans. It leveraged the NCQA PCMH[20] program at some point as well. And it was backed by statewide data exchange through SHIN-NY[21]. And importantly, the implementation allowed flexibility and regional variation because often things are a

20 Patient-centered medical home
21 Statewide Health Information Network for New York

little bit different when you get closer to the community.

Now, I know the CMS[22] analysis around SIM models across the country showed mixed results on costs and outcomes, but models like this were successful in creating alignment and focus and harmonization. And it's possible that different levers are needed to be embedded into these programs and a longer timeline is needed to truly see the impact on population costs in health.

The main takeaway for me is that convening payers, getting to even partial alignment, and aligning with care delivery in important domains like primary care, delivers real value and should be a big part of the solution.

If we can go on to the next slide. So at the NCQA, we're focused on at least three areas to start where we think we can play a role and support this movement.

The first is the transition to digital quality measurement. This is not just about using technology and data because it's available. It's about reducing burden,

22 Centers for Medicare & Medicaid Services

leveraging the data that is available with standardized mechanisms to enable clinically meaningful quality insights at the point of care and in your real time and aligned across all the different levels of the system because the way that things are being computed would then be the same. This would radically reduce burden and enable much more real time population health management.

The second is measure cohesion and alignment. We are starting to talk about how do we evolve HEDIS[23] to focus on populations that matter, bundles of measures that can be aligned on and harmonized across programs and partners, including the domains I mentioned before, cross patient-reported outcomes, midpoints and endpoints around clinical outcomes, avoidable low-value care and avoidable end events that no one wants to happen like strokes and heart attacks and amputations and landing on dialysis.

The third is to strengthen the backbone of primary care, behavioral health, and important domains of care. This would help us align across managed care and care delivery

23 Healthcare Effectiveness Data and Information Set

with uniform notions of quality and outcome success, and help us establish more data sharing, as well as more of a shared value framework that can address some of the gaps I mentioned earlier.

So we see NCQA's role as a neutral and independent convener, leveraging the evidence and best practices to align on what good looks like in quality definitions and measurement, and to work with all the policy stakeholders and constituents to achieve that goal. So thank you for the time today and look forward to the Q&A.

DR. BOTSFORD: Thank you so much. So next we're excited to welcome Ms. Emily Transue, who is the Chief Clinical Officer at Comagine Health. Welcome, Emily.

DR. TRANSUE: Thank you for having me. I'm going to speak a little bit to a Medicaid perspective today, among other things. Let's go on to the next slide.

I'm the Chief Clinical Officer at Comagine Health. We are a national nonprofit health care consulting firm and contractor. We work collaboratively with patients, providers, payers, and other stakeholders, including a

number of folks who you've heard from on the panel today and yesterday, to reimagine, redesign, and implement sustainable improvements in health care. We have a number of service lines, including care management, data solutions, quality improvement, and research and evaluation.

On to the next slide. My background, prior to coming to Comagine Health, I worked for a number of years as a Medical Director at the Washington State Healthcare Authority, which is the agency in Washington that oversees both Medicaid and public and school employee benefits. And I'll be speaking a lot to the work that we did there in my talk today. We convened the Washington Multi-Payer Collaborative, which created the Primary Care Transformation Initiative, and I'll be talking more about both of those.

Prior to that, I have experience as a Medical Director at a managed care plan and also spent many years as a primary care internist at a physician-owned practice. So I come to this question of multi-payer efforts having sat at many seats around the table.

Next slide. Starting in 2019, the

Washington Healthcare Authority convened a group to develop a new primary care model, working with the state's payers and with the primary care provider community. We had both separate and shared meetings with payers and providers, all of the Medicaid MCOs[24] in the state, as well as all of the state-contracted commercial payers were involved.

We also included a broad variety of providers looking for diversity in size, location, rural versus urban mix, and payer mix. We invited a neutral convener, which was the folks from the Center for Evidence-Based Policy at Oregon Health and Sciences University. They helped us to maintain antitrust guardrails, among other things. And this work drew on prior multi-payer experiences that our CMO had had in Colorado and elsewhere. I think you've heard a lot already that each of these efforts builds on other efforts, and we were certainly doing that as well.

Next slide. This resulted in two memorandums of understanding. The first in 2020 established the general principles of the collaborative and agreement on the general

24 Managed Care Organizations

structure and key components of the Primary Care Transformation Initiative, which we'll look at in a second. Each of the signatories committed to being part of the initiative and making good faith efforts to implement it.

The MOU[25] was renewed and updated in 2024, with signatories agreeing to ongoing active participation in the work and supporting its strategies. Signatories agreed to adhere to the alternative payment policies for primary care that the group developed, and also to using the Washington Primary Care Practice Recognition Program to inform their provider partnerships and contracting strategies.

On to the next slide. This was kind of the background of the Primary Care Transformation Initiative. There were commitments from both payers and providers. Payers committed to aligning payment and incentives, and to increasing financing in primary care measured as a percentage of spend. Providers committed to work to increasing capacity and access, and to applying actionable analytics crossing clinical, financial, and social domains.

25 Memorandum of understanding

That was all in support of really experiencing primary care as integrated whole-person care, including behavioral health and preventative services, and having a shared understanding of care coordination and where providers fit in that continuum. The goal was for all of those things to result in aligned measurement of value out of the model, incorporating all of the triple-aim outcome measures. This was kind of the general background we were working from.

On to the next slide. I'm going to talk about a number of challenges and how we address these. All of these themes are familiar to you from the last couple of days, as well as your previous work: alignment, convening, trust, assumptions, incentives, risk adjustment, and some specific sticking points.

Next page. So alignment is always kind of a bugaboo, I think. Everyone always agrees that alignment is critical, but I joke that many of us interpret that as all of you should align to whatever it is that I am doing. There's a reason for that, which is really that systems are already aligned to the many disparate forces that are influencing them.

And any time you try to impose alignment with a given program, you run a risk of pulling folks out of alignment with the other work that they're doing.

So for example, if as a state you require all the payers to use a common data platform or portal, a national platform may lose the functionalities in the programs that they've built into their national platform. Similarly, for providers, if you agree as a state to work with a common quality measure set, your Federally Qualified Health Centers are still going to be accountable for the UDS and CHRQ[26] measures, so you may not have reduced burden as much as you thought you were going to.

I think bottom line, it's really important -- it's really easy to be myopic about alignment within a given model, but it's really critical to be aware of the larger picture and consider the impacts that you're having in a holistic context.

To the next slide. In Washington around quality measures, we were helped by the existence of the Washington Common Measure Set,

26 Community Health Quality Recognition

which is a statewide set for contracting that was legislatively mandated in 2014 to try to reduce burden around the many quality measures that are out there.

This set is maintained by a multi-stakeholder group called the Performance Measures Coordinating Committee, and we were able to convene a subgroup of that to select primary measures for the Primary Care Transformation Initiative. That included both a primary set and then a secondary set for different populations. Of course, it's always challenging to consider different populations' interests, you use very different measures than pediatricians, for example.

The Common Measure Set helped us in Washington. Clearly, at a national level, the increasing use of the CMS Universal Foundation measures has the potential to be a huge facilitator of multi-payer work. I think broadly, having a really commonly accepted and parsimonious measure set is very critical to enabling a multi-payer effort.

Next slide. Even when you are working on a state-based program, Medicare is still the elephant in the room. Medicare has

such a high percentage of payer mix, particularly in rural areas. Medicare also enables consistency across states for national payers, and many Medicare models have a time horizon that is long enough to justify the investments that all participants make in participating in a multi-payer model.

In Washington, we had really hoped that the Making Care Primary Model, which was closely aligned with the model that we were developing, would be able to drive our primary care efforts forward at a speed that wouldn't have otherwise been possible. Obviously, in practice, that didn't exactly work out. But I think that when that alignment with Medicare is possible, it's a tremendous, tremendous force at the Medicaid and state level as well.

Next slide. We have heard often that change happens at the speed of trust. Discussion really needs to happen both within and between different groups in a model. We found that there was much more frankness in rooms where we had just providers or just payers. People were willing to say things that they weren't willing to talk about in a larger group, and that really needed to be heard. And

at the same time, it was also essential to have meetings together to really build trust and relationships, and also to enable addressing key conflict points.

This is a map below of, in the first year of this work, how we convened primary care providers and payers separately and then together. We also really found that having a neutral convener was critical to supporting that trust building, as well as to navigating some of the hazards around antitrust issues and others.

Next slide. There are a lot of unstated assumptions, and it's very easy to go happily along through a model and then suddenly realize that people are not talking about the same thing. So a few of those, looking at really is the model intended to increase the overall amount of money in a system, even a subset like primary care, or are you really talking about rearranging or redistributing or changing the timing of how dollars are being spent?

Are providers expected to increase the number of patients that they're caring for? The idea of moving away from volume and into

value means very different things often to payers and policymakers than it does to providers. Where does downside risk fit into the equation? I think we've seen some real changes in how this is perceived, particularly since the COVID epidemic.

Which services and which providers are included in the model? It may seem very simple to say primary care and primary care services, but there's a lot of complexity in defining what is in and out of that, and that has huge impacts on the model. These are the kinds of things that you may not realize are critical assumptions and may forget to address, but really being explicit and clear about this is critical to having a successful model.

Next slide. Incentives. Multi-payer efforts are time- and resource-intensive, and it can feel like there's a lot of risk to be engaging for both payers and providers. I think it's important to include both the incentives and requirements. We found it was successful to require payers to come to the table and be part of the conversations.

States have a number of different kinds of contract methodologies that they can

use to lean on their payers, both on the Medicaid side and on the commercial side. We used a lot of those in different ways in our work. I think it can be really successful to incentivize early adoption and then think about penalties later on. So you're making it worth people's while to participate early, particularly providers, and then later use penalties to pull people in.

Really though, a model should be self-sustaining once it's in place. I think it makes sense to really push people to engage, but a successful model ought to be self-sustaining and rewarding to all players involved once it's being used.

Next slide. Social risk adjustment. Risk adjustment in general, of course, is critical to equity and to avoid penalizing providers who care for challenging populations. I think a special note, particularly in Medicaid, is that social risk adjustment is also really critical. That's true in Medicaid and also in other programs that address similar populations. So the exchange population, programs for undocumented persons just won't work unless you have social risk adjustment.

I don't think it's as important that that be standardized across payers necessarily, but the methodology or methodologies have to be credible to the provider community.

Next slide. A number of sticking points will come up. You've heard about many of these. I've talked about some of them. Attribution methodology, data platforms, and reporting, risk adjustment, quality measures, which services and providers are included and excluded. All of these can be standardized. Not all of them necessarily need to be.

I think for efficiency's sake, it's essential to build on what you have. For Washington, that included the existence of the Common Measure Set and pre-existing work that had been done around definitions for primary care. But differentiating what you're going to standardize and not, and really, really prioritizing what's essential versus what's just nice to have as you move forward.

Next slide. So a couple of lessons from our work to summarize. Alignment, try to think beyond the model that you're working on and look at a much global level -- more global level of alignment. Always move at the speed

of trust, otherwise you will think you're accomplishing things, and then they will fall apart when it comes to a crunch point.

Be very explicit in confirming your principles, assumptions, and goals. Convene peers and providers and policy folks both together and separately. Think about the use of both positive and negative incentives. Really lean into social risk adjustment, especially in the Medicaid population and similar populations. And when it comes to those sticking points, really try to build on what you already have in a system and then prioritize what's most important. That's it for my slides. I look forward to the discussion.

DR. BOTSFORD: Thank you, Emily. Last but not least, we are happy to welcome Dr. Rushika Fernandopulle, who is the Chief Executive Officer at Liza Health. Please go ahead, Rushika.

DR. FERNANDOPULLE: It is wonderful to be here with everyone, and thank you for having me. If you go to the next slide, please. So I was going to give a bit of a provider perspective as leading a physician

group, but we were not at all a typical physician group. So I'll give you a little bit of context.

So I'm a primary care doctor, general internist. About 20-something years ago, I woke up and realized that the current primary care model was fundamentally broken. And I'd spent a lot of my career doing what everyone else did, which is what I call the incremental change model. Maybe we can just tweak it a little bit, whether it was called total quality management or CQI[27] or Six Sigma or whatever you want to call it, and sort of decided maybe the thing was rotten to the core. And that we had built a system based on transactions, document code build next, as opposed to based on relationships and actually improving health.

So in a fit of craziness in 2004 when the doctors didn't do this sort of thing, decided to quit the day job and start a practice, Renaissance Health, and revert to primary care. We want to build a new model from scratch, and I'll talk a little bit about that. We did that for several years. We

27 Continuous Quality Improvement

realized that this sort of model -- and this sort of model wasn't just better for patients, but was going to lower total health care costs.

We ended up working with some employers, one of the first people to do so. We did a pilot with the Boeing Company in Washington, then called the IOCP, the Intensive Outpatient Care Program, and we were sort of led by a gentleman named Arnie Milstein that many of you may know.

We then worked with the casino workers in Atlantic City. Atul Gawande wrote a nice article about us called "The Hot Spotters" that allowed us -- it was a cover story in *The New Yorker* in 2011 that allowed us to raise some capital. And I said, I want to try and do this at scale. So we created Iora Health in 2011 to try and build this model. We grew that over 10 years, and I'll talk a little bit more about that. We merged with a company called One Medical, and then we sold the combined thing to Amazon, as Lindsay mentioned. And we're now the basis of most of Amazon's care delivery model.

So next slide, please. So I thought that if we want to change how we deliver care

to people, right? And remember, the basis of Iora was starting from scratch, but what does a care model look like if we're going to do the right thing for patients? And realize you have to change four different things. We have to change the process of how we deliver care.

Once you start completely changing the process, you realize you need a different IT platform. You can't do this on Epic or Cerner or Allscripts or Athena, because they were not surprisingly built for the current model of care. That requires sort of a different people and culture. And then probably most importantly, you need to get paid correctly in order to make this work. So let me go through those in turn.

So the next slide, please. So the model was very different. A lot of things are now incredibly obvious and lots of people are doing. Remember, we started doing this in 2004. People thought we were out of our minds. We thought, again, the job to be done was not see one patient at a time and do the best job you can, build as high as you can, move to the next one. But the job to be done would be the population of people. They are our problem.

How do we improve their health, keep them out of trouble, and do whatever it takes?

And so yes, we have doctors. Their job, as doctors, is to diagnose and prescribe. The hard part is not that. And what we do is we see people in a visit, we tell them what to do, and we say, good luck, sucker, I'll see you, and we pick a random interval for them to come back, right? That's not very effective.

So what we need is to wrap a team around people. So we had people we called health coaches. They're from the community, spoke the language of the people they served. Their job was to really accompany people, the kind of Paul Farmer, who sadly passed away. You know, it was his death anniversary. You know, to really hold their hand what's the right thing to do, kick them in the behind when it’s the right thing to do.

We also started integrating behavioral health and social work. You know, all this stuff is fairly obvious now. Omni-channel care delivery, proactive and not just reactive. Groups of people, provide transport if you need to, et cetera. So very different care model. Pretty much everyone on the call

who's talked about this knows what this model is. It's not that we don't know what this is, by the way. We just have to do it.

Next slide. And again, you can't do this -- this care is not a little different than typical care. It's completely different. And you can't do it on Epic or Cerner or Allscripts, right? Because they're fancy billing platforms that were designed to help you charge more and get more 99214 and 99215 codes. If you don't care about that, you need a different one. So we created our own, we called it Chirp. It's a care collaboration platform, not really an EHR[28]. It's more a CRM[29] than an EMR[30], and really helped us do our job.

Next. And this is key. Like, you cannot do this in a fee-for-service model. You cannot even kind of do it in a fee-for-service model. I think trying to innovate the care model without innovating the business model is a waste of time. I think that's why a lot of the medical home stuff is a waste of time, right?

So we started to the right of this, of the line, where at the very least, we would

28 Electronic health record
29 Customer relationship management
30 Electronic medical record

take a primary care case rate. Our first practice in Arlington, we were one of the first direct primary care practices in the country, along with Garrison Bliss in Seattle, and Chuck Kilo in Portland.

And a handful of us, where we simply asked our patients -- at the time, payers wouldn't give us a time of day, and we simply asked our patients, look, we're going to try and do something very different. Last I checked, your payer's too stupid to pay us the right way. So last I checked, I took analysis review and not them. So here's the deal. If everyone paid us about $40 a month, we'll break even. If you're rich, pay us more. If you're poor, pay us less.

We then evolved where people would do that. And we went to the payers, and we did our first Boeing pilot. Boeing would give us a fixed case rate. Occasionally, they had some bonuses on it or some shared savings. And eventually, when we moved into the Medicare space, we started doing full risk and taking full 100 percent up and downside risk.

The dirty little secret is that primary care is, I think as we mentioned on

this by other panelists, are typically five to six percent of total health care spend, and that's completely underinvesting in it. And we ended up, you know, spending 10 to 15 percent on primary care. And what you do, of course, is you then keep people out of the hospital and out of the ER[31], and the total costs go down.

So next slide, please. So we grew this to 49 practices in eight different markets, and you see the map here. We partnered with a number of folks, including Humana, United, CVS, Aetna. You know, we also ended up working with CMS directly to create a model, which was initially called direct contracting that morphed into ACO REACH, which is soon to morph into LEAD[32], which allowed us to do this sort of care for -- directly with original Medicare patients, work some Blue Cross plans and also some employers like Boeing and Dartmouth, as I mentioned.

If you go to the next slide. I was very proud in 2022, the first complete year of CMMI direct contracting. We were the top in the country of performance, 22.3 percent net savings rate, 22.3 percent net savings rate,

31 Emergency room
32 Long-term Enhanced ACO Design

right? Imagine how transformational that would be for the country if we could lower Medicaid costs by 22 percent.

By the way, I think there's a problem with CMMI demos where what we do is we do a demo, we get a lot of people in. And what we do is we judge the demo by how the average does. And there are a lot of jokers who come into these things who don't know what they're doing. You know, and instead of judging by the average and a lot of good demos have been thrown out, we should look at the people who actually perform well and say, we should keep you and kick out the people who don't do well and then move forward with the people who actually know how to perform. So in any case, these models work, right? And I think we all know that by now.

Next slide. You know, if you ask like, why is it that we perform well? If you look at almost all the people at the top of those -- that chart for CMMI direct contracting is we didn't do what the vast majority of practices did, which is the classic foot on the canoe and foot on the dock and tried to run a practice where we're doing optimizing fee-for-

service and optimizing value-based care in the same place. That is a fool's errand. It does not work. It's not a little different, it's completely different. So we just simply made a decision.

Again, I'm a doctor. I took notes to serve my patients. I cannot serve them in a fee-for-service model. So we're going to stop doing it. And so our attitude was we're going to be fully in on value-based care. So all of our patients were in a value-based care model, right? I think that is the biggest thing for multi-payer alignment is getting everyone to the value-based care.

By the way, I think a mistake the industry has made is saying we're going to move slowly to this new world. I think that's probably the hardest thing because you're then stuck with the foot in the boat. You really have to move there quickly. That's the only viable model.

So next slide. So even given we were only doing this, you know, we started our life with single-payer practices. So we started at Dartmouth in Hanover, New Hampshire, with Dartmouth Health Connect. It was a

practice that was solely serving Dartmouth College employees.

And then over time, what we did is that we thought of it like building a shopping mall. We'd get an anchor tenant like Nordstrom's and then we'd add lots of little other people around them. And so we had Dartmouth in there, and then eventually we added other employers like King Arthur Flour, UnitedHealthcare, gave us a Medicare contract for people.

Similarly in Phoenix, we worked with Humana. We were single-payer with Humana for several years. And then we branched out and started seeing people from Devoted, some Boeing commercial patients who were sicker and older, and then did direct contracting within the site. So again, we moved to multi-payer in all of our sites because that was a way that we could actually serve multiple populations.

Go to the next slide. So we are not typical, right? The way we got alignment between multiple payers is we simply insisted on it. And there are a few features of that. So one which I think is really important is that our relationship with our payers is one of

a long-term trusted partner, not a vendor. We tried very hard not to go through the consultants who would try to bid people every couple of years, treat you like a vendor. No, we are long-term partners.

You know, it's funny. Boeing once pointed out, we buy tires for our 787s. What we don't do is say any schmuck who makes tires just come slap them on our plane. Of course they don't. We're going to find a few people who do this well, going to work as partners with them over the long term, and we're going to build better planes that way. And we're going to do -- and by the way, one of our biggest suppliers, it's our health care. So why don't we do that with you too?

So long-term agreements are very key. Our first agreements like -- were three-year agreements. At Dartmouth, we moved to a five-year agreement. And then when we did our Humana contract, they were 10-year agreements. Ten years makes a complete difference.

And then the seller of the services, Iora, would determine how we get paid. And the buyers either agree or they don't. It's funny, in every other industry in the world, the

people who deliver the service decide how they want to get paid. If I open a restaurant, I say, this is how I want to get paid. If you don't like it, don't come here, right? And so the goal is just say no, right? And eventually people come around.

Simplifying the arrangements are really, really important, right? We have gotten way too complex in these sort of models. And again, I think in these long-term partnerships, you can actually do that and simplify and then streamline reporting.

My favorite payment model is what Jim Kim at Dartmouth and we did. We literally, we decided to build this practice for Dartmouth employees. He said, how do you need to get paid? And I said, look -- and he was self-insured, right, so he could do whatever he wanted. And I said, look, we need really to do this simply. So here's the deal. How much do you pay for primary care right now? And the answer was roughly $40 per person per month.

Of course they paid it per visit with all the ancillaries, but that's what it turned out to be. I said, great, let's double down on primary care. I want $80 per person

per month. My billing was a one-line email once a month. We had 1,800 patients times 80, send me a check. It meant, by the way, that we could ask the question, not is there a billing code for this, but will it help the patient?

Now, trust but verify, right? Of course, what we said to Dartmouth is you need to believe that this sort of intensive primary care, value-based care is going to save you money. So every five years, we will get an independent academic to do an evaluation of the praxis. We'll do a case control using RTI[33] methodology, propensity matching to take the people in the practice, match a group of people that chose not to join the practice, do a trend over trend analysis.

And if, as long as we're saving you money on total health care costs, including the extra primary care you're paying us, we keep going. If not, you should fire us. And actually, you shouldn't fire us because I'll quit because we're wasting our time here. And so that was it. And we've been doing this for 15 years now up there, and it continues to work.

33 Research Triangle Institute

And then the key is to be willing to adjust both ways. We had places where the rate we picked was too low, and we were transparent about economics. Again, that's a long-term trusted partner. And we adjusted it up. There are places we were getting paid too much. We worked with the Freelancers Union in New York. We're getting paid too much, and we adjusted down the rate, right? And that's the way you work, is you work as partners.

So, last slide, please. So a few thoughts on multi-payer alignment for value-based care. So it is absolutely necessary to transform practices. Again, you cannot practice different ways for different payers. We've tried that before with color-coding charts. It's a nightmare. It's morally and practically untenable. You've got to do it one right way, and that leads to better outcomes.

The biggest barrier today, by the way, I think is getting the commercial payers on board. You know, who would have thought that Medicare would be leading the way and Medicaid behind them? The commercial payers, despite the rhetoric, have tiny amounts of real value-based care. And then that needs to --

and they need to do it for both fully insured and ASO[34] lives. I'm happy to talk about that.

We need to sync on the model of payment. That's the first thing, that's fee-for-service versus capitation. But then also, as everyone else mentioned, getting risk adjustment quality frameworks reporting aligned is also important. But the biggest one is really aligning around -- we are going to align our practices around treating people in this value-based way. And then again, likely we'll need some government push and allowance for this to not fall afoul of antitrust rules. So I will stop here and looking forward to the questions. Thank you.

DR. BOTSFORD: Thank you, Rushika. All right. Thanks to all of the experts for those wonderful presentations. I'm sure there's going to be some questions to follow. So we're going to move into the discussion portion of this session. So at this time, for all the PTAC members, please raise your hand in Zoom if you have questions for our guests.

Additionally, we want to encourage our experts to ask follow-up questions of each

34 Administrative Services Only

other. You can signal that you have a question by raising your hand in Zoom. In the interest of ensuring balance across different perspectives, we encourage you to keep your response to a few minutes. All right. With that, I see Krishna, first in line here.

MR. RAMACHANDRAN: Thanks. Yeah, excellent job, team. It's great to hear your perspective, just these lived experiences and insights as well. Fantastic. Most of you, I think thematically mentioned the sort of data that is trusted, data that's actionable. And obviously, Rushika, you mentioned this platform you had to create because the core EMR systems didn't work as well.

It's a topic close to my heart, given the decade I've spent trying to make it better as well. And much like care delivery, I feel like the data landscape is also fragmented. There's EHRs and portals and data files, and there's a lot of variability there as well in our health care landscape. Curious on any recommendations based on your work on just how do we reduce the fragmentation? What does the path forward look like? I would love just some recommendation insights, particularly

as you do this nationwide.

DR. FERNANDOPULLE: Well, I have a few thoughts on that, Krishna. And thank you for the question. You're right. And particularly when you're working with, you know, the whole point of doing -- I think this is centered a lot around primary care, and I think everyone who's tried to do real value-based care realizes that we have to rebuild the system, not top-down, but bottom-up, right? Start with the consumer and then move upward. I think that's why these initial ACOs sort of failed, to be quite honest, because we started with the hospital and tried to trickle down. We have to start primary care up.

But now if you think -- and primary care has to be a lever. If all you do is change primary care, who cares? Primary care has to be a lever to then rationalize the whole rest of the system. But if we want to do that, we have to get the data from all these other places, right? And that's where the problem comes.

And despite what the laws say, we and everyone else who's tried to do this run into all sorts of information blocking that

goes on, right? Because both the EHR companies and the health systems and the health plans think that they own the data. I think we have made a strong statement that no, the data actually belongs to the patient. That is the right thing.

By the way, many countries who do this better than us, they don't even keep records at the provider or the plan level. The patients -- you know, I was in Thailand in Sing Buri Province, and everyone has a little book that they keep with them in a very guarded place at home. When you go to the doctor, you bring the book, and the doctor looks at the book. He looks at the labs. If he adds a lab, he writes it in, changes the med list, and hands the book back to you. One source of truth, belonging to the patient. That's better than we have, right, with the billions and billions of dollars we're spending.

So I think we're now finally getting there. There have been lots of problems with trying to build PHRs[35] is, you know, Google and Microsoft and a bunch of people tried this. They weren't very trusted. They probably

35 Personal health records

shouldn't be. But I think now, and particularly with AI and with some of the 21st Century Cures Act, ONC[36] Final Rule and using the TEFCA[37] rails, it's finally starting to happen. That's part of what we're working with on Liza Health. And I do agree with you. We have to fix that.

DR. GARG: Yeah. I would just add from the NCQA perspective, the organization spent a lot of time on the digitization of quality measurement, as I mentioned briefly. And I've been taught by the team by the massive levels of data fragmentation, as Rushika said, that exists. And it ultimately comes down to where should the data be tracked, and who should it follow? And my guess is we should all say it's available longitudinally to patients and their families and caregivers. That is not how the data ecosystem is organized. Krishna, I'm sure you know that better than many.

You know, there are massive issues around data quality. That's one area that NCQA is going to be spending more time. But I think if you just take a step back and say, will we

36 Office of the National Coordinator for Health Information Technology
37 Trusted Exchange Framework and Common Agreement

get to the kind of universal quality and outcomes signals that really matter based on claims data? No. I think we would posit that you wouldn't. There are many richer things that should guide care in population health management that require interoperable clinical data.

And then you get to this data fragmentation issue, and then you start to drill in and say, what is this? Are we really using standardized data models in data exchange mechanisms like FHIR?

And many organizations are at much earlier stages of that journey. So we are hearing regularly from plans, analytics partners, health systems about the amount of investment and time and change it would take for them to set up their data and the way that would be required in the future. I think that's something else that needs to be considered, which is not every organization has the scale, the sophistication, or the resources to go in that journey.

MR. RAMACHANDRAN: All right. Thank you.

DR. TRANSUE: Just one thing I would

add to that. Another piece of the question is social data. Because I think to do this work, we also really, really need to be exchanging social data and involving CBOs[38] and others in it. And so as we think about building better data systems, let's not forget about that part, because really for this to work, we need that too.

MR. RAMACHANDRAN: Great plan. Thank you all.

DR. BOTSFORD: All right. Larry?

DR. KOSINSKI: Great session this morning. I actually have three questions, one for each of the speakers, but anybody else can join in. But Vivek, my first question for you is, I've been in the leadership of the American Gastroenterological Association for decades, and we are always developing measures and metrics and trying to get them into approval by NCQA so that they can then be incorporated into EHRs and so that we can actually use them clinically. But the time factor takes so long.

Are you working on anything to make this more nimble? Because frankly, it takes years to get a measure approved through the

38 Community-based organizations

process and then implemented, and we cannot move at that speed. We have to move faster than that.

DR. GARG: Yeah, it's a great point. I'm starting to learn about that challenge. I think our own team would say they want to be able to accelerate the process while maintaining the integrity. And maintaining the integrity means the scientific integrity, the feasibility testing. Ultimately, there are going to be ways to enhance that process, but we're also not the only party. As you know well, it's a multi-stakeholder approach. There's a consensus-based process through CMS that Battelle coordinates.

So we're all participants in different levels of the process and structure, but we are going to be looking at how can we accelerate our part of the equation while maintaining the scientific and feasibility integrity so that ultimately the measures that get developed and aligned on can be produced in an accurate and insightful way. So no clear answer yet, but yes, that will be in a moment.

DR. KOSINSKI: We're going to hold you to that. That's going to be one of your --

DR. GARG: And on the flip side would be we have to work across the quality development, measure development ecosystem, including medical professional societies to say, how do we create those universal signals together? And where do we adopt best practice frameworks from each party and use them mutually?

DR. KOSINSKI: Well, that's a great statement to help me with my second question because one of my other endeavors at the AGA[39] has been to convene multiple payers across the country to try to come up with common processes around guideline development, around correct coding initiatives, and around value-based care. But I'm going to address this to Ben and Emily. And putting multiple commercial payers, you guys made -- Emily, I think you made the statement that, you know, we need to convene the payers.

Well, when we convene the commercial payers in one room, they'll talk about coding, they'll talk about guidelines with each other in the room. But when it comes to value-based care, they quiet up. They get very proprietary

39 American Gastroenterological Association

about their financial arrangements. So tips, how do you get them to open up and work together in the same sandbox instead of trying to one-up each other?

DR. TRANSUE: So it's a great --

DR. KORNITZER: So --

DR. TRANSUE: Go ahead.

DR. KORNITZER: Go ahead. Go ahead, I'll follow up.

DR. TRANSUE: You know, I think absolutely it's a challenge. I think one piece is really trying to be deliberate. Plans, and I've been on the plan side. So, you know, there's a tendency to say like everything is special sauce, right? It's all special sauce. We don't want to talk about it. But you know, there really are only pieces that are differentiators. And so I think to the extent that you can probe, okay, can we talk about this? Like the structure of the program is not likely to be a special proprietary thing. Really defining out what's proprietary, what people see as something that differentiates them versus not.

There will be things that are non-starters, you know, figuring out how people are

selecting their patients for case management is not likely to be something that people will talk about. But there are other things that I think you can agree on.

So I would say my general answer is bring people together in a room and then be explicit about what you want to talk about and let them be explicit about what they consider to be proprietary and then sort of move forward from the pieces that you can find in common. And in my experience, people tend to open up a little bit.

DR. KORNITZER: Yeah. Emily, very much appreciated your sentiments. And Larry, I think it was a great question. You know, I can step back and say the previous role, you know, I had worked for an organization that had a value-based contracts across a number of payers. And so very familiar with navigating that environment.

You know, what I would say is this, first of all, we should always have the patient at the center of everything that we do. And to the extent that there is clarity on what are the best health outcomes, what are the right measures, like how should we be thinking about

managing patients with heart failure and goal-directed therapy? How should we be screening patients for CKD[40]? How should we be ensuring that, you know, older adults are getting high-value tailored care? None of that is mysterious.

And so I think that there's probably actually more overlap than there is differentiation from one payer to another. That being said, I think that there's a couple of things that we can do to probably be more effective collaborators. One, we talked a little bit about the alignment of quality metrics and data collection, you know, both across ACO models and Medicare Advantage. I think that will create just a much more streamlined environment so that the conversations on quality will be similar.

I think investing in data interoperability, whether it's through HIEs, whether it's making sure everyone's using FHIR standards, again I think those create the chassis that allows it to be much easier for providers to practice high-quality medicine and have reasonable conversations with providers.

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I think, you know, a challenge has also been longitudinal care. It's impossible to have a fragmented system where a third of your population churns every single year. And so thinking through how do we create longer longitudinal relationships?

Quite honestly, there are a number of practices that are probably suboptimal that benefit from patient churn, right? Whether it's deceptive marketing, and so just making sure that we create longer-term runways so that people can make investments, right? If you think about it, if you're a GI and you're doing colonoscopies, you know, there may be a decade before that member actually benefits from that screening. But we need to create situations where everyone benefits from that activity similarly.

So, Larry, I hope that sort of gave you some sense of how we're thinking about this and where we think there are opportunities, you know, potentially collaborate differently across different payers, and do it in a way that really benefits members. Thank you.

DR. KOSINSKI: Thank you. Rushika, I did not forget you. I saved a question for

you, but you're free to comment on anything else that I ask. But I'm really impressed with what you've done. This is phenomenal that you had the vision when you had it to build what you did and how you approached it. I was hanging on everything you wrote, and I have a ton of comments. And one of the things the PTAC Board knows I do is I grab quotes. And I'm going to use yours. Innovating the care model without innovating the business model is a waste of time. I love that. We've talked about that at PTAC.

But my question is this, how did you deal with your specialists? How did you bring value-based reimbursement to your specialists when you're at full risk? What was your strategy?

DR. FERNANDOPULLE: No, it's a great question, Larry. And I think, as I said, if all you do is innovate primary care, you're wasting your time, right? It's five percent of health care spent. Who cares? It's got to be the lever, which then allows you to rationalize the rest of it. By the way, this whole, we'll let the consumers do this navigation themselves, give them skin in the game and good

luck, sucker, like that's a fool's errand too, right? There are such asymmetries of information, asymmetries of power thinking a consumer can do it.

But as a primary care doctor, we can actually do that as their partner. By the way, that makes us really important that we are 100 percent aligned with the consumer. I think there are too many models where the primary care doctor is actually not working for the patient. They're working for someone else, i.e., the health system or the health plan, et cetera.

That's problematic, right? For a lot of reasons. By the way, we would never allow that in financial services. We would call it a conflict of interest, a violation of fiduciary duty. But somehow we allow it to go on in health care, right? So put that aside.

So how did we do this, right? So we started by saying it's our job to help people navigate the whole system. And so we started by building what we call good folks list. So we partnered with our health plan. We got as much performance data as we could. You remember, we were doing this a long time ago,

the data wasn't that great, but we did as good as we could. And we identified the people we thought were good guys, right?

And you can imagine all the things you could look for in the data to do that. And then we go meet with them. And we say, look, so for instance, gastroenterology, it's like, look, here's the deal. We want to look for one GI group that we can work with. And here's what we're looking for. Are you willing to work with us? Let's re-engineer the interface.

So when I'm sending for a colonoscopy, I don't need them to meet with you before the colonoscopy. You don't want to waste your time doing that. Tell me what prep you want. I'll do all of that. And then by the way, if it's a normal exam, you don't need to come back to see. I can tell them that. And I can tell you what the follow-up is, right? So we can re-engineer all of those things.

By the way, what we found that's interesting is what's more important than finding good folks list is actually finding the bad folks list, a little like Santa Claus. Because there are a handful of specialists in

each thing that are just doing egregious things. And we need to make sure our patients never go to those people. So you start with the bad folks list, you then go to the good folks list, and you engineer it.

We then eventually started putting some people on retainers. So what if we put you on a little bit of a retainer so that we can actually round together and talk about patients? And people actually really like that. We do it over dinner. We would do a lot of curbside consulting and the like, right?

And eventually in some markets when we got to critical skip mass, like in Phoenix, we had 12 practices. We had 20 percent of all the Humana lives at one point. We did then even start hiring some of our own specialists to work with us. So that's -- you know, we have to explicitly do this, build this bottom. What we're building, by the way, is a bottom-up ACO, not a top-down ACO, right? But that's what we all have to get to. Thank you.

DR. KOSINSKI: I love that. Thank you.

DR. KORNITZER: Yeah. I just want to quickly add to that, that really there's a

significant gap, I think, in the relationship between payers and providers, and creating the right trust is so important. I love the thought that, I think Tom Lee said, the way that you get trust is that you give trust. And so just thinking through how we can change that dynamic. And so I'll give you -- since you're a gastroenterologist, helping us understand what are the things that we should be thinking about?

So I don't have access to add no detection rates. When I have something getting a speed and colonoscopy, what I really want to know is how good a job is that GI doing at taking their time and finding adenomas, which is the entire purpose? And so figuring out how we can get that type of data so that we can reward those providers who are taking the time, who are thorough, who are getting the best outcomes. And that's part of a bidirectional. We've got work to do on the payer side, and we need to create those bridges. I think that's really what's going to -- when there is that disconnect, I promise you the patients feel it.

DR. GARG: And I just want to quickly add to what Ben said. In the absence

of that kind of alignment around what real clinical outcomes and excellence look like, and the data sharing can enable that. People are using claims that are mostly looking at cost and their contracting arrangements. And that does not add up to the kind of population health improvement that everybody's individually mostly oriented around in their own practice or the patients want from all of us.

DR. KOSINSKI: Thank you, everybody. I've used up enough of our break time.

DR. TRANSUE: But just one more sec. I mean, just to call out, I think that was a great answer. And also it only works when you're an independent primary care group and there are independent specialists to contract with that you can pick and choose, which is not the way of the world in general. So it's a huge challenge.

DR. KOSINSKI: Great point. Thank you.

DR. BOTSFORD: Great point. Lauran?

MS. HARDIN: Excellent presentations. Really excited to hear all your diverse perspectives. So I've spent many years

really focused on complex populations, definitely designing models in urban environments. But I'm really curious to hear from each of you. Emily, you mentioned social risk adjustment. I'm interested in how -- what kind of unique adaptations, approaches, or supports have you needed to design in for rural environments?

I've been involved in frontier environments, Alaska, the border with Mexico, many, many rural communities need that support to be successful in this. So I'm curious how each of you address that and what considerations you may want to share for us to consider as we look at this topic.

DR. TRANSUE: Oh, that's such a great question and hard to tie a quick bow around. I mean, I think there are so many fundamental principles around what's happening in a rural setting that are just radically different from what's happening in an urban setting all the way from, you know, it's nice to talk about, let's find the best gastroenterologist that is going to have the highest rates that you could access.

But if the only one in a 500-mile

radius is, you know, that lady over there, you're going to see that lady over there. I think a lot of the contracting mechanisms kind of break down because again, you can't pick and choose if there are not hospitals and others to pick and choose between.

So and then there's trying to understand what cost looks like in a setting that is so different. So many of our mechanisms to control costs kind of hinge on being able to see people in a certain timeframe, being able to send someone home from the hospital and have them follow up the next day, you know, all sorts of things that just aren't possible across that kind of distance.

And then there's the additional challenge that so many rural providers are really kind of catastrophically financially struggling. And so you don't have the ability to put the kind of pressure on a system that you would have often in an urban environment. So I think a lot of that is about realizing that especially as you get into those more frontier kind of environments, you're going to have to loosen the rules, you're going to have to have an up-front system that is kind of more

generous in how it approaches and assesses impacts.

You're going to be really thinking about impacts that are more along the lines of are we maintaining access? Are we keeping providers in the area that are there and need to be there rather than sort of the winnowing down to the most productive few that a lot of models rely on? And again, adapting financial models to recognize the realities of systems in which not every level of care is available and not every kind of follow-up is available.

DR. FERNANDOPULLE: So Lauran, I'll just say a couple words. So maybe inherent in your question is that health care is local, and we have to be careful when we build these things, you know, to get alignment. It's not trying to align across everywhere because health care is different. *The New York Times* wrote a great front-page business story on this many years ago. It's called "the Starbucks of health care." Despite my quote saying, this is not like Starbucks, right? You have a Starbucks in one community, they look exactly like one another.

But in health care, we have to build

for the community, right? The expectations are different, the disease burden is different, the provider landscape is different, the logistics are different, right? So there are some things which we have to do the same because it's the right thing to do, but many things that have to adapt. And we just have to be careful not to over-specify the alignment.

You know, we know what to do in a lot of these things. So telemedicine obviously is the right thing to do, home visit teams, helping people with transport and the like. One of our biggest struggles when we, you know, Hanover, New Hampshire, is sort of rural, is it's much easier to attract physicians to work in New York or San Francisco or Boston or Phoenix than it is in, you know, Alaska or Mississippi, et cetera, right? So I think that's part of what the struggle is.

We would try to create these sort of fellowship programs where we would sort of get people to be willing to go places and then, you know, in a couple of years, then you can come and work in Seattle or wherever. But by the way, most other countries do things like that. And I think we have to solve the provider

shortage issue in these places.

DR. GARG: I would just add one thing that NCQA has done is to create managed care and care delivery programming around looking at disparities. And I think part of the impact of what you're flagging are disparities in health and care that exist for the reasons Emily and Rushika were describing.

So we have a program called Health Outcomes Quality Accreditation that really a lot of state Medicaid agencies are asking their managed Medicaid MCOs to adopt, which creates a baseline foundation of data to stratify populations by race, ethnicity, disability, other factors, and ultimately say, what are your improvement plans based on the gaps you identify once you stratify that data, leveraging, obviously, best-in-class standards that have been developed nationally?

And another partner to that is a community-focused care program to highlight organizations that are adopting robust social needs screening and interventions. And you can imagine the two working hand-in-hand.

And that won't -- those things themselves won't solve the problem, but they

will hopefully create a more consistent foundation for the partners who adopt them to say, what are we doing, what are the gaps that emerge, whether it's because we're in a rural area or there's specific community dynamics based on the people who are there, based on their experiences and level of health need, and are we closing some of those gaps?

DR. KORNITZER: And the only thing I would also add building on that is just, you're considering making the telehealth provisions permanent, given the fact we want providers who are at risk to be able to meet patients where they are, and that's going to be an increasingly diverse population over time.

MS. HARDIN: Thank you all.

DR. BOTSFORD: All right. We're approaching our last five minutes for discussion here. I'll add a quick one unless there's -- okay, Lee's stepping in. Go ahead, Lee.

CO-CHAIR MILLS: Such a great conversation. I was struck, I think, Rushika, you said that, you know, the slow, steady development along the HCPLAN[41] land continuum is

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a fool's errand because it just prolongs the time you spend with the foot on the dock and the foot in the canoe. Boy, have I lived that, both on the provider and the payer perspective. And so I love the group's thoughts about -- I mean, HCPLAN laid out this wonderful landscape that seems like it's a developmental landscape.

But in certain early stages, like the provider has to go through maybe a pay-for-performance because that's when you learn that your data is or is not hooked up, and your EHR code sets are or are not updated to be received and meet NCQA requirements and HEDIS review, all that stuff, right? I mean, that may be an important and necessary developmental step.

But I just love your thoughts on what you see has worked contracting and what elements you pull out of different parts of value-based care, and when is the right critical mass to make a jump to full primary care capitation or some other models? Just how do you see that developing compared to how much of the market is trying to do it now?

DR. FERNANDOPULLE: You know, so when we did our first Humana contracts, we created explicitly what we called road to risk

models. So what we said was, look, we're just starting out, and we did this every market we'd go into. So we would say, it's going to take us a while to build these systems because we don't have them already, right? And to get the, as you said, get this stuff working. So we had roughly three-year road to risk models.

Year one, we are just at a primary care cap, right? So we're not at any up or downside risk and just pay us a primary care cap, and this is our sort of get the systems ready. Year two, we would go to, you know, 25 percent upside and no downside. Year three, we'd go to sort of 50 percent up and downside. By year four, now we're running at full risk, right? So I think that was really important for us to, sort of, two things. One is to have that clear road and an expectation of when this will happen so you can build for it.

The problem today is that it's uncertain, right? If you knew in three years we have to get here, then you can do. And it takes time. It doesn't happen when you snap your fingers. But to put those sort of explicit pathways in place, I think was very helpful.

DR. TRANSUE: I would say the pathway also, I like that description. I think there's a distinction between sort of what a carrier is offering and what a provider is choosing. So I think the provider has to move that way, but a carrier can -- doesn't have to say like everybody's got to start early if they already know how to do it. So I think having the opportunity to offer to meet providers where they are in terms of those capabilities is really important.

Another thing that I would say, you know, all of those models that you just described were capitation. So it was the fee-for-service part of it, you kind of had out from the beginning and then added the risk, and I think that's a really good model. There's still some challenges. We had a famous example in Washington that resulted in a big lawsuit between an MCO and a direct primary care provider in terms of, you know, are you capitating?

Essentially, the root of that was they were capitating a whole bunch of people, and the provider was only seeing about five percent of them, maybe it was 10 percent. So

figuring out exactly even what capitation means is important, but I agree that you can fix capitation earlier than risk and be safer.

DR. KORNITZER: Let me just add one thought. And I'm a deep believer in value-based care, but, you know, value-based care in and of itself is not necessarily a moral good. The outcome that we really care about is our patients getting better care, and value-based care is a powerful tool that we can use to align people and to get them that outcome.

As I think through it, you know, just going back on that comment I made about the relationship between payers and providers, trust is so important, and I think we need to get out of this mindset that it's a zero-sum game and what we should be doing is arm-wrestling over the percentage of premium, but figure out what are the unique capabilities that we as payers have and that providers have, and how we can partner together to get those better outcomes, which is what I think really matters.

And I'll be honest, right? You know, when I was on the provider side, even when we had millions of members at risk, we

didn't have the sophistication, the data, to really create the predictive analytics, the high-value networks that we needed. And so I think the ability to go and say, how do we set one another up for success, with the idea being that when we have a JOC[42] in a year from now, or in two years from now, three years from now, you know, we are all going to be delighted with that outcome.

And Rushika, I love the example that you gave about whether it was the freelancers union or another, where, as part of the reconciliation, it showed that the dollars weren't where people predicted, and so you made adjustments. When you create a real relationship with people, you're able to do that and do it longitudinally and effectively. And I think that mindset and that partnership is actually really what the key is to create those successful outcomes.

DR. BOTSFORD: Thank you. All right, we're in our final few minutes here. If there's any rapid-fire comments from our presenters or things that haven't been said in your final moments, this is it.

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DR. FERNANDOPULLE: So I just want to thank the PTAC for taking on this issue. This is a huge issue. And like I said, I would push you to focus on the commercial insurers. You know, I think we've already gotten a lot of alignment around Medicare, and Medicare's leading the way, but until we get the commercial insurers on board, it's going to be very hard for the vast majority of practices to actually transform.

DR. BOTSFORD: Thank you. All right. Well, I think at this time, I'll go ahead and thank all of our experts here for joining us to kick off Day 2 with some great conversation and for sharing your insights. You're welcome to stay and listen to as much of the meeting as you can, but at this time, we are going to have a break until 10:50 Eastern Time. Please join us then as we welcome any public stakeholders to share comments, and then our day will conclude with a final Committee discussion.

(Whereupon, the above-entitled matter went off the record at 10:40 a.m. and resumed at 10:51 a.m.)

*** Public Comment Period**

CO-CHAIR MILLS: Thanks so much. Welcome back. And now the Committee will discuss everything we learned yesterday and today based on this public meeting. I do need to check in and make sure for the public comment period. I'm not aware that anyone has signed up for public comment. Let me check in with our host. Any public comments online? Hearing none, we will -- last chance. All right. Hearing none, we will proceed with Committee discussion. This closes the public comment section.

*** Committee Discussion**

CO-CHAIR MILLS: For Committee members, please refer to the potential topics for deliberation document. And if you have a comment, raise your hand in Zoom. We're going to discuss everything we heard yesterday and today and pull out the themes and the pieces that will most inform our report to the Secretary. So, Committee members, please raise your hands. Henish, please go ahead.

DR. BHANSALI: Overall, I thought the conversation was fantastic. I think a couple of the key takeaways that I have -- I apologize. Someone is ringing I need to step

away.

CO-CHAIR MILLS: No worries. We'll pitch it to Lindsay.

DR. BOTSFORD: Thanks, Lee. All right. Well, I'm going to channel a former Committee member, Jen Wiler, here and give my top 10 comments or suggestions from today here. You know, I heard a theme from similar meetings, which is extending telehealth provisions would be beneficial as we think about improving value and meeting patients where they are. I heard the importance of a neutral convener, whether that be a state, a neutral party, or maybe the federal government here.

And I think three is the theme of trust and needing trust between payers and providers, especially those that come from longer-term relationships than an annual churn cycle. I did also hear using both positive and negative incentives as needed, which is, I think, a theme of maybe the moving faster and moving not slower there. I think as we do all this, don't forget about social risk adjustment. Especially in Medicaid populations as we move quickly.

And then some themes around, you know, the potential to build on what you have as opposed to just inventing and trying new things. And again, that concept of simplifying whatever we do have in current state to get us closer to the goal. I also heard potentially a different take on evaluating the CMMI models and different innovation around not just judging by the average performance, but looking at the top performers to think about models that could work.

And then the last one is, I think, one we hear almost at every meeting, but that's the importance of data. And despite what might is be on paper, the information blocking and data asymmetries are real and need to be solved to be able to get data there. And that's my top 10.

CO-CHAIR MILLS: Great. Thank you, Lindsay. Krishna?

MR. RAMACHANDRAN: Thanks. And Henish is back. Do you want to finish your --

CO-CHAIR MILLS: Go ahead and start, Krishna, and we'll come back to Henish next.

MR. RAMACHANDRAN: Okay. Sounds good, yeah. I thought, yeah, fantastic second

day as well. Really, yeah, really appreciate the conversation there. Lindsay, I liked your sort of top 10 approach there as well. I think things that stood out, I mean, for two days for me, certainly the, how do we sort of align on the models, right? Whether it's the, you know, the same, same, but different. I think there's a need for us to truly, between Medicare, commercial, getting more alignment. Having consistency in the model certainly came up, which is primarily the theme of this whole discussion there as well.

Financial stability continued to sort of be a theme from yesterday and today as well. Like how do we sort of like front-load some of these incentives, make them meaningful to make the transformation? Certainly data interoperability continues to be sort of thematic, sort of a through line as I would expect as well, just given past discussions there we had.

And there’s speed of trust that came up today as well. How do we sort of, you know, much of the change can -- is going to be limited by how fast we can move from our trust we're building. And so creating spaces where

we can have that happen, whether it's an independent convener that is trusted and can take the time to build a trust, I think is key. Harmonization. You know, from a quality measures domain, I appreciated Dr. Garg's comments as well there. I think that too many quality measures too. So how do we sort of streamline, have a common set, I think was helpful.

And then particularly with our role PTAC, like where Medicare can lead the way to sort of bring the other stakeholders together, because it's always the, quote, unquote, elephant in the room, as Dr. Transue mentioned there as well.

I also liked the unstated assumptions part of it, having spent time on the provider and the payer side on value-based care. I think there's definitely some unstated assumptions in any of these multi-payer efforts. And so putting it on the table where comfortable, I think will also go a long way. I feel like in building trust, creating transparency, but also making sure that everybody's sort of goals are clear as well. So overall -- fantastic two days and great to

be part of the conversations.

CO-CHAIR MILLS: Thank you, Krishna. And Henish, let's pitch back to you.

DR. BHANSALI: Maybe to add a couple of things to what's already been said. One is maintaining the creativity of Medicare Advantage plans or payers while creating some guardrails or maybe some processes that are expected of all Medicare Advantage payers, specifically having to do with attribution, for example. So we learned that there's quite a bit of variability within MA, and we don't want to stifle innovation and creativity.

But having some standardized processes in place, whether it be around -- well, specifically around data sharing, but also around understanding for risk-bearing entities to understand who the attributed population is early so that the population can be managed. Can things like that be more standardized or expected of Medicare Advantage payers, as it is for other CMMI-CMS programs like MSSP and REACH?

The other piece that I heard was around commercial payers, that there isn't nearly as much of value-based care arrangement

penetration in that sector. And how can CMS-CMMI be sort of the leader, but have commercial payers follow suit to have VBC[43] optionality in that sector?

CO-CHAIR MILLS: Okay. Thank you, Henish. Larry?

DR. KOSINSKI: Well, I'll add to what I said yesterday at the end of the meeting. As we've said, a little bit more simplification comes out. I like what Lindsay added with consistency. Like, I think CMS needs to have a steady hand on the rudder and guide this instead of continuing to come up with new programs and enforcing that the providers to shift direction. So consistency, simplification, steady leadership in a direction. Hopefully that doesn't change with administrations. But, you know, that came out clear to me.

The other word I want to put in is commitment. We heard that, you know, if we don't have CMS at the table, it's difficult. Are they going to invest in the value-based program? How committed are they? But we're going to fail if we don't have a commitment

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from the top. Third thing is, again, we heard it again today from Rushika, you've got to focus on the business model. You have to recognize the success of the business model of the providers or else whatever you do, it's going to fail. We all got to play in the same sandbox.

And I love the little nuances that Rushika gave about how he brought specialists in. I heard a new term, retainer. Oh, my God, that's something I haven't heard in any of these meetings. And then the final bullet I have is conveners. I think we need to better define conveners. Because what we heard today is a little different from what we heard from CMS yesterday where you have to be a provider to be a participant. And does the convener have to be a provider? Can the convener be an entity that is not necessarily providing care?

So those were my five bullets from the two days. I thought it was a great meeting. I learned a lot. Whoever, the team, PCDT, you've got a lot of credit for picking KOLs[44] that really made the gears in my head move.

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CO-CHAIR MILLS: All right. Thank you, Larry. David.

MR. TYSON: Yeah. So I think I'd echo a lot of what folks have already said. But I think one of the things that came through for me, and maybe this is a place where the PTAC in particular can be more supportive, is this inherent tension between, let's call it incrementalism and rapid adoption. And I think that happens on both the payer and the provider side of things.

And a lot of that comes down to trust, trust in incentives, trust in the data, that most folks on the provider side of the house have been sort of loath to jump in with both feet because we've seen that work to varying degrees. And I think that moving into a place of widespread multi-payer sort of like soup to nuts adoption is going to require a bit of hand-holding and a bit more trust-building for sure on the provider side in particular.

Because we've heard maybe not explicitly laid out, but just inherently and certainly what Dr. Chernew said of these changing priorities, the shifting landscape that we've seen from administration to

administration, none of that builds a lot of trust. And so how do we as the PTAC instill more confidence amongst people? So to Larry's point, maybe PTAC needs to be more of a convener and bring more people to the table. So that was just some of the pieces that stood out to me.

CO-CHAIR MILLS: Excellent. Thank you, David. Lauran?

MS. HARDIN: Agree with all the comments. I think it was an excellent meeting. I'm just going to put some emphasis and repetition on some of those. So one of the biggest themes is this is longitudinal change. So really having the infrastructure in place for a long enough time that the system can actually shift. The core value of really deep emphasis on trust building and the investment in that is really critical to get to shared outcomes, as well as shared value proposition for real change.

The investments in capacity building, practice change, and then really strong emphasis on that neutral convener, the integrator role to deeply work on the system improvements for integration to get the impact.

And then considering social risk adjustment or other local context adjustments to get long-term change across the board.

CO-CHAIR MILLS: Thank you, Lauran. I'll insert myself here and give the final members a few more minutes to think. But I agree with everything that's been pulled out.

I was also struck that we heard a lot about, you know, we've spent so much time talking about simplifying metrics in PTAC, and we've talked about programs, but it was interesting to pull out elements of, you know, MA has Stars, states have their own metrics for Medicaid, and yet even inside Medicaid, FQs[45] have their own mandatory measure set. And it clearly is still that it's not that -- it may not so much be that payers can choose to streamline around the CMS core measure set. It's almost driven more of a line of business consideration.

And so there's a role, I think, for policymakers to work on trying to get it right now. It feels like we've got 90 percent dispersion, and only 10 percent or less are in common. Maybe there is a role for CMS and

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policymakers to look at trying to sync up the measure sets for, to a greater degree than there are now, Stars, FQs, ACL[46] metrics, et cetera. There aren't that many things that truly matter most, right?

We heard an element about that, that several people spoke about, it's just important to use MA for critical mass to get above that 50, 60, maybe 70 percent threshold of providers involved that major provider and health systems need to get attention and to move the machinery. And I think that was a new element.

And I guess the last thing I'll just pull out this element about not thinking of it as incrementalism or incremental development, moving along an HCP[47] line. At some point, once basic capacities are built, there's a jump, there's a tipping point, to borrow Gladwell's term. And I don't think we've really fully elucidated how that works.

And obviously, it'll be different for different people at different places. But maybe that bears more thought and elucidation about what are the metrics or the elements that tell you you're leading up to the tipping

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47 Healthcare Professional

point, and you're ready to jump and skip incrementalism. And so I think that maybe bears further thought in the future, so. Walter?

DR. LIN: Thank you, Lee. So I'd like to first begin by just thanking the PCDT, ASPE, NORC, for convening this important discussion on this important topic. The subject matter experts were really great and have given us a lot to think about. So I was inspired by Lindsay's top 10 list just now. I appear to be running only at 50 percent of her insight capacity. So I'm going to offer a top five list.

First, again, returning to a theme that we heard yesterday as well. I think our panel this morning emphasized how primary care must really be the anchor in a multi-payer alignment world. Sustained investment in primary care, both in terms of team-based care, as well as the ability to create longitudinal relationships with patients, is the fundamental lever that drives downstream reductions in utilization and improved outcomes.

Second, data seems to be the lifeblood of success in multi-payer alignment.

Timely, interoperable clinical and social needs data are required so that providers can act proactively, and often today's data fragmentation prevents that.

Third, we heard about harmonizing quality measures and performance incentives. This idea of a parsimonious course measure set and the transition to digital quality measurement is critical to reducing administrative burden and to send consistent signals to providers across payers, Medicare, Medicaid, commercial plans.

Fourthly, payment design matters. This idea of a staged road to risk pathway, you know, the path that Rushika's companies have taken from taking on case payment, case rate payments to full risk contracts, credible risk adjustment, including social risk, are what really seems to enable providers to make the investments needed to transform care.

And fifth, trust and durable partnerships between payer and providers, not short-term transactional vendor relationships, are essential.

One kind of concrete idea that came up during our discussion and one I'd like to

lift up to the Committee and CMS relates to specialist quality transparency. So Rushika described curating a good folks and a bad folks list to guide specialist referrals, to improve care coordination, and protect patients from low-value or harmful care. This is something that's kind of near and dear to my heart in our current practice and would love the ability to have access to a CMS developed specialist-level performance data list so that PCPs can use to identify high- and low-value specialists locally.

It would seem like CMS could, with the help of others, define metrics that matter for specialist performance drawing from the claims data and other sources. And it's going to be important to identify how case mix and social risk adjustment would be handled for fairness. And there'd be a lot of details that would be needed to develop such a list. But I think that would really help primary care practices to reliably build high-value referrals without compromising access and equity.

CO-CHAIR MILLS: Thank you, Walter. And I think Josh brings us on home.

DR. LIAO: Well, I'll bring you home, going from 10 to five. All I can operate on is three, but I'm cheating because I won't restate many of the things I agree with from other Committee members. But the first thought that I had from a really rich one to two days is really this idea of discipline flexibility.

This underscores some of the things that I mentioned yesterday, but I continue to believe that alignment here doesn't equal uniformity. You know, we need flexibility in product design and benefit structure and network configurations. And I think, you know, that is true. At the same time, I think without discipline, that quickly becomes administrative noise. I think some of our subject matter experts highlighted that.

I think every additional permutation of quality metrics, attribution logic, and risk adjustment methodology, reporting cadence, adds potential friction to clinicians and organizations who are already operating across Medicare, Medicaid, multiple commercial lines. And I think that really came out.

I think just to make that point finer, I don't know that it's a binary choice

between standardization and customization and options. I think it's a continuum. I think the work before us as PTAC and others in the policy and practice community is to calibrate that continuum. And I appreciated kind of the humility and pragmatism that I heard from our guests at the meeting about how to go about doing that.

I think where variation is essential to preserve product integrity, to give choice to the public for public good, for statutory requirements, we should acknowledge that openly. I think where variation is more historical drift, you know, or competitive signaling, we should think about ways that might be appropriate to narrow that.

I think one of the kind of complementary points to this idea of discipline flexibility is to acknowledge that the things that we're talking about are inherently complex, at least to me, because of the models of attribution, risk adjustment, risk corridors, you know, spending adjustments.

These are complexities that I don't think we can just pretend can be harmonized away. I think that they're realities we need

to focus on. It doesn't mean it's an excuse to maintain variation heterogeneity, but it's just something to acknowledge. And I think where standardization is possible in those things that I mentioned, we should think about meaningful ways to do that. And so I think that's the first thing, discipline flexibility.

The second thought that kind of comes to mind is kind of this alignment requires kind of proverbial skin in the game financially. I think, you know, we are the PTAC because I think inherently we recognize that incentives and the way payment occurs is not the most important, perhaps, or the only thing in health care, but it is a very important signal. Some of our subject matter experts underscore that. So I think one of the takeaways for me was that shared expectations without financial consequences or accountability, I worry, may not drive durable change.

And so one of the things that came out from our sessions was this kind of leadership and disproportionate focus from Medicare and CMS. And I think that that asymmetry is worth us noting, right? That

other segments, including commercial, often trail in scale, in financial commitment, et cetera.

And so I think if we want true alignment in the way we're thinking about, not just a CMS-led demonstration with some partial follow-on, I think thinking about what I heard from some of the subject matter experts is, how do we think about making more comparable financial commitment across payers? So I think that needs to be worked out, but I would highlight that, is that we do need that engagement.

And then, finally, at the risk of semantics, I was struck by, you know, how we're thinking about what we described in the PCDT as kind of exact versus directional alignment and what is good enough for alignment. And so I hope that one thing we can think about maybe as a step on the way to alignment is this idea of coherence. And so, you know, alignment implying kind of exact or pretty close to shared incentives, accountability, financial architecture.

And this may be a good end state as an ideal, but I think given the system that

we're in, the heterogeneous benefit designs, statute of requirements, competitive dynamics, all the things we've highlighted and talked about the last few days, I wonder if kind of the concept of coherence, meaning consistent signals, harmonized core elements, you know, de-conflicting operations may be a more pragmatic and durable step. I think that in some ways, I'm trying to name what I've heard from many people today.

I will say, I think the distinction matters. I think if we accept alignment as the only acceptable outcome, there is a risk of kind of paralysis in the face of complexity. And so I think the idea of using coherence as an intermediate step there to synchronize all the things we've talked about, measure sets, reporting cadence, attribution, risk adjustment, I do think that can be helpful and really builds the conditions under which I think deeper alignment can be feasible. So kind of thinking about that.

So in summary, I think I've heard a lot of good things about challenges and rate limiters of aspirational ideals for alignment. And I think disciplined flexibility, I think

making sure there's comparable financial accountability and skin in the proverbial game. And I think thinking about how we cohere, as well as align, in a multi-payer way, I think are some of the things that I'll take away from our meeting this time. Thanks.

CO-CHAIR MILLS: Thank you so much, Josh. Great thoughts. Any other final thoughts? I think everybody's had a chance. Okay. Well, thank you to all the Committee members for sharing your valuable insights and the themes summarized over two days of incredibly rich conversation.

*** Closing Remarks**

CO-CHAIR MILLS: Before closing, I need to check in with the ASPE staff to see if there's any clarifying questions or comments. Marcia, Steve, any dangling threads we need to pull on?

MR. SHEINGOLD: No.

CO-CHAIR MILLS: Okay.

DR. CLARKE: Nothing for me. Great sessions.

CO-CHAIR MILLS: All right. Thank you so much. So I'd like to thank everyone for participating today, our session experts, my

PTAC colleagues, those listening in, and especially all the amazing staff that made today possible. We explored many different topics regarding improving multi-payer alignment and value-based care. Special thanks to my colleagues. There's a lot of information packed into these two days, a lot of incredible perspectives shared. I appreciate your active involvement and participation and thoughtful comments.

*** Adjourn**

The Committee will work to issue a report to the Secretary with our recommendations coming out of this theme and from this public meeting. And with that, one final thank you to the Committee and all of our session experts for joining us and making this memorable and informative PTAC public meeting. I will declare this meeting is adjourned. Thank you very much.

(Whereupon, the above-entitled matter went off the record at 11:17 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: 02-24-26

Place: virtual meeting

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate complete record of the proceedings.

Neal R Gross

Court Reporter