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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Monday, February 23, 2026

PTAC MEMBERS PRESENT

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

PTAC MEMBERS IN PARTIAL ATTENDANCE

LINDSAY K. BOTSFORD, MD, MBA
KRISHNA RAMACHANDRAN, MBA, MS

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

9:30 a.m.

* CO-CHAIR MILLS: Good morning. Welcome to this 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 co-chairs of PTAC, along with Dr. Chinni Pulluru.

Since 2020, PTAC has been exploring themes that have emerged from stakeholder-submitted proposals over the years. Previous PTAC theme-based discussions have focused on topics such as reducing barriers to participation in alternate payment models and supporting primary and specialty care transformation, encouraging rural participation, improving management of care transitions, and using data and health information technology to transparently empower consumers and support providers.

At this meeting, we've brought together various subject matter experts to gain perspectives on improving multi-payer alignment in value-based care. We know that this topic is also of interest to the CMS[1] Innovation

1 Centers for Medicare & Medicaid Services

Center. Before our first session of the day, we're honored to have opening remarks from Ms. Amy Turner, Deputy Director for Policy at the Innovation Center. Ms. Turner brings over 25 years of experience in employee benefits, regulatory policy, and health care administration. Prior to joining the Innovation Center, she was Deputy Director for Policy for CMS' Center for Program Integrity, where she was responsible for preventing fraud, waste, and abuse in Medicare, Medicaid, and the Marketplace.

Ms. Turner began her career at the Department of Labor, where she led numerous HHS[2], Department of Labor, and Treasury health care regulatory teams, including serving as the ACA[3] implementation lead for the Department of Labor and eventually Deputy Assistant Secretary at Department of Labor's Employee Benefits Security Administration.

Welcome, Amy.

*** Amy Turner, JD, Deputy Director for Policy, Innovation Center, Centers for Medicare & Medicaid Services**

2 Health and Human Services
3 Affordable Care Act

(CMS) Remarks

MS. TURNER: Well, thank you. I am very excited to be here, although I admit here is actually my basement because it is snowing. I am sorry that I don't get to see everyone in person. I understand for those flying in, it probably ended up being a better call because it would've been horrible, particularly if you were connecting through some airport or something like that, to get stuck. Look forward to the opportunity, maybe, to see people in person next time. That would be great.

But I wanted to follow up just for maybe five or 10 minutes on some of Abe's remarks from last time when he talked to you in September, and talk to you about some of the progress that we've made, because I think we have been doing a lot to promote value-based care in ways that are of mutual interest since he spoke in September.

So folks may remember when Abe talked last time, he spoke about our strategy, which really just it is a piece of everything we do. We all have it memorized. We all think about it daily, if not hourly. We have three

strategic pillars. One is promoting preventive care. The second is empowering patients. The third is driving choice and competition. And that is all built on a foundational principle of being careful stewards of taxpayer funds.

So what have we done since September? A lot. We actually, in 2025, when Abe came in, he took a very holistic view at the entire model portfolio, and there were some models that were terminated early. There were some where it was a decision made that they would be terminating soon and just to let them terminate because they weren't really showing the results consistent with our statutory mandate to either improve quality while holding costs constant, reduce cost while holding quality constant, or sort of, like, the perfect scenario, nirvana, which is bringing down costs while improving quality.

So there was this very holistic look, and there was a decision made to launch -- the hope was to launch 10. We ended up launching nine new models in 2025. The tenth model will hopefully be rolling out in the next month or two. Those models all fit within those principles. Four of them were drug

models. They all have these really catchy names. BALANCE[4], GLOBE[5], GUARD[6], and GENEROUS[7]. The drug models, very, very focused on trying to reduce costs in both Medicare and Medicaid, free up those dollars for states, free up those dollars for the Medicare Trust Fund, and, speaking of multi-payer alignment, really maybe set some principles and do some things that other kinds of payers can also copy, employer-sponsored insurance, for example, so that the entire health care delivery system is benefiting from savings.

So there were the four drug models. We also did -- we did WISeR, which is the Wasteful and Inappropriate Services Reduction Model, before he spoke to you, so I'm not going to focus there. But we launched the ACCESS[8] Model. ACCESS, I think, is really exciting. Like WISeR, it -- the idea is to leverage technology to try to improve both care delivery and reduce costs.

The thing about ACCESS is is that it's using technology-supported care for people

4 Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth
5 Global Benchmark for Efficient Drug Pricing
6 Guarding U.S. Medicare Against Rising Drug Costs
7 GENErating cost Reductions fOr U.S. Medicaid
8 Advancing Chronic Care with Effective, Scalable Solutions

in original Medicare, but the payments are outcome-aligned payments. So that, I think, is really exciting and really new, where the payments are not just a service was performed, pay for it, an item was given, pay for it. They're outcome-aligned payments. The payments are tied to actual outcomes. I think that that is a very, very exciting proposition.

Earlier this month, we announced a wide range of payers representing 165 million Americans with Medicare Advantage, Medicaid, and private health insurance, that had signed on to adopt an outcome-based payment structure that is aligned with the ACCESS Model. More and more information is starting to come out about how we think that's going to work. We really look forward to hearing folks. Folks have been very active in giving us feedback, and we're looking forward to continuing to iterate with a wide variety of external stakeholders to test ACCESS and see how we can make it work in a way that really drives both cost savings and improvements in the quality of care.

Another thing I wanted to talk

about, MAHA ELEVATE[9]. This was announced on December 11th, and this is -- as its name portends, it is the Make America Healthy Again agenda. The idea, I think, the way I think about MAHA ELEVATE, is we have a lot of ideas. We have a lot of really, really smart people with interdisciplinary backgrounds. They are physicians. We have pharmacists. We have economists, PhD economists. We have lawyers. We have people with all sorts of different backgrounds. But despite the fact that the Innovation Center prides itself in innovating, we don't own all the good ideas. We are very, very aware of that.

So one thing we do is we meet with a lot of people and we take ideas, but MAHA ELEVATE is actually put -- would put money out there, put grants out there, essentially, for other people to come up with ideas. So this is, I think, a great opportunity to allow others to find ways to attack sort of the root causes of disease and health problems and look for ways for others to innovate with grant money given by the Innovation Center, we'll be

9 Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence

taking applications, and look for ways to improve health.

The last thing that I was going to sort of focus on is the LEAD[10] Model, which is kind of the follow-up to the ACO[11] REACH Model. So it's kind of -- I think of ACOs as kind of the bread and butter of the Innovation Center. But what we're trying to do there is just constantly improve, constantly iterate. So the idea behind LEAD, I think, is to sort of -- well, there's a lot of different ideas, but one of them, and one I want to focus on with this group since we're talking about multi-payer alignment today, is really to emphasize on the integration of Medicare and Medicaid services, working with our partner states to develop a framework for ACO-Medicaid partnership arrangements. I think that that is very exciting. There are a lot of people who are duals, near-duals. I think there are a lot of opportunities there.

So those are the -- some of the things that we did in 2025. There were a rush of them at the end of November and in December,

10 Long-term Enhanced ACO Design
11 Accountable Care Organization

and there is a lot more that we have plans that I am sworn by secrecy, I can't talk about, but I think there will be a lot more. Roughly the same number of models we announced in 2025, I expect there to be on or about a similar number in 2026.

Some of those models will be finalizing rules. For GLOBE and GUARD, they were rulemakings. We did a notice of proposed rulemaking. Same with IOTA[12], the kidney care model. So we're -- we'll be looking to finalize those in 2026. But there are also other things that we are very energized about, very excited about, and we'll be looking forward to make announcements in 2026.

So appreciate thinking and talking and discussions you guys are going to be having today. We have a lot of our team that are going to be listening in and doing other presentations and looking for ways that we can collaborate and share all of our learnings and make sure that what we're doing is sort of putting out the best ideas that we can, and making sure that we're leveraging the multi-payer alignment to have the most sort of bang

12 Increasing Organ Transplant Access

for our buck, thoughtful, and well-constructed approach to improving health care delivery.

So with that, I think those were most of the things that I planned to talk about. I want to thank you in advance for your time. I think it is a really, really, really important goal and agenda and sort of mission that we all share, which is to bend the cost curve, frankly, and do something about the fact that currently in this country, we are throwing massive amounts of money at health care while getting, my words, kind of meh, mediocre results. Compared to other OECD[13] countries, we don't live as long. We don't live as well. We throw a lot of money at the problem.

So working together, I think we can find ways to turn that around and do a better job for Americans. So thank you for having me here today. I will be in and out throughout the day, listening to some of the conversations that you're having, and really appreciate the work that you're doing. Thank you very much.

*** Welcome and Co-Chair Update - Improving Multi-Payer Alignment in Value-Based Care Day 1**

13 Organisation for Economic Co-operation and Development

CO-CHAIR MILLS: Wonderful. Thank you for sharing those remarks, Amy. We appreciate your continued collaboration, support, and engagement, and we look forward to continuing our collaboration with the CMS Innovation Center moving forward. So thank you for those remarks.

For this public meeting's agenda, we will explore a range of topics on improving multi-payer alignment in value-based care, including perspectives on multi-payer alignment across programs within Medicare, lessons learned from state value-based care models that have implemented multi-payer alignment, and addressing challenges to advance multi-payer alignment.

This public meeting will focus on direct multi-payer experiences with the goal of identifying practical, actionable steps, lessons learned, and innovative approaches that CMS and other stakeholders can apply to advance and operationalize multi-payer value-based care models. The background materials for this public meeting, including an environmental scan, can be found on the public meeting registration site and will be posted online on

the ASPE PTAC website's meeting page and the public meeting registration site.

Throughout the meeting, we will hear from many esteemed experts with a variety of perspectives. I want to mention that tomorrow morning will include a public comment period. Public comments will be limited to three minutes each. If you would like to give an oral public comment tomorrow but have not yet registered to do so, please email ptacregistration@norc. Again, that's ptacregistration@norc.org.

The discussion, materials, and public comments from this public meeting will inform a report to the Secretary of HHS on improving multi-payer alignment in value-based care. Over the next two days, the Committee will discuss and shape our comments for the upcoming report. In December, we posted a request for input on the ASPE PTAC website to give stakeholders an opportunity to provide written comments to the Committee on improving multi-payer alignment in value-based care. And to date, we have received four responses that the Committee may consider during their discussion time.

I would also like to note that, as always, the Committee is ready to receive proposals on possible innovative approaches and solutions related to care delivery, payment, and other policy issues from the public on a rolling basis. We offer two proposal submission tracks for submitters, allowing flexibility depending on the level of detail of their payment methodology. You can find information about submitting a proposal on the ASPE PTAC website.

Lastly, on behalf of PTAC, I'm pleased to share that 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, along with the input of experts at the public meeting. Currently, six Issue Briefs, along with highlights from PTAC's 2020 through 2025 theme-based public meetings, are posted now on the ASPE PTAC website. The Committee will be publishing new Issue Briefs on additional topics in the near future.

*** PTAC Member Introductions**

CO-CHAIR MILLS: At this time, I'd like to invite my fellow PTAC members to please

introduce themselves. Please share your name, your organization. If you'd like to, feel free to describe any experiences you have with our topic. I'll start out.

I'm Lee Mills. I'm a family physician. I serve as Chief Medical Officer of Aetna Better Health of Oklahoma, one of the state's three contracted managed Medicaid plans. I spent 25 years in health care and medical group operations and had the pleasure to practice within, guide, or lead approximately six CMMI[14] innovation models over the last 20 years.

Next, we will turn to Henish.

DR. BHANSALI: Morning, everyone. My name is Henish Bhansali. I'm a primary care physician by training in internal medicine. I spent about 15 years working in value-based care on the inpatient-outpatient side, most recently as Chief Medical Officer for Medical Home Network, prior to which I was at Duly, DuPage Medical Group, as their Senior Vice President for Medicare Advantage and ACO REACH. Prior to that, I was at Oak Street Health. Before that, at the University of Chicago.

14 Center for Medicare and Medicaid Innovation

I think the next person is Lindsay.

DR. BOTSFORD: Thanks, Henish.

Good morning. I'm Lindsay Botsford. I'm a family physician in Houston, Texas, where I continue to see patients, including Medicare beneficiaries, as a PCP[15], and serve as the Regional Medical Director for the Midwest and Texas for Amazon One Medical. I've been working in ACOs and value-based payment models for the last 15 years, including currently as the Chair of the governing body of the Iora Health Network, our ACO REACH entity, which is continuing to produce savings over the last couple performance years.

I'll pass it to Walter.

DR. LIN: Good morning, everyone. My name is Walter Lin. I am a practicing physician, founder of Generation Clinical Partners. We are a medical group based in St. Louis focused on the care of frail, expensive Medicare beneficiaries living in senior living. I'm also the Chief Clinical Strategy Officer for LTC ACO and a Medical Director for our PACE[16] program as well.

15 Primary care provider
16 Program for All-Inclusive Care for the Elderly

I'll go ahead and pass it over to Larry.

DR. KOSINSKI: Good morning, everyone. I'm Larry Kosinski. I'm a retired gastroenterologist. I practiced for 35 years in the Chicagoland area, building the largest GI[17] practice in Illinois, the Illinois Gastroenterology Group. Submitted one of the very first PTAC proposals back in 2017, Project Sonar, which was ultimately recommended (audio interference) testing by the Secretary.

What Project Sonar did launch was a -- SonarMD, which has taken the same value-based initiative and applied it in the commercial space. We are in multiple Blue Cross plans around the country, and it's now been active since 2020.

I am also the fractional CMO[18] for a startup, Jona, which is an AI[19]-powered microbiome company. And then finally, my most recent initiative is a company named VOCnomics, built around a patient monitoring device, which you can think of as an olfactory Alexa. I've been on the Committee for five years. I look

17 Gastrointestinal
18 Chief Medical Officer
19 Artificial intelligence

forward to the next two days.

And I will --

CO-CHAIR MILLS: Lauran?

DR. KOSINSKI: -- pass it on to -- oh, Lauran. Okay.

MS. HARDIN: Good morning. I am Lauran Hardin. I'm a nurse by training and Chief Integration Officer for HC^2 Strategies. HC^2 is focused on building healthy, connected community approaches to complex populations. My current work involves a lot of cross-sector integration, bringing public health, health systems, counties, states, and community-based organizations into integrated models to serve those with the highest needs.

My background has primarily been focused on complex populations, originally design and care management and multiple value-based payment arrangements, as well as leading an all-payer complex care center model that scaled, was very successful, and was recognized by the National Academy of Medicine and the American Academy of Nursing.

I joined the Camden Coalition and was part of the initial team to start the National Center for Complex Health and Social

Needs, scaling models for complex populations across the country with multiple partners. And now I'm working deeply in that cross-sector work, as well as innovation in Medicaid.

I will pass it on to Krishna.

MR. RAMACHANDRAN: Thanks, Lauran.

Krishna Ramachandran. I'm Chief Information Officer for UnitedHealthcare. I've spent 24 years in health care from a technology, provider, and payer perspective, most of it furthering value-based care, and spent a few years in the multi-payer alignment work as well. Yeah. Good to be in this meeting. Exciting topic.

I will pass it on to Josh.

DR. LIAO: Morning, everyone. Josh Liao, internal medicine physician. I've had the pleasure over the last decade or more to work on Alternative Payment Models and value-based care and population health in a number of different ways, including leading a portfolio of research, engaging with state and other policymakers, including states that have had multi-payer initiatives and alignment, and also kind of having system roles related to population health and payment and care delivery

redesign strategy.

Currently, I'm a National AVP[20] for Clinical Transformation at Ascension, where we target Medicare and other Medicaid and populations with technology within a policy framework, including those related to APMs[21]. I'm also a professor at the University of Texas Southwestern Medical Center.

I believe I'll pass it to --

CO-CHAIR MILLS: David.

DR. LIAO: -- David.

MR. TYSON: Did you say David? Okay. Yeah. Good morning. David Tyson. I'm at Novant Health. I'm the Senior Director of Public Policy. I believe I'm the newest member of the PTAC, and also one of the few non-physicians, so happy to be with you all and look forward to getting started with the PTAC moving forward.

*** PCDT Presentation: Improving Multi-Payer Alignment in Value-Based Care**

CO-CHAIR MILLS: All right. Thank you all. Now, let's move to our introductory

20 Associate Vice President
21 Alternative Payment Models

presentation. PTAC members, you'll have an opportunity to share any comments and ask follow-up questions after the presentation. Four PTAC members served on the Preliminary Comments Development Team, or PCDT, which has collaborated closely with staff in preparing for this meeting.

Josh Liao was the PCDT lead, with participation from Lindsay Botsford, Lauran Hardin, and myself. I'm thankful for all the time and the effort the PCDT has put into organizing today's agenda. The PCDT will share some of the findings from their analysis to set the stage and the goals to frame up for the meeting.

I'll turn it over to Josh. Take it away.

DR. LIAO: Thanks, Lee.

And as Lee mentioned, you know, I am one of a few members of the PCDT. And even though I am holding the proverbial microphone, a number of people and effort went into this report, not just Lindsay, Lauran, and Lee's time, but also staff from HHS and our partners with NORC. I wanted to extend a word of gratitude to them. Without their effort, we

wouldn't be able to present what we're having here in this presentation.

So next slide, please.

So I think, just to give you a sense of where I'd like to go over the next, you know, 30 minutes or so, you know, I want to begin with this idea of, you know, why are we here online at this meeting? And why does PTAC care about this topic of multi-payer alignment? And then we'll zoom out from there, you know, and kind of start with the why purchase and begin with the proverbial end in sight.

You know, I think many conversations about the health care system often begin with what's broken and what needs improvement. And that's important, and we'll give that treatment. But I think beginning with the outcomes that we want both in the ideals, but also in -- for patients. And not just what we want for models, but also for markets and communities I think is important. So we'll begin there with vision and value, and then we'll kind of back our way in in this conversation, and then think about if that's the vision and the value of multi-payer models, what might components of high-functioning

models look like? Identify some challenges along the way.

And while that concept is really good, I think it's also important to ground it in what's happening now. What have we learned, so to speak, from the ground? So where have we seen public and private initiatives converging? What's real? What's aspirational still? We'll talk about those initiatives. And then finally, just to kind of come back in, we'll preview upcoming sessions that we have with some of our subject matter experts over the next day and a half.

So with that said, maybe a next slide, please, and we'll jump right in.

So the reasons and objectives for this theme-based meeting. I think, you know, one is to identify successful approaches and solutions for overcoming barriers to multi-payer alignment in value-based care. And we mean that widely, not just federal or state models, but also across public and private payers. Again, those ideas are great but really identifying what are some concrete short-run steps to get us to that alignment that we aspire to. But then still, finally,

keeping our eye on this long-term goal of alignment. You know, alignment is not just getting quality measurements set up or a playbook, but it is much bigger and much broader, and it ends with the health and better outcomes for patients and communities. So those are our objectives here.

Next slide, please.

So why does PTAC care? You know, we have spent a lot of time and a lot of deliberation over a number of meetings, over a number of years, looking at different proposals. And you can see there, of 36, 28 of those have been deliberated in our public meetings like this one today. And Committee members have found that half, 14 out of 28 proposals, have included potential approaches that either focus on or relate to multi-payer alignment, which is to say that a large proportion of the Committee's work has focused on things that relate to multi-payer alignment, and this issue is very salient to us as a Committee.

Next slide, please. So again, next slide, please.

We'll start with the vision and

value of these multi-payer models. So as a level set, you know, how are we approaching this word? You know, I think oftentimes, you know, we say the same things, but don't always mean the same thing in conversations like this in the policy and practice and health community.

So PTAC is working off of this definition for multi-payer alignment. I will read this word for word, just so that we are all kind of level-set here. So we are conceptualizing multi-payer alignment as agreement among payer programs and products, including those offered through traditional Medicare, Medicare Advantage, Medicaid fee-for-service and Managed Care, commercial insurers and employers, on model alignment areas necessary to promote value-based care. Model alignment areas in this definition include but are not limited to the goals and strategies, care delivery, financial incentives, quality measures, and data sharing.

And while I think this was our attempt at being thoughtful about how we define multi-payer alignment, we do want to acknowledge that this will continue to evolve

as we collect information from stakeholders.

Next slide, please.

So why multi-payer alignment? At the risk of kind of stating the obvious, it's important to surface this, regardless, that value-based care can help improve population health, which is the reasons to launch models like those you heard from Amy and those that have come before it and to reduce spending growth. However, you know, the financing landscape remains a mix, not just in kind of the different payers in that landscape, but also the mix of incentives such as fee-for-service or value-based care incentives.

If those are the design and incentives, also, the implementation has variation across program and payer, and so this concept of alignment becomes very important for us to address these issues. It's hard to address these first two bullets without really thinking about alignment.

Next slide, please.

So you know, what are some of the potential benefits of multi-payer alignment? More collaborative work and alignment between providers and multiple payers serve to yield a

number of benefits, including stronger care pathways for disease prevention and management, more time to focus effort on care transformation, greater data-sharing and more informed clinical decisions, lower cost for investing in capabilities to improve care, and less administrative burden and costs. Again, a number of things that perhaps many of us that are tuning in today have known, felt, have maybe lived in our jobs and responsibilities. Certainly, these are many areas that the PTAC has discussed that all relate to multi-payer alignment.

Next slide, please.

So a little bit of a taxonomy here, because, again, I think a word and a concept as big as alignment can be hard to really talk about concretely. So you know, we as a PCDT identified a few different dimensions of alignment that are worth highlighting. The first, perhaps most obviously, is the types of alignment. I think most people and groups think about this as across payers, but we wanted to highlight that -- not just alignment across different payers, but within payers, so recognizing their different products and

programs within each payer. Alignment there is very important as well. Perhaps a little more pragmatic in terms of whether it's achievable, but relevant here.

Beyond types, we think about extent of alignment. So are we talking about the number of programs or payers involved? That's one way to measure extent. Other ways include the level of payer involvement, so number of staff involved, length of time a payer is engaged in a multi-payer initiative. And then another might be geographic spread of patient populations within payers engaging in multi-payer initiatives.

Beyond types and extent, we've also conceptualized degree of alignment, so thinking about things that are exact versus directional, exact being agreement or alignment on specific details of a model. And we'll get into this in subsequent slides, very important, but challenging, giving goals, and very time-consuming. As opposed to directional alignment, which is that we agree in direction of certain measurement or certain goals or care delivery strategies or incentives, but maybe not matching up specifically in the details.

So different types, different extent, and different degrees of alignment I think are relevant. And I hope this provides a scaffolding for everybody here as we go into our sessions and deliberation.

Next slide, please.

So bringing together kind of how we are going to spend the next 10 to 15 minutes, a lot of the things we -- I've talked about in the last few slides really live on the right side of this slide. So you know, what are the outcomes we want? You know, again, better outcomes for patients, less administrative burden for providers, you know, benefits to payers and different stakeholders.

But that's one thing, to say outcomes. Look at the left part of the slide. To get there, what do we need? Well, we need payers and multiple payers. There are a number of critical stakeholders, patients and populations being one, but providers, purchasers, convener organizations that facilitate value-based care being others. And then these payers and stakeholders then kind of flow into a number of factors that live out in the environment. So engagement of

stakeholders, market circumstances, certain regulation related to compensation -- competition, I'm sorry, and trust, facilitator involvement, et cetera.

And then it gets into the technical aspects of model design. If we want a model that's aligned across payers, not only do we need to align in the who's at the table and the stakeholders that inform these models. But also, you know, the goals and strategies, the care delivery specifics, methodology for payment and incentives, measurement of quality, attribution, benchmarking, risk adjustment, data interoperability. It becomes very technical and very pragmatic in some ways. And so we wanted this slide to represent both the aspiration and the goals, but also the technical details that we need to land in order to get there. So I hope this is kind of a framing piece for us as we keep going here.

Next slide.

Getting into those components, this -- one more slide forward, please. This will put words to some of the things you're seeing in that conceptual diagram slide, but in more detail. So when we think of stakeholders, we

think of that in a broad sense. As I listed earlier, payers, providers, purchasers, and employers, patients, and state agencies, and also municipalities. These are all different groups that we need in collaborative design, implementation, and evaluation of multi-payer models. Perhaps more than any topic that is relevant in value-based care and Alternative Payment Models, when you think of multi-payer alignment, the necessity of having multiple stakeholders is essential, right?

And, you know, in that, one of the outflowings of that essence is a governing body that oversees activities and promotes transparency and accountability. The governing body would be benefited by a trusted facilitator, such as a convener. That might be a state entity. It might be a different type of group that's put together. But the key idea is that facilitators kind of balance and align competing interests, manage expectations, facilitate collaboration among payers, as well as stakeholders. And then having measurable goals is really important to monitor progress and ensure engagement.

Next slide, please.

So as I mentioned earlier, you know, there are aspirational ideas of multi-payer alignment and initiatives, but there's also technical aspects of it, and so having technical assistance for those who need it is very important. We give an example here of how CMS has supported facilitated learning collaboratives to share best practices in different models and different initiatives. And I think some version of that is going to be important for any future models that we were to create.

Consideration of characteristics and needs of different patient populations and providers. I think that goes without saying, but it's worth still boldfacing and highlighting here, that really understanding we're solving for patient populations and clinicians and delivery organizations that take care of those patients is important. We're not designing alignment in a vacuum. And then I think having a common payment model with, you know, things that are standardized to the best we can, whether that be rates or enhanced transparency or ways to reduce provider burden, I think become very important as well. So just

a few more kind of technical and pragmatic components of this.

Next slide, please.

Just continuing on here, flexibility. So while we want standardization and kind of system-ness, we also want to provide flexibility in structuring payments to accommodate different, really, patient population, as well as provider and payer needs. And when we think about the other things I showed you on that conceptual diagram slide, performance and quality measure alignment, things like attribution benchmarking, risk adjustment, data interoperability, health information exchanges. Again, things that you see on this slide here, these are all really successful -- components of successful multi-payer and aligned models. And as we'll get into over the next day and a half, really require a lot of effort to design intentionally and thoughtfully.

Next slide, please.

So if we've talked about the vision and the value, the vision is really improving the health of our patients and communities, and the value is not just for those patients and

communities, but also for the providers and the payers and the purchasers, public and private. If there are values there, there are benefits there. And the components are what I listed out, both aspirational, but also technical, related to a number of areas. What are some of the challenges standing in the way? Why don't we have multi-payer models suffusing our community left and right here? And so I'll spend a few slides talking about that.

So most fundamentally perhaps, payers may have different goals for payment models related to the things you see there. I think affordability and quality of population health, reduce disparities, and reduce provider burden, are all agreed-upon goals. How we get there, though, becomes a little bit different and how, for different patient populations and communities, these might be weighed against each other may vary.

Achieving exact alignment on model areas can be challenging as a result of that, because of the differing needs of patient populations and really organizational priorities. And so you know, this is where we talked about exact versus directional

alignment. Perhaps in these cases, directional alignment can allow different participants and payers to align, but tailor those care delivery approaches within a payment model to enable and facilitate flexibility. And getting exact matching on attribution, benchmarking, and risk adjustment may then be less feasible. Allowing variation there as long as things are directionally aligned may be potentially useful here.

Next slide. Other challenges, I think you can see here, significant financial and technical barriers that the PCDT identified and want to surface for discussion here today, related to data sharing and who bears responsibility to develop solutions for that. Payer measure sets. Measures themselves can be different, but then access to measure sets may be uneven because of proprietary sets. And that in turn impedes broad use and standardization using measure sets.

And when we think about, kind of, delivery organizations and clinicians, their existing billing systems and other, kind of, processes that they use may be difficult to adapt across payers and multi-payer

engagements. And then workforce shortages, you know, and churn. It's easy to design these models, assuming that we have the individuals and the teams and the units that we need. But as we know from other prior PTAC meetings and other sources, that's not true, that shortages and churn can really make it challenging for delivery organizations and clinician groups to navigate all these processes, even in a single-payer initiative, much less a multi-payer.

Next slide, please. Just a few more challenges here. Again, as I alluded to earlier on the conceptual diagram slide, you know, some things are challenges within a patient population or a provider group, but also thinking now about, more broadly, what about competitive market conditions in a region? What about community needs in that region? Specifically thinking about, is it practical to customize models and multi-payer models within markets of large or small scale, including -- particularly small market areas? And then thinking about, you know, payers' willingness to engage in these initiatives, how they're influenced by market share. You see here, payers -- we've identified that payers

with a dominant market presence may be more likely to steer decision-making. Payers without that dominant presence may be less likely to benefit from those improvements. I think it's also important to note that in markets where competition is the strategy, alignment here really highlights some of the challenges in getting alignment across payers.

Next slide, please. Federal antitrust laws restricting collaboration among payers to do the things that would be required for multi-payer alignment are really notable. You can see a few, kind of, sub-bullets that we've highlighted. How certain initiatives at the state level may be eligible for immunity from certain laws. But that, you know, non-state-led initiatives may need to work around some of these things and acknowledge them. We've highlighted anti-kickback and Stark Law as specific examples that prevent certain care processes, like referrals, that involve kickbacks and financial benefit that may impede the types of, kind of, patient flows and interactions and coordination that we may want. Critical laws, very important for integrity and regulation, but how does that interact with

some of the goals of payment models that we may want to see and, in particular, multi-payer ones?

Next slide, please. So we spent some time again, just talking about where we want to go, what are the components of the aspiration around multi-payer alignment, but some of the challenges therein. I want to spend the -- kind of the rest of our time, the bulk of it talking about what's been done over the preceding years. This is not a blank canvas. Many entities have engaged and participated in some of these initiatives. And so what have we learned from them? What are some of the results, and how can that inform how PTAC listens to and engages with our subject matter experts over the next day and a half?

Next slide, please. So here what we're looking at is kind of the broadest catchment, at least we found in the PCDT assessment, related to multi-state multi-payer models and initiatives. And many of these are led by CMS as really a leader and a vanguard in this space and with a unique position to convene and engage a number of public and

private groups to do multi-payer initiatives. So you can see a number of models here on the left side. I won't read them all to you here, but, you know, they encompass a number of different programs related to primary care, state-based transformation collaboratives, and innovation models. There are a number of years. You can see some of these models date back to the early 2010s. Some are currently present or span into the next decade. Look at the right side of the slide here, payer participants. With a few exceptions, many of these touch Medicare, Medicaid, and commercial, so are really intent and designed to be a multi-payer in the broadest sense. So I think what I take away from this slide is that there has been a lot of work over many years, engaging a number of payers to do multi-payer models.

Next slide, please. So some accomplishments and lessons learned. And this is really not so much about, kind of, the impact and the outcomes. We'll get to that in a few slides. But really about, you know, if stakeholder engagement, a governing body, a facilitator, you know, making sure we align in

some way, to some type, to some extent, to some degree on the goals and the strategies. If that's the goal, then what have we learned about that? And you can see here that some are too early yet to draw conclusions from. But I think some of the themes you can see highlighted in the boldface text are that -- a blueprint to kind of memorialize and articulate multi-payer alignment becomes important. And you know, kind of thinking about ways in which when goals are not aligned, you might have limited payer participation alignment in a program such as PCF[22].

As you see from CPC+[23] at the very bottom there, again, kind of facilitating data aggregation facilitated by a neutral convener. And kind of bringing all lines of business together and aggregating data into a single tool. I think you're seeing a coming together of very specific things like data aggregation, but undergirded by blueprints, convener, and kind of a governing body.

Next slide, please. Just to kind of emphasize that point, again, you know, from the

22 Primary Care First
23 Comprehensive Primary Care Plus

SIM[24] Initiative, we saw really that relationships are everything. You heard a little bit about the pledge that Amy Turner mentioned earlier about groups that have signed on, related to the ACCESS Model. I think, you know, there are echoes of this in prior programs related to relationships, and establishing a pledge and an alignment around the need for multi-payer alignment becomes really critical. You can see this concept of relationships kind of cascading through programs like CPC as well. You begin to see recurring themes around single tools, bringing different groups together to use the same tools or take the same approach. But that collaboration, trust building, all takes time and is complex and -- but is critical to these initiatives. I think that's what I take away from this slide as well.

Next slide, please. So if that was kind of in the how do we convene, how do we govern, how do we build trust, how do we get alignment about where we want to go, we also wanted to be very pragmatic here about some of these models that I showed you on prior slides.

24 State Innovation Models

What are some of the results? And so you can scan the right column here to look at the results. I think in some cases, you can see that there was some effect. In other cases, you can see there was a minimal effect. In some cases, there were effects in certain regions and not others.

And I think, again, if you -- this is a lot to go row by row. We won't do that, because each of these models had very specific design elements that are relevant to the PTAC. But if we kind of aggregate it for those of us on the call today, what are the themes I take away from this slide? I think number one is that multi-payer models have potential. That's what I take away from this. Number two, success is not guaranteed in the outcomes that we want. Third, I think if you put this with the slides you saw before, sometimes when not enough time was given, when the complexity of alignment and governance and shared tools may have not have been given enough time, that may impact success versus failure in certain areas. And finally, you can see that certain areas had certain outcomes versus others. And I think that reflects, again, the market and community

factors and the patient population factors that come to bear.

So I hope this kind of brings to life what we've been talking about over the preceding slides that there is potential. There are challenges. And the factors that we've identified in our conceptual diagram and in the preceding slides really come to bear on this.

Next slide, please. So if that was multi-state kind of broader initiatives, I just want to highlight that as a kind of complement to that, there have been a number of state-based multi-payer initiatives. And a number of these models have also been supported by CMS. And you can see there in different flavors: CMS Innovation Center models, SIM awards, state transformation collaboratives, really focused on individual states. And that while a number of states have engaged, we are going to focus on the subsequent slides on nine states that you see listed here that have taken what we can consider substantial work, implementing multi-payer models and initiatives.

Next slide, please. So again, a busy slide, but kind of lists initiatives from

those nine states. And I think the key takeaway qualitatively from this is that again, spanning a number of years, dating back more than a decade in some cases, but engaging a number of payer segments and payer participants in these models. So a number of lessons that we can learn from and kind of plumb the depths of to understand more from these models.

Next slide, please. So just kind of getting into, again, the lessons learned, kind of mirroring a few slides ago from the multi-state initiatives. If we look at state-based multi-payer models, you can see kind of, again, I'm drawing some qualitative things out from a busy slide, but just to say that, you know, buy-in and engagement become important from stakeholders. Here you're seeing in the Arkansas case, the governor, as well as Walmart as a large private employer, getting stakeholder consensus within the state becomes important, and ensuring that as they move forward, simplifying the design process to allow those stakeholders to engage, were some of the lessons.

You know, the California Advanced Primary Care Initiative, I interpret to have a

similar concept around inclusion of independent practices. It is a reflection in my mind that different states have different stakeholder groups, and it looks different, but engaging as many of them, as widely as possible, becomes critical. And again, one more time, just to kind of underscore yet again. In Colorado, thinking about a broad range of stakeholders and the need to align across plans, including national health plans, are some of the lessons learned from the APM Alignment Initiative.

Next slide, please. So continuing on here, you know, in Maryland, Minnesota, Pennsylvania, again, three more state-based models. And I think the highlight again, the highs and the potential lows of multi-payer models here. So you're seeing similar themes: partnerships, setting groundwork, making things -- make sure that there's engagement, alignment there. Broad stakeholder group in Minnesota for instance. On the other side, you're seeing things related to, you know, what are some barriers? Lack of clear goals. The market conditions that create a competitive nature between plans. When it's time to then land the technical aspects of things, you know, how to

actually do that for different providers such as rural hospitals versus not. And the real things related to predicting global budgets and those technical aspects that have become certain challenges that we've highlighted.

Next slide, please. Rhode Island, Vermont, and Washington, just three more that we'll highlight from this group of state-based initiatives. I'm beginning to sound like I'm repeating myself, but I hope the repetition underscores the critical nature of some of the themes that we're highlighting here. But I think you're seeing, again, where you see successes, it's engaged leadership. It is clear, attainable goals. It's multi-payer alignment. In the case of Washington, at the bottom of the slide, it is developing and getting kind of buy-in on memorandums of understandings and collaboration about what different payers are trying to solve in these types of initiatives.

And, you know, then there are kind of elements of the technical design. Do you make this voluntary, or do you mandate participation? You know, how do you fund these initiatives? And so lots of specifics around

this broader alignment work that each of these states seems to represent in some way.

Next slide, please. So I want to pause here. I've covered a lot in a relatively short period of time, but I hope this presentation has helped kind of set the proverbial table around why does PTAC care about multi-payer alignment? We do because it's critical to the work that we're mandated to do. What is the vision and value for patients, populations, communities, as well as providers and payers and public groups, like CMS and state Medicaid agencies? I hope that's clear. We are not working in a vacuum. There are components that we have identified from initiatives that exist, but also from published literature and from our collective experience. There are components of successful multi-payer initiatives, but there are a number of challenges that dot the path to those goals. And again, these are informed from a number of statewide, as well as multi-state, initiatives that have been implemented over the last 10 to 20 years. So with all that said, I want to just preview what's coming in the next day and a half.

So if you can go to the next slide, please.

We'll start talking about perspectives on multi-payer alignment across programs within Medicare. So again, our definition being broad enough to think about products and programs within a payer. I think we'll begin there with Medicare as an example. And then we'll kind of shift to thinking about state-based models that have implemented alignment. Many of the examples that you saw from the slides, talking about lessons learned and outcomes. We're excited to hear from stakeholders and different groups about that. And then we'll also talk about challenges, in taking us from where we are now to where we want to go with advancing multi-payer alignment. So a really exciting next day and a half. I look forward to learning from them and to the deliberation from the Committee.

Here, I'll stop and maybe pass it back to the PTAC chair.

CO-CHAIR MILLS: Wonderful. Thank you, Josh. Appreciate that really cogent, clear outline of where we are and where we're going in the next two days.

Before I open it to the full Committee, any PCDT members have additional comments to add?

MS. HARDIN: I'll just jump in with one comment.

Josh, you did a fantastic job.

Having been involved in multiple of these models across states, I'm really interested in hearing from our experts about even when you get the financing right and the measures right, a culture change can sometimes be the hardest to implement. So really hearing what facilitated that within payers, within delivery systems, and within communities to really move the dial from fee-for-service to value-based.

CO-CHAIR MILLS: All right. Other Committee members, comments or thoughts?

Well, I'll offer that I was struck during the PCDT's work, as you look at all that's happened in the last 20 years around multi-payer alignment, that -- multi-payer alignment truly is necessary if not wholly sufficient, of course, by itself. It's like, as we've heard in the last meeting or two ago

from CEOs[25] and CFOs[26] of major national health systems, essentially that it takes multi-payer alignment to have enough volume of patients and populations involved, enough revenue involved to be -- to make -- get their attention to be willing to change the machinery of what the health system delivers every day. From a provider leadership perspective, medical group perspective, an initiative that only affects, you know, five percent or 10 percent of your patient population doesn't change the culture of how -- or the mechanics of how a group practices. So multi-payer alignment really is the necessary very narrow thread the eye of needle step to actually get leadership on board to fully engage. CMS, of course, is in a very unique position with classic Medicare, MA[27], ACO, Medicaid, of being able perhaps to move the needle themselves. But we've seen in many of these multi-state initiatives that having commercial payer involved is really critical.

Larry.

DR. KOSINSKI: Great job, Josh. You just -- it was so clear. I enjoyed the

25 Chief Executive Officers
26 Chief Financial Officers
27 Medicare Advantage

presentation. You used the word, at the closure of your presentation, the word mandate. And, you know, we have a mandate, but I'm going to -- I'm going to really look to see how many of our subject matter experts feel that we can do this on a voluntary platform or whether we're going to have to have a -- some type of a mandate in order to get buy-in from all the groups. It may be necessary. We'll be able to -- we'll -- I'm going to be curious to see how everybody approaches (audio interference).

CO-CHAIR MILLS: Yeah. Other follow-up questions or comments from the Committee? We've got about five minutes left before a planned break. Any other follow-up questions or comments? All right.

Amazing job, Josh. Great setup for the next two days.

Seeing no further comments or questions, we will go ahead and move to our break. We will return and start fresh with the live public meeting at 10:40 Eastern Time. Please join us at that time as we welcome a great group of experts for our first session on perspectives on multi-payer alignment across programs within Medicare. Thank you very much.

We're -- we will stand in recess, a brief break until 10:40 Eastern Time. See you soon.

(Whereupon, the above-entitled matter went off the record at 10:30 a.m. and resumed at 10:40 a.m.)

*** Session 1: Perspectives on Multi-Payer Alignment Across Programs Within Medicare**

DR. BHANSALI: Welcome back. I'm Dr. Henish Bhansali, one of the PTAC members. Josh and the PCDT laid the foundation for this public meeting and some of the questions we want to explore. I'm excited now to welcome four esteemed experts to share their perspectives on multi-payer alignment across programs within Medicare. You can find their full biographies and slides posted on the ASPE PTAC website and the public meeting registration site.

At this time, I ask our session participants to go ahead and turn on video if you haven't already done so. After all experts have presented, the Committee will have plenty of time to ask questions and engage in what we hope to be a robust discussion. First, we are pleased to welcome Mr. Nicholas Minter, Deputy

Director of the Seamless Care Models Group at the CMS Innovation Center.

Nicholas, welcome.

MR. MINTER: Thank you so much. And it's a pleasure to be here today. I'm going to give the CMS Innovation Center perspective on multi-payer alignment today, and look forward to hearing the discussion to come.

Next slide. So my name is Nicholas Minter. I have been with the CMS Innovation Center for 10 years. I currently lead the portfolio of models that includes what you see here. It's Medicare Advantage, kidney health, Accountable Care Organization work on total cost of care, value-based payment and care. And then our prescription drug portfolio, which is also growing rapidly. Previously, I spent six years managing the CMS Innovation Center primary care portfolio. And before that, I spent five years at the Assistant Secretary for Financial Resources or the HHS budget office, researching Medicare payment policy.

Next slide, please. So first off, I thought we would talk a little bit about the definition. So multi-payer alignment, as we define it in the CMS Innovation Center, largely

refers to the coordination and the collaboration among health insurance payers to meet, you know, common goals and patient outcomes, such as improving quality and reducing administrative burden. It largely is an acknowledgement that CMS can't influence or can't drive all change alone, especially those that are provider-focused, where a provider is most effective at driving change at a practice level. And Medicare fee-for-service or even Medicare Advantage together are not going to be 60 to 75 percent of a provider's patient load, what is really necessary to compel a provider to change the way that they practice for all of their patients.

And so this is something that we think quite a bit about when we are driving provider-based behavioral change through our models. And, you know, the incentive for us is that we are more able to see how better payments for care coordination, different types of interventions that we believe will make a difference, affect patients at a practice level because we know that that is being delivered to all patients regardless of payer. And for other payers, the incentive is it can be

varied, but often it is better patient outcomes and therefore lower cost of care given the way that the U.S. health system works.

The multi-payer alignment goals and tactics vary by model, but they often fall into three common categories. We often try to align on quality measures because we know that narrowing the focus of what a provider is being incentivized to maximize, to optimize, will help drive their focus on those more narrow set of goals. Payment alignment is really important to, sort of, strengthen the incentives on achieving goals. If we're all incentivizing care coordination, it's going to be a lot more effective than a smattering of incentives incentivizing all sorts of different care. And then aligning data, because data is really important for helping providers to understand what is driving patient outcomes. And in so much as that data is aligned across payers, they're more likely to use those tools and achieve the goals that those are meant to drive forward.

And so you know, while the ultimate goal is to lower cost and to achieve better outcomes, multi-payer alignment does have

intermediate goals that I wanted to acknowledge here as well. And those are to reduce administrative burden. And in doing so, increase provider engagement. In essence, we want the provider to go all in at the changes that we believe will make a difference in patient lives, but that's difficult with there being different incentives and signals coming across the entire payer landscape. And so one way to lessen that is to really align and to ensure that the provider is able to focus on patients and not managing different incentives across payers within their own practice and standard of care.

Next slide. So where are we focused on multi-payer alignment, both present and past? First, I want to acknowledge that we have a couple of models currently that have factored multi-payer alignment into the successful testing and, sort of, our theory of action. The first is the ACO Primary Care Flex model, where we are aligning actively with the Medicare Shared Savings Program, as well as other payers. And then the Enhancing Oncology Model, where we're driving better coordination of care for those patients that are needing

oncology treatment with private payers in a few of the areas in where we're testing. We are also integrating much more significantly, I think, than in some models' multi-payer alignment in the following models: the AHEAD[28] Model, where we're focusing on global budgets across Medicare and Medicaid, to drive better preventive care; the ACCESS Model, where we are making technology available across payers to better address chronic care issues; and the LEAD model, which is our forthcoming ACO model, which is also looking to, among other alignment issues, work very closely in a couple of states, for now, with -- to align Medicare and Medicaid care.

These -- all of these new models, as well as our current models, apply lessons learned from past models that tested multi-payer alignment, particularly in the advanced primary care space. And you see those past models here: Comprehensive Primary Care Plus, Primary Care First, and Making Care Primary. And we're going to talk about what we learned from a couple of those models in the forthcoming slides.

28 Achieving Healthcare Efficiency through Accountable Design

Next slide, please. So first, a little bit about the models that I want to reflect on today. First, Comprehensive Primary Care Plus, it was tested from 2017 and ended at the end of 2021. It was a five-year model for two cohorts. It essentially paid an additional payment on top of the normal fee-for-service set of payments for care coordination in primary care clinics and family medicine, et cetera. It also had a small performance-based payment/debit approach. It enrolled over 3,000 practices at one point across 18 different states and regions. And at model start, had 63 payers across those 18 regions that signed up to provide similar additional support in terms of learning, payment, and data to those practices that agreed to participate in CPC+.

The other model that we'll talk about is the successor model of CPC+, and that is the Primary Care First Model, which began in 2021 and then carried through until the end of last year, 2025. It was a five-year model as well. And it had a -- essentially, a partial up-front payment, as well as a capitated payment for primary care, but also incorporated upside and downside risk. It had 1,700

practices across 26 states and regions and 17 payers aligned at model start. And we'll talk about, sort of, how that changed over time.

Next slide. So wanted to note, again, not specific to each model, but some of the takeaways, both positive and negative, from our experience implementing multi-payer alignment in these models. The first is that just the focus on multi-payer alignment often fosters incredibly important discussion that otherwise may not happen. Often, starting the conversation is the hardest part. And payers due to, you know, different regulations regarding antitrust and concerns about talking to competitors in the market are often not willing to think things through or feel somewhat stymied in their ability to think through how to improve care in a way that will affect providers because they, of course, are dealing with multiple payers at a time. And having CMS at the table had a real tangible impact in that focus.

Additionally, what we found is that, especially in CPC+, some of the collaboration that began during the model and would have ended in 2021 has continued and still continues

to this day. And so that's something that I think has been really interesting for us, in terms of just CMS' presence to move a conversation forward. Also, multi-payer alignment does enhance support for behavioral change. One of the things that's very true is that providers are more willing to participate and more excited about change when they know that it has the potential to reduce friction across the different provider or the different payers that are dictating how they provide care.

So as I said before, Medicare fee-for-service amounts to, what we found in our practices, between 33 -- well, I should say 20 to 40 percent of providers' revenue. And so that leaves 66 percent of revenue that can be pulling providers in a different direction. And if we can have everyone pull in the same direction, then we move a lot quicker. And so aligning data learning and other resources was something that providers universally really appreciated in our models. That being said, it's hard to drive behavioral change without enough payers who are pulling in the same direction. And so as a result, what we did

find, especially in Primary Care First, but also in CPC+, is that in some regions, providers felt that even with a number of payers supporting, there still just wasn't enough momentum for them to change the way that they provided care at a practice level. And it was too disruptive for them to differentiate how they provided care at a patient level.

And so especially in PCF, where we had less multi-payer alignment over time, we actually saw that many practices decided -- started to drop out or jump to test other innovations because they didn't really feel like there was enough oomph for them to make the change that would really improve patient behavior, given that there is friction in making change to begin with.

Let's keep going. Next slide, please. Which gets to, you know, I think one of the more important takeaways from -- that we've learned on multi-payer alignment. Which is that it helps to think and define, both for payers and providers that may be participating in models, what multi-payer alignment is going to be defined as for a given model. Do we want them to be equal partners, such that if we're

putting in a dollar per patient, they're putting in a dollar per patient, or is that equity less important than us all just, sort of, moving in the same direction? What we found is, we defined it more along the first lines, with an idea that we wanted to get payers to be providing more equitable support over time. We never quite got there. And so what we found, and as you see in the graph to the right here, is that CMS ended up paying an inequitable or a disproportionate amount of the payments above fee-for-service and above what would otherwise be available for each model. And so along those lines, we also found that some of the payments that were coming in from other payers were aligned to programs that they already had running. And that's not necessarily a bad or a good thing, but it’s important that we're all, sort of, speaking with the same voice and how we want providers to change.

However, what we found is our provider participants were often confused and somewhat dismayed that they were not receiving more additional payments from all of their payers. And that put them at a position of

either only treating CMS payments with -- or sorry, CMS patients with the additional care coordination and additional services that they believed would affect their entire practice or in effect CMS' additional support was cross-subsidizing care transformation at a lower level because the funding wasn't there to test it at the level we wanted to, but cross-subsidizing that change for patients that were covered by other payers other than Medicare fee-for-service.

And so that brings us to the last, sort of, challenge that I think that we have acknowledged and are grappling with in our models going forward. Which is that the limited scope of CMMI tests creates administrative fragmentation, especially in our larger Medicare Advantage organizations and just general national payers at large. So in PCF, we had six payers that left in the beginning -- I should say throughout the model, not at the beginning, because they realized that they needed a dedicated staff; the capitated payment changes required additional infrastructure; and the return on investment would've been too slow for them to actually,

sort of, see that being a positive for them long term. And I think that is something that we have heard across all of our primary care models, that especially for national programs, they are thinking about driving change at scale. And asking them to invest in smaller changes, especially those that require significant investment up front and have a slow return on investment, is a big ask.

And so that's our takeaway, that multi-payer alignment is hard when the population is broad, the services are numerous, and the return on investment is slow and uncertain. And so going forward, we're thinking about how to focus our change in a different way. And we'll talk about that quickly on the next slide.

So with those lessons in hand, I just wanted to highlight what the future areas of interest for multi-payer alignment is. For us, we are -- these are areas that we're thinking about. We are, you know, in different stages of planning all the time for how to address new health care problems because they are numerous and complicated. And so one of the areas that we are thinking about is

Medicare Advantage, especially as Medicare Advantage has eclipsed fee-for-service over time in terms of the number of Medicare beneficiaries covered, we want to think about how to increase value-based care. We also want to reduce, you know, frankly speaking and specifically, the administrative burden of providers that are participating in multiple models that include Medicare Advantage, because we know that, you know, there will always be, -- unless we address some of these lacks of alignment, there will be friction between things like real-time patient outcomes that come from an EHR[29] and Stars rating -- Stars ratings and those measures because they look at something different. And the incentives are already strong in Medicare Advantage. And so we've got to think about how to align those going forward for providers to be able lean in in models that address Medicare Advantage outcomes.

And the other area we're thinking about quite a bit is condition-specific populations. As I said, primary care models are characterized by prevention, which has a

29 Electronic health record

slow return on investment across a broad population, but there are providers and populations that have -- that are at much higher risk for future acute care issues that we can focus on and believe that we can make a difference in terms of return on investment on a much shorter time frame.

You can think of the chronic kidney disease population as one such area, where averting future crashes into ESRD[30] and hospital visits, as someone reaches that stage of remedial care, can save a lot of money, both for Medicare, but also for payers who have to then fund a very expensive transition period. And so as we think through those potential possibilities, we believe there is a lot of hope and potential for multi-care alignment in the future. Thank you. And I look forward to the discussion.

DR. BHANSALI: Thank you, Nicholas. We're saving all questions from the Committee until the end of all presentations. Next, we are glad to welcome Ms. Dana Rye, who is the President of Value-Based Care at Duly Health and Care. Dana, please go ahead.

30 End-stage renal disease

MS. RYE: Thanks, Dr. Bhansali. And thank you all for the opportunity to participate in this important conversation. I have the opportunity of representing Duly Health and Care.

You can go to the next slide, please.

The largest independent multi-specialty provider in the country. I am the President of Value-Based Care. This is an important and high-performing part of our business encompassing over 400,000 patients across payers and risk arrangements.

Next slide. A bit more about Duly. You can think of us as a large single practice, but we're so much more than that. We're really a full integrated delivery system. We have 1,800 clinicians, 190 different locations, a full suite of ancillary services from lab, diagnostic imaging, ASCs[31], urgent care, and infusion centers. We serve 1.2 million patients, and as I mentioned, nearly 400,000 of those are in some form of value-based care or risk arrangement. We have incredibly high provider retention, best-in-class patient

31 Ambulatory surgery centers

experience scores, and, of course, are most proud of our clinical quality.

Next slide. Now, this footprint makes us uniquely suited to excel in both fee-for-service and value-based care. With our primary care at the center, we leverage the strength of this model to provide timely, cost-effective, high-quality care. Because of our multidisciplinary footprint, we're able to keep the majority of our office-based professional services in-house, which enables countless life-changing stories of same-day appointments and referrals. For example, just a few weeks ago, PCP uncovered a possible macular hole. She walked the patient down the hall for a same-day evaluation by a retinal surgeon who confirmed the diagnosis and scheduled an immediate procedure, likely saving that patient's vision. Just one example of many that happen every single day because of the ability to deliver care across specialties and ancillaries.

Next slide, please. So a large part of the success is because of who we are. We have tenured patients who, on average, have been seeing our highly aligned, mostly

shareholder physicians for over 10 years. That allows the physician to deploy care across specialties and our ancillaries, all while integrating our value-based care data and care management seamlessly into the provider workflows.

Next slide. On top of this core foundation, we deploy programs that wrap around that physician-patient relationship and ensure the patient receives needed support between physician appointments. Some examples of that are noted here. For example, our care management teams are in the clinic, so physically located with the team, serving as a true part of that physician's care team versus an external unknown person, which is how many care management teams will operate.

Duly at Home, a program that enables that patient's provider to treat them even if the patient can't come into the office, facilitating a telehealth with the provider who knows the patient, knows their story, knows their background, while a certified paramedic can actually put hands and eyes on the patient, checking vitals, administering IV fluids, and more. We have programs that manage

hospitalizations, readmissions, and support patients through post-acute and specialty journeys, all of which is coordinated through our primary carers.

Next slide. And our numbers affirm that these -- this foundation, plus our programs, drives positive results, whether it's the important operational metrics, like having 90 percent hospital follow-up visits or proper documentation of acuity achieved by seeing these patients regularly, at the right side of service, at the right time, by the right provider. For example, over half of our orthopedic procedures now take place in an ASC versus a higher-cost hospital setting, and we're really proud of driving that improvement, which is a better patient experience and drives significant cost savings to the system.

I'm most proud, however, that we've reduced hospitalizations by 43 percent for our most medically complex patients in our Care Ally program. This is our version of care management. It is nurses working with the riskiest and most complex patients that we have as an extension of the primary care and ensuring that those patients receive everything

they need to positively impact their health outcomes. We've also reduced readmissions by half for patients that we see at homes through that Duly at Home program or a 30 percent reduction in our oncology patients needing to visit the ER[32] because of those care management programs. We're incredibly proud of this patient impact, and this has translated into significantly impressive and strong value-based care program results across payer types.

Next slide, please. So as I mentioned, we're active and top-performing participants in a range of both Medicare Advantage and original Medicare programs, previously ACO REACH and now MSSP[33]. We have roughly equal patients in both programs, so this allows us to compare results across meaningful populations. Each of them has tens of thousands of patients in them. And importantly, we deploy our internal programs consistently across the two.

We will, of course, distinguish between patients, for example, the highest-risk patients needing a different level of care than

32 Emergency room
33 Medicare Shared Savings Program

a patient of average risk, but we don't look at their insurance when figuring out how to deploy those programs. And so, it is interesting, then, that we see much better outcomes in our Medicare Advantage risk population than we do in traditional Medicare. For example, as you see here, hospitalizations are 35 percent higher and readmissions 14 percent higher for the original Medicare population, even though the number of chronic conditions per patient is not materially different.

So given that these programs are deployed consistently and the population does not appear different in terms of their level of acuity, we see three main reasons for this diversion. First, attribution and the strength of the PCP relationship. When a patient is closely tied to a Duly PCP, outcomes are better. More Medicare Advantage have a Duly -- patients have a Duly PCP, and they engage with their PCP more frequently than ACO REACH patients do.

Number two, data accessibility. Medicare Advantage provides significantly more and more timely data than we've received through ACO REACH or MSSP.

And finally, supplemental programs. These are offered by Medicare Advantage plans, who are also highly incentivized to improve outcomes and lower cost. They use tools like utilization and -- utilization management and prior authorization, which, while not perfect, are an example of why we saw one percent of the skin substitute spend in Medicare Advantage than we did in the ACO REACH population, again, despite roughly equal population sizes. They include a host of other patient services as well, again, sometimes additive to the ones that we provide internally.

Next slide, please. Here, we'll go a little bit deeper on that first point of attribution and PCP alignment, and you can see here that the data clearly shows when there's a -- an aligned Duly PCP, clinical outcomes are better. And, you know, some examples that are listed here, right, 150 percent more admissions in original Medicare when there's not a Duly PCP, roughly 65 percent greater readmissions, roughly 70 percent greater emergency room rates. And as this shows, this is true across payers, but it is more pronounced in original Medicare, as fewer patients have that aligned

relationship due to the stricter, more formulaic attribution compared to Medicare Advantage.

While we make every effort to engage patients and offer them Duly's excellent care, Medicare Advantage plans and their attribution offer exit ramps for patients who are truly not seeing Duly or do not want to engage with the system, as well as multiple paths to add those patients so that we can provide all of these services for them when we're actively providing care for those patients. Our Medicare Advantage patients also see their primary carers more frequently, which enables the PCP to more effectively quarterback that care.

Next slide. Expanding on the other differences that we see, Medicare Advantage provides more and more timely data on the left side of the slide. This allows us to act instantly. For example, our ability to coordinate discharge planning while a patient is still in the hospital for that hospital follow-up versus learning about the hospitalization through claims data much later.

Third-party companies do sell this information, and we purchase it for original

Medicare, but it's expensive. And more problematically, it is not comprehensive, as it requires each hospital to agree to share that data with the third party. So as an example, to put this into context, while we have 35 percent more admissions in ACO REACH than we do in Medicare Advantage, as we showed on the prior slides, you would expect 35 percent more notifications. We see far fewer notifications come through for ACO REACH than we do for Medicare Advantage, meaning it is more difficult for us to act on that in a timely manner.

Lastly, on the right side, Medicare Advantage plans offer supplemental programs that, at times, are additive to our consistent internal approach. Examples of this can include added -- excuse me, expanded care management and wellness programs. Others that I mentioned earlier, like UM[34], which, when deployed appropriately, can be another lever to both help the patient and avoid wasteful low -- low-value spend, such as the skin substitute example that I mentioned earlier.

So to close, we appreciate PTAC's

34 Utilization management

interest in this important topic. And thank you very much for including Duly's perspective. We're glad to address any questions during the Q&A portion.

DR. BHANSALI: Thank you, Dana. Next, we are happy to welcome Dr. Karthik Rao, who is the Chief Medical Officer at agilon health. Welcome, Karthik.

DR. RAO: Thanks, Dr. Bhansali. Appreciate it. And so, pleasure to be here and nice to meet everyone. Karthik Rao, primary care physician at Lahey Clinic in Boston and Chief Medical Officer at agilon health.

Please flip to the next slide. You know, I'll actually start with our mission. So our mission is to be the trusted long-term partner of community-based physicians, ultimately enabling them to reimagine the care experience for seniors and lead the transformation of care delivery in their communities. And so, when we think about our care model and how we do that, there's really three pillars that we focus on. One is partnership; two, our platform; and three, our network.

And so, from a partnership

perspective, every partner or group that we work with is truly a partnership, which means we form long-term JVs[35] for full-risk, multi-payer Medicare lines of business. And what that does is it ultimately aligns economics with outcomes that we are trying to create with that group for those patients.

To our platform, you know, I really think about it as a purpose-built platform specific for Medicare across all lines of business. And I think that the key to note here is what we're really doing in that platform is we're taking disparate pieces of data, claims, EMR[36], ADT[37], creating a patient-level profile of them, and driving point-of-care insights across our care model to ultimately create better quality care. And I'll talk in more depth on how we do that.

Lastly, I think is also really important, which is our network. We are a network of 3,000 physicians, taking care of 500,000 lives, who are all full-risk. And our physicians are entrepreneurial. They're innovative, and we share best practices that

35 Joint ventures
36 Electronic medical record
37 Admission, discharge, transfer

they come up with and drive those across the network, which allows us to innovate quickly and efficiently.

And so, with that, let's move to the next slide, here. And so, where are we? So we're in 28 markets across 12 states. And a few things to know. I mentioned we are roughly 500,000 lives. 400,000 of those are Medicare Advantage full-risk. About 100,000 are in ACO REACH.

We have several different archetypes of community-based groups that we work with: community-based health systems, multi-specialty groups, large IPAs[38], and also singletons, which both creates unique opportunities for us in the value space and also unique challenges that we have to work through.

We can flip forward one more here. And so, you know, I mentioned in our care model, we're trying to create a single Medicare experience for physicians and patients. And on the left, you'll see the challenges are our community-based groups we're dealing with prior and how we've helped solve some of those problems on the right.

38 Independent Physician Associations

And so, to walk through this in some detail, the first I'll mention is disparate contracts with different plans in Medicare Advantage that required different parameters for success. Whether that was quality metrics, thresholds for quality metrics, or how those incentives were ultimately passed back to the group, create a lot of challenges for them in naturally operating to those contracts.

Two is point-of-care insights and data. Ultimately, to perform in these contracts and change the ways care is delivered, you really have to deliver point-of-care insights. That's the core providers making the best decision for that patient in that moment in time. That's very challenging to do when you're data-constrained. Your exchanges are challenged, and you have different metrics you're operating against.

And lastly, you know, I think the reporting against performance has also been a challenge previously. You can imagine the complexity of getting to streamline reporting when there are so many metrics and contracts in place. So on the right, what we've really tried to do through our partnerships with our

groups is create a single line of business for senior lives. And so, we look at a senior life as a senior life. We don't differentiate between plans or CMS full-risk programs. We really just focus on doing the right thing for that patient in front of us. And so that creates a single MA line of business experience.

And two, we spend a lot of effort actually making sure every patient has a complete dataset that integrates claims, EMR data, and ADT data. And we construct our care model to perform against a set of metrics and outcomes that -- where we are trying to optimize both quality of care and reduce unnecessary care that does not add to the experience or benefit of that patient. And we deliver those insights to nudge PCP behavior at the point of care. We think that's critical to actually changing care for those patients.

And so, I'll talk a little bit about our care model on the next slide. And so, you know, just to summarize, single line of Medicare business that we've transitioned our groups to, ultimately trying to standardize quality metrics that they perform against and

delivering those insights at the point of care. So what are those insights really trying to achieve?

And so, if we look at this slide, our care model is really built on a patient-centric lens of understanding where we have the biggest opportunities to improve quality of care but also reduce spend that does not contribute to better outcomes.

And the way we think about this is really in three ways. One, really understanding who our patients are, and so we use algorithms to risk stratify patients based on a number of factors. Two, really matching and really being purposeful about the interventions that we are creating for those patients. We can't do everything. So we really have to focus on a narrow set of activities that we think will meaningfully move the needle. And I think that's important to be focused because we make significant investments on core capabilities that you see across the bottom of this slide, on really getting good at those things and continually optimizing. And I'll share a few examples of what that looks like.

So for our most complex patients, which you see in the second column, these are patients with advanced illness, end-stage heart failure, end-stage renal care, end-stage COPD[39]. We offer 24/7 access in the home for these patients because they are at critical points in their care journey. And we think we can really meaningfully make a difference in their lives by offering them that added level of service. And that also holds true for many of our high-risk patients, which are in a slightly separate tier, but again, multi-comorbid patients often in and out of the hospital. They're dealing with coordinating care across a number of different specialties and entities. We have in-home care capabilities to support them as well.

Clinical pathways. We really believe, for the majority of seniors, there are about five conditions that we want to be best-in-class at managing proactively and end-to-end. And you see those here. CHF[40], COPD, dementia, CKD[41], and diabetes. These are conditions that are high -- highly prevalent in

39 Chronic obstructive pulmonary disease
40 Congestive heart failure
41 Chronic kidney disease

the senior population. They are conditions where we see significant care gaps in care patterns that exist today. And it's for good reason.

PCPs are busy. They often don't have the time that's complex to actually treat a lot of these conditions and really close all those care gaps. And so, what we found as a common theme through a lot of these conditions is a need for pharmacy care. And so we have pharmacists across all of these conditions that help close care gaps, will help patients with any cost concerns and find alternatives. And we've seen, just an example, in CHF, moving our guideline-directed therapy rates from baselines of around 20 percent to 70 percent on three- and four-drug regimens. And as a result, we've seen readmissions and admissions for that cohort come down significantly.

You know, like most groups in value-based care, we also focus on burden of illness and quality, episodes of care, and high-spend specialties. And, you know, I think -- and we continue to progress and optimize in those areas, as well.

So next slide, please. And so we

talked about a few things coming together. We talked about our platform. We talked about what our care model looks like, and we talked about our network that helps us innovate. And so, where has that gotten us in terms of results that we've been able to achieve? From a quality perspective, we consistently perform above four stars. We've done that, you know, going back to 2020, and our results continue to be promising in that area.

From patient access perspective, we think access is critically important. And we think that's a part of right care, right time at the right place. This is just one measure of that, annual wellness visit completion rate. We're well north of -- we're at 76 percent north of the fee-for-service average, but you also see access metrics such as touch points and PCP-to-specialist visit ratios be meaningfully better for our network relative to comparison groups.

And lastly, from an outcomes perspective, are we reducing unnecessary utilization? And so, on readmissions, hospital admissions, and ED[42] visits, you see our

42 Emergency department

outcomes to the right. And what you see across those three metrics is our readmissions being about 20 percent lower than a fee-for-service benchmark, our hospital admissions being about 15 percent lower, and our ED visits being about 35 percent lower. And so, I think through our care model, our proactive care, our focus on specific disease segments, we've really been able to move the needle on how we perform, both from a quality of care perspective and experience for seniors.

Next slide, please. And so, what have we learned through this process? And so, you know, I'll start with the top line, and I think that is full-risk in MA can really mean different things by plan. And what it can sometimes feel like, we operate across 30 different payers, that you're really in 30 different programs, and that plus ACO REACH and MSSP that we operate in creates a lot of complexity.

And I'll hit on three areas where I think that really comes to light. One is attribution. And so our -- we are obviously at full risk for all of the lives that we take care of. We have -- we see real differences in

when we get attribution data by plan. So our best payer partners gives -- give us attribution data in January, which allow us to be proactive in engaging with those patients and really helping them benefit from what we -- from our full-care model. Other plans don't provide us attribution data until April or May, which really puts us several steps behind both in engaging those patients and put our contracts at risk from being delayed in what we can do. Those tend to be smaller regional payers that are less sophisticated.

Two is data asymmetry. We generally have a pretty good experience in ACO REACH, both from the timeliness of data and also from the completeness of that data that we receive. In working with MA plans, we see a lot of variability and timing of data. Incomplete datasets both can be on the claim side and also on the risk adjustment side, and also different data structures.

And, you know, again, mentioned we work across about 30 different plans. We spend, you know, upwards of half a million dollars for each of those plans to restructure data, making it usable, allowing us to be able

to do things like point-of-care insights that allow us to change care patterns for the patients in our care model.

And last, measuring success, which others have hit on as well. And so, there's variation in MA plans and even by MA plan, ACO REACH, and MSSP, and the difference in quality metrics, the thresholds for those quality metrics, and how incentives are paid out create a lot of complexity in how we manage both from a contracting perspective and delivery of care and also in contract performance.

And so, you know, moving forward, I think we have a real opportunity to be more clear on what it means to be in full risk by stakeholder, whether that's data requirements, attribution, or quality metrics. I think creating consistency across those things where we do see administrative burden in succeeding these programs and ultimately allow us to focus more on care delivery and the physician education that's required to succeed. And so I'll pause there.

DR. BHANSALI: Thank you, Karthik. Finally, we're excited to welcome back Dr. Michael Chernew, Professor of Health Care

Policy and Director of the Healthcare Markets and Regulation Lab at Harvard Medical School. Please go ahead, Mike.

DR. CHERNEW: Yeah. Thank you so much for having me. It's wonderful to go last. Listening to Nick and Dana and Karthik is really educational for me. I think the reason I do this is so I can just hear what the other speakers say and get the questions. And I have to say, it warms my heart to see all of this type of activity going. And I actually do think there's a lot of merit in what some of these organizations like Duly and agilon are doing, and so we actually see some care transformation happening. And I think the evidence might not be as overwhelming as people would've liked, but I think there's clear evidence that well-designed programs can improve quality and reduce spending. And so, I'm excited about all of that.

So now, since -- unlike the other speakers, I don't actually do anything, I'll have a shorter set of comments, and then we can go to the Committee’s questions. But can you advance the slide?

So first thing I need to say is the

opinions, everything I'm going to say now, they're just my personal views. They don't necessarily reflect the views of any organization I'm affiliated with. Most importantly, they don't reflect the views of MedPAC[43].

All right. Next slide. So I think a key thing here that everyone has emphasized, so I won't emphasize it; I just have more pictures than words, is it's just really hard to succeed when physicians are facing multiple incentives. So they're getting different incentives from the MA plans. They're getting different incentives potentially from ACOs. There's obviously fee-for-service. And this is largely just in Medicare.

Now, the way that I put this out, I have the ACO incentives coming at the physician separately from the MA plans, but I think one of the things you've seen from both Dana and Karthik is the ACOs can actually be between the MA plans and help harmonize what goes on. I think that's a very important role for conveners, but the key point here isn't how the arrows go. The key point here is it's very

43 Medicare Payment Advisory Commission

hard to practice medicine if a lot of different groups are telling you how to practice medicine.

So let's go to the next slide. So this is my main point. This will come up again at the end. And, by the way, I'm almost at the end. Alignment's important, and it's easier to align the programs if there are fewer programs. One of the problems that I've seen and that I worry about is there's just a lot of programs, and they're just changing a lot. And so I'll say a little bit more about alignment in a minute, but it's just very hard if you're trying to align population-based health payments, episode payments, and the MA plans are doing their own thing, which CMS doesn't have a direct insight into, and then you have a series of other programs that aren't necessarily exactly episode or ACO-type programs.

And so, my sort of first broad comment, and I would say the main theme of this is it is hard to align. Nick pointed that out very clearly for a bunch of reasons, but it's really hard to align if you have so many things going on and you're trying to align micro parts

of all those things. And I think one thing that came from Dana and Karthik's point is there's maybe some big-picture areas where alignment might help for at least some of the population-based health things.

So let's go to the next slide. So what dimensions of alignment are there? So one is quality measures, and I think that's important. I think there's a lot of stuff going on for quality measures. The more they can be aligned, that's important, so it came up -- data requirements matter, and the -- I think CMS. And the more they can modernize the data requirements and modernize the data flows, things will be better.

Risk adjustment matters. So I think there's big differences. Risk adjustment itself, I think, needs a real serious overhaul, but I think aligning it across similar programs ends up being quite important. The one that I think Dana and Karthik mentioned a lot was attribution, and I think that certainly matters a ton. It's hard to succeed in these models if you don't know who's in the model.

And then the last one is financial incentives. And I'm going to say a bit more

about financial incentives because it happens to be an area of interest of mine, but you do want the financial incentives to work in a way that helps providers succeed if -- financially, if they do the right thing. And that ends up often being a tension between fee-for-service-type programs and ACO-type programs. But I would be remiss if I didn't note that one thing that's happening in fee-for-service is the addition of a whole bunch of codes that are kind of not like population health code -- they're sort of like population health codes, but they're not really ACO total codes, a bunch of G codes and things like that. And it's very hard to align the incentives if you're trying to do everything in every program.

So next slide. So some challenges to alignment. The programs often have different scopes. So we've talked a lot about total cost of care programs, which is often these groups that take full risk, ACO and even contracts, MA plans where you take full risk, but there's also a bunch of episode-based models. And I think aligning between the episodes and the population-based models will end up being particularly important.

There are inherent attribution differences between ACOs and MA. So a lot of people talk about attribution. So I'm not going to dwell on it now, but again, I do agree that attribution and getting it right matters. And I should say the nuance there is that we attribute people to MA plans well. The actual attribution of MA plans to practices is something that's sort of outside of CMS' direct purview. And as was noted, plans -- some do that better than others, but the ACO-type attribution is something that CMS does and figuring out how to align that with other attribution models and across attribution models would be important.

One big problem ends up being the multi-nature layer of care. So there's population-based programs and fee-for-service, a bunch of others. There's not enough room to draw all them that affect the provider group or the health system. So there's money going there, but then the doctors themselves or other professionals -- they're getting incentives maybe from their health system that may not exactly match the type of incentives that are coming from the payment model to the provider

group or the health system. And so aligning that -- so for example, this fits into the statement that people say, look, you're giving us total cost of care to the delivery system, but the doctors are still rewarded on some fee-for-service basis.

So there's some amount of aligning that I personally believe is the responsibility of the provider group or the health system to harmonize their different incentives so that the doctors and the other professionals and all the other things that are going on are kind of moving in the same direction.

One of the big problems ends up being legacy systems. You want to align things across payers, but not every group can manage in their IT[44] systems doing a bunch of things, so it ends up being quite hard. If you want to align quality, for example, or if you want to align risk, you really need to think through how the IT systems in these different groups are working. And those legacy systems can sometimes be a real barrier to what's feasible on the ground.

And then the other problem, which I

44 Information technology

think is particularly true when you think amongst, let's say, the MA plans, is alignment often requires some version of standardization. Maybe we can have a semantic discussion about the distinction between alignment and standardization, but, typically, it involves some aspect of standardization. And there's often organizations that believe they have some type of secret sauce, and they don't want to align. They want to see what other people are doing and then add their secret sauce sort of on top or below or besides what that is, which is fine, but it makes it complicated to do alignment.

The problem is, if you do that standardization, you worry about innovation. You don't want organizations -- say you could do better attribution or better quality or whatever it is, not to be able to do that because now you've aligned everybody doing the same thing.

So I think my personal view is we need a little bit more standardization in the scheme of things. I think the administrative burden and the lack of alignment is actually a worse problem, but I think that issue remains

up for debate, and the devil will be in the details when there's a particular proposal on the table.

Next slide. So this is really my last original slide, but I want to raise one other point about alignment that hasn't really been raised, which is this point that I've made in another piece, which is waste is an asset. So the goal here is that we want to incentive delivery system, provide higher-quality, lower-cost care, and share the savings with them, hence the things like shared savings program. Different Alternative Payment Models assigned the gains from efficiencies to different stakeholders. So there's a total cost of care models, but there's also episode models, and there's different things that might go on in the fee-for-service system when you add certain types of chronic care management codes or certain activities, like avoiding a post-acute stay or shifting someone to a lower-cost imaging procedure, or doing a whole bunch of things, that savings is going to have to get split between organizations, and you may have different organizations that have some claim on that saving, say an episode can be an episode

provider or a -- an ACO. And so it's important to think through how waste is assigned, because it affects the incentives to save and participate.

So in a world where we have a whole bunch of different models that are floating around, thinking through the participation rules, and who gets to keep the savings, and how to do that in an aligned way, matters. The general gestalt of the MedPAC recommendation, which I believe in, is the APM should be synergistic and default to population-based, say total cost of care models, and then they should add synergistic episodes or other models on top of that base foundation. But I think too often, one problem we have with alignment, is people begin to ask, how can we build a model to accomplish this particular small goal, chronic care management? Well, that's a big goal. But managing a particular patient type in a particular way.

And the issue is, even if you do that correctly, understand that in these population-based models that -- the organization that holds population accountability has an incentive to do that.

And so trying to figure out how to align the incentives across different types of programs, and how to manage who's able to participate in them, matters. And I think it becomes complicated when you try and build a bunch of population-like features in fee-for-service, which is inherently not well oriented, the population-based management to then align that with what's going on in other say, more direct population-based management type programs, and if you don't do that well or if you're not cognizant of it, you'll mess up the participation decisions, and the entire thing will just become administratively burdensome and too complex to operate.

So let's go to my last slide, which was really one of my first slides. So I'm just going to close with this, and I look forward to questions, and I hope I get to engage with Nick, Dana, and Karthik on these points. But again, I think a core point is, it's much easier to align the programs if there are just fewer of them. Having a general vision and building that vision out in an aligned way is, I think, important. And I think that's hard to do if we come to the discussion with the

notion, all right, we've launched a bunch of programs in 2026. What are we going to launch in 2027? Or if we come to it from the point of view of, well, I'm in charge of the Part D program, or the Part B program, or pick your letter, and we also need to do something related to chronic care management, drug pricing, psych care, whatever issue you want, and so we're going to launch a new model to try and get it back.

Because every time you try and launch a new model to try and get it, whatever the particular thing you're worried about, you have to think about how it interacts with all the other broad models, particularly the population-based models which ideally would be able to have a much more holistic view of pulling these things together.

So the next slide, which is just going to say "End." I've enjoyed at least my brief time to be able to talk with you all, and I really look forward to the discussion. So thank you very much.

DR. BHANSALI: Thank you so much, Mike. And thank you to all our experts for these great presentations. Now, let's move to

the discussion portion of the session. At this time, 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 other. You can signal that you have a question by raising your hand in Zoom. In the interest of ensuring balance across different perspectives and questions, we encourage experts to keep each response to a few minutes.

Now, I am going to take a look to see who has their hand up. And if no one, then I -- oh, I see Lauran with her hand up first.

Lauran, please go ahead.

MS. HARDIN: Thank you, Henish. Excellent presentations.

Dana, I have a couple questions for you, and I welcome the other panelists to comment as well. I was really intrigued by the care management infrastructure that you have, and to see the diversity of roles from paramedicine to nurse case managers managing the highest complex, and it looked like as well community health workers potentially in the Care Ally role. So I'm curious how you coordinate that infrastructure, if it is

coordinated and connected at a central level, and what insights you've gained from working with different disciplines and that coordination to achieve the outcomes, reductions in costs, and improvement in quality that you've seen.

MS. RYE: Sure. And thank you so much for the question. And it is -- with living in the day-to-day of it, to take a step back and look at that comprehensive suite in the way that we lay it out in that slide is very special for me and something I'm very, very proud of that we've built. And, yes, it is a whole host of individuals, including many of the ones that you mentioned, and a lot of ones that don't jump through. Like there's, you know, MD specialists, for example, involved in that as well. There are front desk employees at our clinics. There's call center staff that serve all of our 1.2 million patients.

And so, yes is the short answer. It requires a tremendous amount of coordination. I'm sure we've all seen examples of when, you know, additive services are done in a way that is not well integrated. It makes for, you

know, at best, a clunky experience. And then when it plays out worst, you know, patients getting conflicting instructions from different places, which leads to, you know, again, at best, neutral outcomes, if not, you know, poor outcomes.

And so we have, because of the scale of our programs and our commitment to value-based care, invested in those back engines, I'll say. And that's everything from data, the processes, and probably the part I'm most proud of, the team, to help make sure -- a team of excellent operators who've been in this space for a long time. And I really do think that is what's necessary to make those pieces all come together. One of the many reasons why it's so, so hard for smaller organizations that don't have, you know, the confidence, the track record, the dollars to invest in aggregating programs to those levels and one of the reasons why I am glad that there are organizations like agilon out there for groups that wouldn't be able to do this on their own. So happy to go into more detail on any of those pieces if helpful, but we'll leave it there for now.

DR. BHANSALI: Dana? Lee?

CO-CHAIR MILLS: Yeah, wonderful presentation. I appreciate that from everybody. I was really struck that I think I've heard -- you know, involved in PTAC now going on seven years, I guess. I think I've heard something across all four of you that's the first time I've ever heard it said this way in a PTAC meeting or discussion, which is, you know, Dana and Karthik, your team's out there doing the good work every single day. You all both in your own way said really clearly that MA is the winning model, and you try to bring Part B wrapped in an ACO alongside that.

But the -- you know, MA is superior for attribution, relationship, better data sharing. I love -- and agilon talked about essentially blending all that together and providing both financial and program arbitrage for your provider so they only see one program. But it makes a big part of that.

You know, Mike, you said, you know, it's hard to align with lots of programs, and so fewer programs may be better. And that's the theme we've picked up before saying maybe it's time to stop making up new models and time to start enforcing what we know works, however

we do that, right?

And then Nicholas, you talked about, you know, CMMI is increasingly aware that it's hard to get to 65 or 70 percent of the patients involved to move systems and providers. If MA isn't involved, and CMMI sounds like it's looking at how MA can be involved, and so that's really a first. And so I guess I'd love to throw it open to all of you to talk about that specifically. Are we kind of entering a new era where multi-payer alignment from CMS' perspective is going to include weaving MA into programs in trying to streamline, you know, metrics, policies, philosophy, as much as we have been focusing for the last 15 years in PTAC pretty much around just Part B alone. So love to hear your reflections on that. Whoever wants to go first.

DR. RAO: Yeah. Maybe I can start and then others can layer in. And, Terry, you know, you mentioned one of the things that came out was, maybe MA is the clear winner, and I might take a step back from that and say, I actually think we do pretty well on the ACO REACH side too, and we've had a good experience there. When I think about the 30 MA plans that

we work across, it's really tough to say they're all the same.

There's a lot of heterogeneity within that. And I would say some are clearly at the top quartile of who we work with. And in that top quartile, what we generally see is pretty standard data requirements, like timely attribution, and I would say benefits that align with our view on what good care means for a patient. Which I think really allows us to get on the same page pretty quickly with them to focus on patient care without all the administrative burden of what we're trying to do in the background.

And so I do think there -- to your point on how we can work through requirements, like, it's clearly going well in some places on the MA side. What can we learn from what they're doing and even components of ACO REACH to say, how do we create standard components of that that everyone can get behind?

I think Michael mentioned one of the biggest challenges, which is a lot of small regional MA plans have very dated stacks of technology and other things they're using. And if you were to ask them to do that today, they

just can't. And so there -- there's probably a will, but not a way. And so there's areas, and I think that's part of the challenge, to work through.

MR. MINTER: I guess the one thing I would add -- I mean, I appreciate the summary, and would agree that, you know, multi-payer alignment, I think what we have learned over time -- and I know I walked through two of the models that we had tested from 2017 to now and in main care primary, which, you know, just started getting off the ground before we changed priorities, we saw the same. It's -- it is really hard unless you can solve these alignment issues to get to what we see as the tipping point for practices to really lean in on behavioral -- sort of behavioral change. To change the way that they are administering care.

And it is a challenge that we continue to sort of think through, especially on the MA side. Because obviously they are our systems that we're putting in place, just to acknowledge CMS sort of regulates both MA and fee-for-service, but it is difficult to move either boat just because of, like, the given

inertia and the incentives that exist. It is something that we know we need to think about.

I don't know, and I will probably get the best solution is fewer, you know, solving -- or having fewer pieces of the puzzle, so to speak. I think maybe it is sort of designing them smarter so that they are less confusing when viewed together. But especially, as we have been using an only carrot-based model for multi-payer alignment, it is something we have to think quite a bit about.

DR. CHERNEW: Yeah. Let me add one quick point. First of all, I am a big fan of MA. I think the evidence suggests -- and this may have been implied by the question -- that MA, on average, is lower-cost and comparable, if not slightly better quality. But to Karthik's point, there is widespread heterogeneity, so it's important to what one thinks there. But my enthusiasm for MA doesn't imply that we don't need to work or build a better fee-for-service system for a few reasons.

One is the current MA model is structurally built like on fee-for-service

benchmarks and stuff. And second, I think there's a range of reasons why people might not want to subject themselves to some of the other challenges of MA. We focused on a lot of the positives of MA, but we have another meeting about some of the challenges. But in any case, we do need to have a fee-for-service system that is efficient as the fee-for-service system can possibly be, both because some people are appropriate for fee-for-service and because the fee-for-service system sets the benchmarks for the MA plans.

So I think the challenge ends up being that Nicholas can only control so much once things get sent over to the private sector like the MA plans. You can't control their legacy systems. Can't control the way they do attribution. You know, and we want that. The whole point of MA is to give them the flexibility to bring innovation and care management. But it does limit our ability to make everything completely harmonized.

So, to the extent possible, I think building a better fee-for-service system and harmonizing it around the types of things we would expect in MA, attribution, maybe some

quality measure things, core incentives about population, health-type stuff, I think that's really the fee-for-service side where we can -- ignoring for a moment aligning with MA, just aligning within the CMS pro payment models would be sort of step one.

Then you got to figure out how you may or may not be able to align with MA. I think again, after quality measures, risk adjustment might be a good place to start. And then of course, there's all the other payers that aren't actually MA. I would start with Medicaid because at least the government controls Medicaid, but again, there's a federal-state issue there. This is a very complicated part of the American health care system, and I think for starters we need to try our best to keep it as simple as we can -- it will not be simple. As simple as we can to then begin to align things to work in the right direction. But we're going to need a fee-for-service system. Or I should say a non-MA system. It may actually not be fee-for-service, and I really will be upset at myself later for that misspeaking.

DR. BHANSALI: Oh, thank you for

that, Mike. And thank you to all the presenters who responded, maybe as a response on comment and maybe even a question to what's been said already. So I've had the chance to work at Duly as a primary care provider, and worked on the value-based care side. And what we had, to the points that have been brought up, is at least the friction that was probably the most prevalent from a primary care provider's perspective was not having as much to do with attribution or risk adjustment, et cetera, it really had to do with the quality piece of things.

And this is intra Medicare Advantage, so within all the different Medicare Advantage products, and then between Medicare patients, so if a patient was ACO REACH, or MSSP, or Medicare Advantage. And the quality piece really came into play because the variability of that quality -- of what quality meant when a patient showed up. If it's a total cost of care model, or upside only model, or if the attribution is different, that did create some challenges. But it really had to do with the quality piece.

And if we believe fundamentally that

the outcomes we want to drive for Medicare patients are standard across Medicare products, then I think this question probably goes to Nicholas first, is: How are we thinking about creating uniform set of quality metrics within a payer class so that the abrasion from a care delivery entity perspective, from a PCP seeing a patient perspective, is minimized? Or the variability of care delivered is minimized?

MR. MINTER: I think it's a great question. And to your point, it is -- you know, I think we -- I spent a little bit of time talking about quality being one of the real building blocks for alignment as well, for this reason. It will require us at CMS to think through, internally, sort of where we can not necessarily replace wholesale quality systems, I would proffer, but how we can meld sort of, you know, quality systems in new -- forget, call it fee-for-service, original Medicare models with what is being done in Medicare Advantage.

The Medicare Advantage quality payment system -- or quality bonus payments are big. There's a lot of momentum behind them. They're not going to be replaced quickly. And

even altering them, as you all know, it's a comparative system. And so, you know, changing sort of how we are measuring the Star ratings measures for a CMMI model is really complicated, because it creates ripples in terms of who's being compared on what measure that go far beyond the area and the population that we're testing.

But those are the questions that we need to confront. Because, to your point, we don't want to just layer on more quality measures and more incentives and different types of outcomes on top of what already exists. So it is something that we are thinking a lot about. I think it will require us to intelligently try to balance the equity of the way that Medicare Advantage measures quality and distributes payments there, which are significant and move quite a bit of mountains, metaphorically speaking. As well as making sure that, you know, we are addressing Stars ratings measures that may be pulling focus away from the things that we believe tomorrow's health care system really should focus on, and that is best for payments. That's not -- I don't have the how-to plan

here. I can tell you it is something we're thinking deeply about and hope to see quite a bit in future models.

I will note, we have a little bit of experience with sort of modifying Stars ratings measures in the past, and we moved away from, and I think it's something we're thinking more about. The Enhanced MTM -- sorry. Enhanced Medication Therapy Management Model, which was tested back in 2015, it changed the way that medication therapy management was done for participating plans. For those plans, we actually did alter the Medication Therapy Management measure, because it was prescriptive when we were giving freedom, and I think that there's a blueprint there that we need to keep thinking about for improving the quality system in such a complicated landscape. I'll stop there and turn it back.

DR. BHANSALI: Mike, I think you're speaking --

DR. CHERNEW: Yeah. If I can just -- if I can just say very quickly. I'm much more skeptical about the entire paradigm around improving quality, I think we need a much more bigger redo. But I'm going to leave that for

Nicholas to sort out.

DR. BHANSALI: Thank you, Mike.

Walter, I believe you're next.

DR. LIN: Well, I wanted to thank our panelists for a really informative and thought-provoking presentation and discussion so far. It's just great, and I have -- actually, several questions. But I'll start with one. And it's primarily for Karthik.

So Dana had highlighted the differential performance at Duly with MA versus traditional fee-for-service for the possible care models. And I'm just wondering, Karthik, through agilon's single Medicare experience for its physicians and patients, if agilon's been able to see a narrowing or elimination of those disparity in outcomes between Medicare Advantage and your ACO REACH Model.

DR. RAO: Yeah, it's a good question. You know, the short answer is we haven't. We still -- so we see narrowing from a baseline of when we started with that fee-for-service full-risk population that we bring it down year over year in working with them, but we still see a delta between our fee-for-service full-risk lives and our MA full-risk

lives. And I think Dana hit on some of the key reasons for why that's happening. I think its relationship with the PCPs tends to persist for longer periods of time, and we know that's generally one of the biggest components of driving behavior change. And so I think it's that.

And I do think, you know, as much as we all kind of point at UM and prior auths, like, some of those are helpful for reducing things like skin substitute spend, and I think there's value in figuring out how can we -- how we can be probably more targeted to reduce some of the abrasion and keep some of the quality improvement or unnecessary spend down in those areas.

DR. LIN: Thanks.

DR. RAO: Joshua.

DR. LIAO: Thanks, everybody. Appreciated those comments. I was -- a few of us on the Committee kind of serve on the base Preliminary Comments Development Team, and I had the privilege of leading that for this meeting. And I was thinking about what you shared and what our team kind of put together. I have a few points, and this is driving to a

question, I think, directed at probably Karthik and Mike, but I'd welcome other, obviously, any and all thoughts here.

So the idea, you know, from some of our work was that, you know, clinicians and authorities don't operationalize care around pilot programs. They're looking to do things that are more system-wide and transformative. Speaking as a primary care clinician as well, you know, you're not trying to target, you're trying to do the best that you can for all the patients that come through. And I appreciated, Dana, some of the comments that I think reflected that sentiment.

In that way, you know, Mike's vivid slide about many incentives and payers coming makes it hard to practice medicine. But one thing I appreciate from Karthik, you -- and I think Mike, you alluded to this as well, is there's actually even more than multiple payers. I think most people think of different public and private payers, but within MA, what I've heard is there are multiple different programs. A couple dozen, Karthik, if I remember your comments correctly. Mike, you mentioned heterogeneity.

So I guess, is there anything, maybe one or two practical things you would say, how should we deal with that thing, right? Dealing across Medicare, Medicaid is something -- public, private something. But just within MA, if different plans present almost different programs, right, and there's a lot of heterogeneity, how should we think about reducing that if Mike's point, which I agree with, having fewer programs is better? Some standardization without losing innovation. What are some pragmatic ways to do that? Be curious your thoughts.

DR. RAO: Yeah. You know, do you -- Mike, do you want to start this one? I maybe --

DR. CHERNEW: No, I don't have an answer. You go, Karthik.

DR. RAO: I surely don't have an answer, but maybe a couple ideas. And so, you know, one of the things that I think about, right, is even if you take an analogy like railroads, they all had a different gauge they were using when they started, and we switched to the same gauge to basically get interoperability across the country. And Josh,

to your point, like, when we think about the senior line of business, like, what are those parameters of standardization that we need? Like, what are just things you have to have? And I think those things you have to have to ultimately promote healthy competition for better quality care and what we're trying to achieve.

I think a few areas where we can remove some of that variation are attribution, like we've hit on, I think everyone's hit on that here today, that creates a world of administrative burden that we have to go chase down. Figuring out how to create common, you know, parameters around that would be hugely helpful.

Two, I actually think about, from a senior line of business, like, what are we really trying to solve with our care models? And Mike hit on this from like, there's a lot of different care models out there, and it sometimes feel like we kind of flip the table upside down every few years. And which creates a lot of change that you've got to go create in a group, and a change story that you then have to tell physicians on why we're doing what

we're trying to do.

And so I think being really clear on what we're trying to do within the senior line of business -- and it could be quality goals, or just a very like specific problem statement that spans different elements of that care model, I think would be really helpful for us in terms of program design and prioritizing what we're able to go and do.

And ultimately, I think it comes down to, you know, going too broad means you're not focused on anything, and we face -- we kind of battle that a lot within our own organization. So where do we really think, over the next three to five years, our biggest opportunities are in that line of business, I think would help create some clarity for a lot of people operating within this space.

And then three, I think this is, like, you know, one of the constant challenges too, but it's data requirements, standardization, and exchange. It's not just us. I think a lot of people spend a lot of effort in this space dealing with different formats of data and creating interoperability within different data systems to ultimately be

able to provide the care that we want to provide. So I'll throw those out as a few ideas, not answers, that others can build on.

DR. CHERNEW: So just a few quick things. First is, in a world that's sort of MA oriented, which is based on competition, you're going to have a lack of coordination across the MA plans, which you kind of want. And so I think just going into this, you have to be humble about how you're going to solve that problem. I would start by trying to identify -- I don't know what they are, maybe others would, what are the most egregious problems, and how CMS might prevent those? The one area that I know there's a lot of work going on at CMS now that maybe Nicholas can speak to is standardizing aspects of prior auth, at least the data needed for prior auth. And I think that ends up being important.

Other than that, I think, as long as we have a bunch of competing MA plans, the MA plans are going to vary in whether they want the providers to engage the patients or they want to engage the patients. Or they want to manage the referrals or the providers managing referrals.

One of the things -- so, since I don't have a better answer, I'll try and sum up with a completely tangential point. Independent of any of this, we need to support the delivery system at large. You can't have a well-running primary care system if you don't have a well-running primary care workforce, and so there's a whole bunch of things unrelated to this topic about just how we manage that. And one of the things that's going on in that space has a lot to do with integration. There's both integration of the primary care workforce with large health systems, I mentioned that briefly. There's also integration of primary care workforce with actually large carriers, including many MA plans.

And in general, at least in my world, that's viewed with some disdain. And maybe appropriately, I'm not arguing against it, but there is some advantage of having an intermediate structure. If you listen to what I think Duly does, and agilon does, and other groups do, they provide some ability to take very different types of incentives coming at the system, and harmonize them, so when it gets down to the actual people providing care, they

can manage the workforce and what happens. And there can be some standardization, or layer, that's not necessarily the layer going in and what -- that's top line layer. But what you need at that top line is you need some harmonization so that folks that are the -- running, say, a big health system aren't trying to figure out, should I be in this MSSP track or what about REACH? Wait, now it's going to be LEAD, but I got new TEAM[45] Model. But you know, if I stay in fee-for-service, I can then get paid with the ASM[46] Model. And maybe I'd -- be better for me if I sorted that out and then -- you know?

There's all these different choices that these big organizations have to make. And I think the more you can simplify those big choices, keep the core paradigm of holding the delivery system accountable for clinical and economic outcomes, you can get to a place that is broadly better and focus on getting rid of the most egregious problems. Maybe you need another meeting on what are the most egregious problems; it sounds like attribution is one in

45 Transforming Episode Accountability Model
46 Ambulatory Specialty Model

many contexts. And just say, you know what? We have a very fragmented health care system. That's the way the American health care system is built. And the fragmented health care system has some pros and cons. And let's just try and amplify the pros and get rid of the cons.

But we're not going to solve harmonization between five or six different MA plans with different benefit designs and different people trying to run what goes on. We just have to limit the extent to which that lack of harmonization causes problems. And that may involve some pruning of types of things that those orgs[47] can do. I wish I had a better answer.

MS. RYE: I would agree with Michael on this one. It -- it's -- we've all heard it's hard to be both simple and fair across all of this, as well, which is probably another problem. But candidly, this standardization of quality metric is not the biggest thing that keeps me up at night. We can overcome a lot of that. It's clunky. It's expensive. It's harder. Karthik was absolutely right about all

47 Organizations

of those things. I also recognize I have a smaller number of payers than Karthik has to deal with, though it's not, you know -- it's probably about a third of what you do, not one. But we can overcome a lot of that if we have the right data.

If we don't have the right data coming in in the right, you know, formats with the right components, then I -- there's no amount of muscle that helps us get through that to the point where it's all seamless for the provider, getting an alert at the point of care to do the thing that we need them to do. So I would encourage looking at standardizing data requirements as a place to start. So to Michael's point, I think that's more realistic than harmonizing quality measures across plans.

DR. LIAO: Yeah, I just -- I -- I'll point quick if that's okay, Henish. I think, I appreciate that. And I ask the question, not having any, you know, perfect answers myself, but I think what I'm drawing from this is that -- and we can bring this up more on future sessions to other Committee members, but the idea that part of the model and competition is part of what we're talking about with MA, so

stepping out completely may not be realistic or even desired. I do think there's a spectrum, though, from my view of kind of competitive ability and product flexibility turning into administrative noise. That's kind of what I'm hearing here, as well. And so finding that right dial is just really important, so thank you.

DR. BHANSALI: Josh. Thank you, everyone.

Larry?

DR. KOSINSKI: Thank you, Henish. Like everyone else, I truly enjoyed the session this morning, and I have to compliment the PCDT and staff for an excellent selection of KOLs[48]. This was really something this morning. I always like to grab a quote from one of you, and I'm going to steal Michael Chernew's quote. It's very difficult to practice medicine when multiple groups are telling you how to practice medicine. Love that line. I think it goes to the heart of our problem today.

The theme of my question here is, you know, we heard from all of you that increasing participation is key to the success.

48 Key opinion leaders

Can we reach critical mass provider participation in a purely voluntary model system? When we look at the landscape right now, Medicare is fully at risk. Medicare Advantage, each of those plans are basically fully at risk. But on the ACO REACH side -- on the, you know, the -- looking at it from the provider's point of view, it's not as cut and dry.

And I would like to ask a lead question to both Dana and Karthik. What percentage of the total revenue of your organizations is currently being derived from risk-based, value-based care? You can answer it a very simple way, minority, majority, without going to a specific number, because I'm trying to make a case.

MS. RYE: We are equal. 2025.

DR. KOSINSKI: Oh, that's impressive. That's impressive. Karthik?

DR. RAO: Yeah. For us, it's actually between 95 and, like, 98 percent. So we are across all of our lives and full-risk global cap.

DR. KOSINSKI: Okay. All right. That last one was a little surprising. But

looking at each of your provider groups inside your organizations, what percentage of their revenues is at risk?

DR. RAO: Yeah. So it's pretty close to what Dana said. 50/50.

DR. KOSINSKI: Yeah. Yeah. And so the -- I -- I'm a specialist. And looking at it from the specialist point of view, the problem always in getting more participation -- maybe this falls into Michael and Nicholas' realm now, that in getting participation is getting those incentives right. On the -- for the cognitive care, are you providing prepaid payments -- your pre-service payments to the providers to build that infrastructure? And are they really incentivized to participate, or can they just crank their fee-for-service revenue from their procedures and not really participate at the same level? How do we move this mountain, Nicholas and Michael?

DR. CHERNEW: So I'm not going to say much about mandatory except the obvious, that if you make things mandatory, more people will be involved. I think -- there's organizations I think should be forced to participate the larger you get. I think it's

very hard to become mandatory when organizations are smaller. I think we can do a -- if we design the programs better, I think you'll get more participation. And I think we have to be cognizant of what we do in fee-for-service that will encourage or not encourage participation in these other types of models.

I actually think with Medicare Advantage growing as rapidly as Medicare Advantage has grown that we actually are doing pretty well at overall participation. I think there's an interesting question, which I, again, don't have a good answer to, about the extent to which you need, for example, hospitals, for that matter some specialists, to be literally on the list participating versus just influenced by the primary care group. I think one of the things we've found, for example, is it's hard to keep people out of a hospital if you're a hospital. So having a world in which the risk is borne by independent primary care groups that can engage the hospitals or move people across hospitals isn't necessarily a bad thing.

So again, I come to these things, and I always get encouraged because hearing all

the stuff that Nicholas is thinking about and what Dana and Karthik are doing, you can see the potential for success here in a lot of stuff that's going on. I think we need to try and stay the course, but that means, in part, simplify the course. Like just -- I think part of the problem is, and what I would take away from this, is too often we get to where we are, and someone sits around and says, okay, where are we? We've made a lot of progress. What new things do we need? What new things do we build? We had a REACH, now we have LEAD. Soon there'll be next-gen LEAD, LEAD 2. You know, there'll be -- there -- there's TEAMs, and then there's going to be ASM. We need something for the fee-for-service specialist that doesn't want to be in the TEAMs Model, but doesn't have something at -- in BPCI[49].

I just think we need to be much more humble about what we can do, and try and build a very basic structure. So again, my view, I would just get rid of -- I would just get -- we can't do this legislatively. I would get rid of MIPS[50]. I realize that's not what we're

49 Bundled Payments for Care Improvement
50 Merit-based Incentive Payment System

doing. Just get rid of MIPS. I would dramatically transform the Stars program. I think it's just making things way worse. You can read the MedPAC reports. I'm not talking for MedPAC, but I think Stars is well beyond, oh, we need to change the payment measures.

I would work on attribution. I would work on some risk adjustment changes. I know CMS is doing a ton of stuff on risk adjustment. Maybe Nicholas is doing all of that. And then I would just try and let the system practice. I think all the groups, like Duly and agilon, and some others. I know Aledade. They are really helping physicians practice in a very, very difficult environment. And I think they need some stability, better data, some stability about what the system is going to be like in 2030. I think if you tell them what the system is going to be like in 2030, they will find a way to make the system look the way you want in 2030, which is different than saying, oh, but we're going to, you know, change it here. There might -- even if we don't change the program you're in, we might put another one in that's better. Or we might take away some. You put a -- build a

program to keep people out of post-acute care. But you know what? We have a new model for post-acute care, and some of those savings are now going to be given to nursing homes, or whomever, right?

I think you just need to be very cautious about how the broad infrastructure changes when you do things. So doing less more simply for a longer time horizon I think is important. And I worry some that our penchant to experiment is problematic, because people don't really want to transform if they're just in a few-year experiment.

DR. BHANSALI: Thank you so much, Mike. I think we are at time. So I'd like to thank all four of our experts for joining us today. You helped us cover a lot of ground during this session, and you're welcome to stay and listen to as much of this meeting as possible or as you can.

At this time, we'll have a break until 1:10 p.m. Eastern Time. Please join us then. We have a great set of speakers for our second session, which focuses on Lessons Learned from State Value-Based Care Models That Have Implemented Multi-Payer Alignment: Part

1. Thank you so much.

(Whereupon, the above-entitled matter went off the record at 12:10 p.m. and resumed at 1:10 p.m.)

*** Session 2: Lessons Learned from State Value-Based Care Models That Have Implemented Multi-Payer Alignment: Part 1**

MS. HARDIN: Good afternoon and welcome back. I'm Lauran Hardin, one of the PTAC members, and we're excited to offer this afternoon two very interesting sessions focused on Lessons Learned from State Value-Based Care Models That Have Implemented Multi-Payer Alignment.

In the first session, we will hear about the Maryland Total Cost of Care Model and the Vermont All-Payer ACO Model. In the second session, we'll hear about the Pennsylvania Rural Health Model and the Arkansas Health Care Payment Improvement Initiative.

At this time, I'm happy to welcome for our next session four remarkable experts to discuss the multi-payer models in Maryland and Vermont. You'll find their full biographies and slides posted on the ASPE PTAC website and

the public meeting registration site.

At this time, I ask our session participants to go ahead and turn on your video if you haven't done so already. All four experts will present, and then our Committee members will have plenty of time to ask questions.

First, we're very excited to welcome back Ms. Katie Wunderlich, who is the Principal of KKW Consulting.

Welcome, Katie. Please go ahead.

MS. WUNDERLICH: Thank you, Lauran, and welcome, and nice to be with all of the PTAC members virtually. My name is Katie Wunderlich, and I'm going to talk a little bit about the Maryland Total Cost of Care Model from the state's perspective. So there'll be other panelists talking more about the provider or other perspective, but really want to give you a little bit more in-depth experience and/or feedback from the Total Cost of Care Model from a state perspective.

So the next slide just talks about just basic learning objectives. I want to try to identify some of the strategies that we used during the model that facilitated specifically

multi-payer alignment and contributed to the success of the model, how those strategies were used to enhance certain parts of the model and to drive success, and third, finally, of course, understanding how these lessons or strategies could be used to inform future developments of value-based care models that align multi-payers in CMS models.

So the next slide, you know, I'm not going to go under -- I'm not going to go through Maryland's Total Cost of Care Model because I know you all have heard lots about it. There have been many evaluations. But just a little bit as a back -- a slight background. We have operated under a CMMI model since the inception of the Innovation Center in 2014. So we had the All-Payer Model from 2014 to 2018, and then the Total Cost of Care Model from the -- from 29 -- from 2019 to 2025.

Really, during that time, the state demonstrated success in reducing total cost of care, reducing unnecessary utilizations, adding enhanced primary care, and developing coordinated statewide population health interventions to drive success. The state

largely met or exceeded all contractual goals, that -- and that eventually led to the evolution under AHEAD, which is where Maryland sits now, under the AHEAD Model within CMMI.

Now, the contract for both the Total Cost of Care Model and the All-Payer Model, they included Medicare-focused metrics. However, there was intentional alignment with Medicaid and commercial payers on both cost and quality metrics that was really crucial for maximum impact and for broadest reach of the model.

So for the rest of this presentation, I want to talk about four specific strategies that I think were really important from the state's perspective to drive success under the Value-Based Care Model, which was Maryland's Total Cost of Care Model, and specifically how -- why it's important from a multi-payer perspective.

So those four strategies here: utilizing existing infrastructure to build on successful care delivery models; creating a governance structure that's inclusive of all health care entities; generating buy-in and stakeholder engagement in both implementation

of the model and then also methodology development as the model evolves; and then, finally, identifying shared objectives for statewide priority to leverage resources and improve chances for long-term sustainability.

So those are the four kind of lessons that I'm going to go through. On the next slide, we'll start with the first one. Really, why it's important and what are some of the examples of how it played out in Maryland.

So the first one, utilizing existing infrastructure. This is so important to understand from a state's perspective: what does the history and context of that state or that region look like? What are the exist -- who are the existing players? What are the existing payment and care delivery chassis? It's really important to understand where states and regions are starting with so that you can build onto successful and already-existing infrastructure for care delivery for different payment – Alternative Payment Models for care coordination.

This really increases the chance of sustainability when it's built on an existing platform. So that would be the very first

thing to really drive home to increase the chances of success.

And how that played out in Maryland. We have a history of an all-payer system. As I mentioned, we had been under CMMI models from 2014. But even previous to that, we had a history of all-payer rate setting systems. So we had a history of engaging and aligning payers within the State of Maryland under regulatory structures and also under health care delivery system.

The other example is our state-designated health information exchange. We are -- the acronym is CRISP[51] in Maryland. But it enabled data to be shared across providers and settings. And this was really important for care coordination and risk stratification as the model developed. It was a really important piece of infrastructure that we had as a state, that we continued to invest in, that was really important -- oh, an important piece of success.

The next slide goes to lesson number two, which is an inclusive governance structure. And governance structures are required and encouraged by many CMMI models.

51 Chesapeake Regional Information System for Our Patients

You know, it -- they are both at the beginning when you are setting up a model, but then work group governance structures to monitor the model as it goes forward. It's so important to have -- for there to be in -- those governance structures to be inclusive of multi-sector representation, multi-payers, providers, health systems, state agencies.

Those governance structures and work groups, moving forward, they really benefit greatly when there is engagement and representation from the different health care sectors. And this really helps to create methodology that's transparent, that can evolve over time as necessary.

In Maryland, there were a number of examples of this, both at a high level, a governor's stakeholder group that was really a very high-level, broad stakeholder group that was meant to kind of be the vision for the model in Maryland. But then there were also ongoing work groups where -- that were attended and participated by payers in Maryland, providers, community organizations, et cetera, that helped to look at payment models. So developing innovative payment and delivery

models that bridge those different specialties between primary care, specialty care, inpatient, post-acute, long-term care. Having representation on these work groups helps to understand what does it look like on the ground? What do we need to change? What obstacles are there? Where can we address issues of operational feasibility as we -- as you roll out models? So really having an inclusive structure, an inclusive governance structure that hears and has representation from many groups.

The next slide is the third lesson that I wanted to kind of talk about, which is generating buy-in through strategic engagement. So, of course, there is buy-in through ongoing governance, but really, as states are looking to add tools or as models are looking to add tools, it's really important to go right to the provider organizations that are going to be delivering the care to understand -- and the payers who will be supporting those providers -- provider organizations to understand how tools can be added.

So why this is important. Of course, strengthening that provider

participation and model stability by getting feedback; addressing fragmentation of care, which we know happens regularly in health care, but engaging payers and providers in that model development helps to address that fragmentation; increasing the chance of long-term viability; again, methodology development, understanding that methodology; and then, of course, creating consistent quality and financial targets for providers to work towards.

So Maryland did this in two strategic tools that it added to its Value-Based Care Model and the Total Cost of Care Model. One was Maryland's primary care program, which we know is a really important element in value-based care to put prevention and investment upstream to improve health. As Maryland was looking to develop that primary care program, it reached out to CareFirst, which is its -- one of the major commercial payers in Maryland, to help identify and align the Medicare primary care program with the CareFirst PCMH[52]. So to help address provider administrative burden for primary care

52 Patient-centered medical home

providers really was important to make sure there was alignment -- strategic alignment for the primary care program.

The second example in Maryland was a bundled payment program. They called it EQIP, Episode Quality Improvement Program. And it really is a bundled payment program for specialists in Maryland. And as the state was putting it together, it is a Medicare -- it's a Medicare program, but they used episode groupers that the commercial payers used to foster that alignment.

So not exactly, you know, a matched program, but the underlying episode groupers they did, the state really wanted to use something that could be adapted by the commercial payers when they were ready. And so really enabling that connection during strategic times as the -- in strategic instances when the model was being developed and when these tools, primary care tool and the specialty bundle payment tool, was being developed.

On the next slide is the next -- the fourth lesson I wanted to talk about, which is identifying statewide or regional priorities

that include shared objectives. And this can really spur engagement and really make limited resources go so much farther. When you identify what priorities and programs payers in your state or region are focused on, then you don't duplicate resources, you can leverage those existing underlying programs, increasing feasibility and long-term success. Really important because we know that states have limited resources, payers have limited resources, so to the extent that we can identify where there are shared and overlapped goals, we can leverage that instead of duplicating.

And in Maryland, I want to talk about two examples of how this played out in Maryland. One was that the statewide integrated health improvement strategy was kind of the quality and population health addendum to the contract, and it identified population health goals and care coordination goals.

And one of the population health priorities that both the state and CareFirst, our commercial payer, had was around diabetes management. It was a driver -- diabetes was a driver of poor quality, poor outcomes, and

increased cost. And we really saw that as an area where we could work together, public and private partnerships working together, to address a major chronic condition in Maryland that would benefit both the residents in Maryland and also the payers, Medicare, Medicaid, and commercials.

And then the other example in Maryland were our regional partnerships in care transformation initiatives, and this encourages hospitals, provider groups, and payers in certain regions to work together on shared goals. There was some state seed funding, but still it encouraged and enabled that collaborative -- a collaborative work for a specific population in a geographic area.

On the next slide -- so, you know, those were the four that I thought were really important to point out to really increase and improve the chances of success in multi-payer models, driving value-based care and total cost of care. And again, just to kind of reiterate some of the themes that I've mentioned. Why does this matter for multi-payers? One, because we want to enable providers to actually be able to implement models. And to the extent

that we can reduce administrative burdens, we can create consistent incentives, we can strengthen that provider participation by aligning financial and cost -- or financial and quality incentives across payers, it really helps the provider community be able to participate more fully. And of course enabling that broad population impact and long-term sustainability for value-based care.

I have just one more quick little slide. This is really towards what -- you know, how can we use some of Maryland's takeaways as we look at what does the future development of value-based care models look like, specifically trying to facilitate multi-payer alignment? Really, that is the key word, is alignment. Having clear shared goals; standardized quality and performance metrics; transparent data; transparent quality and financial methodologies and the development of those methodologies; strong state and regional conveners to make sure we know what's going on on the ground, how can we give -- you know, relay that back to payers and providers; and engaging them early and often.

So, a few of my takeaways that could

hopefully inform and direct some future model developments for value-based care.

That concludes my slides, and looking forward to hearing the rest of the panel.

MS. HARDIN: Thank you so much, Katie. Very interesting.

We're saving all questions from the Committee until the end of all presentations.

Next, I'd like to welcome Dr. Joseph DeMattos, who is the Senior Vice President of Public Affairs at Marquis Health Consulting Services. Joseph, please go ahead.

MR. DEMATTOS: Thank you for the warm welcome. And I wish it were doctor, but it is not doctor. Thank you all so very much for being here. I'm looking forward to hearing more of my colleague presenters, as well. Katie, my friend and colleague, did an outstanding job teeing up our Total Cost of Care Model and its evolution and how we can continue to inform more efficient, better care in the future.

I think the undercurrent word that I heard in Katie's presentation was collaboration. Collaboration at the start, in

the middle, at the end as we adjust. And honestly, I think collaboration in Maryland under Katie's leadership and others really was a differentiator.

But going again in next slides, I'm presenting here based on my experience as the President and CEO of the Health Facilities of Association of Maryland, which I had the privilege of leading from 2009 to 2025. It was at the time the largest, oldest provider association, representing skilled nursing and rehabilitation centers, senior living in Maryland. We had 226 SNFs[53] and then a handful of CCRCs[54] and a bunch of assisted livings.

More presently, I work for Marquis Health Consulting Services. We provide administrative and consultative support for 118 facilities in eight states. Here in Maryland, our campuses provide more than 300,000 days of post-acute and long-term care in Maryland or to Marylanders in need.

Next slide, please.

And so, this I've already covered, but I think the workforce is really, really,

53 Skilled nursing facilities
54 Continuing care retirement communities

really important, that the post-acute workforce in many of the communities in which these 226 SNFs operate, they're the largest employer. And most of those communities, that care provided for, whether it's post-acute or long-term care, to the patient or the resident is closer to the home and to the family members of those patients and those residents. So, with a combined workforce of both direct and indirect of about 72,000 workers here in Maryland.

Next slide, please.

Now, a key, key point, and something that is a historic strength in Maryland, is that we don't have LTACs[55] in Maryland, and so Maryland skilled nursing and rehab centers, SNFs, have been providing fairly high-level post-acute care for close to 40 years in Maryland. We led the nation in post-acute ventilator care in the country. And there were times when we had pediatric long-term care units that were not present in the rest of the country. And that's really important to the throughput that's relied upon by Maryland hospital providers under the total cost of care contract.

55 Long-term acute cares

Next slide.

So, this begins a series of slides about chronic care, and I tremendously admire the work of the physicians on this call and Dr. Howard Haft, who was instrumental in the Primary Care Model under the total cost of care contract and how it was designed and implemented. You know, job number one of these physician-led models is the management, the cost-effective, but more importantly, the clinically efficient methods of reducing, in the case of the Total Cost of Care Model, the number of Marylanders that convert to pre-diabetes to full-blown diabetes.

And the good news is, is that the work that we did on the total cost of care contract made a difference on that front. The bad news is, is that there's still so much work to be done in Maryland and across the nation on bending the clinical incidents and the cost of managing chronic illness in our country. We haven't fixed that yet, and we're not going to fix it on this call, but maybe we can talk about some ways together that we can work towards fixing it.

Next slide.

So, this slide just gets into the specific fact that Maryland is aging a little faster than the rest of the country. And, you know, we decided -- we on this call and the leaders at PTAC, we all decided that this was going to be a virtual meeting, brilliantly so, given the snowstorm. But let me say that just about three miles from where I am presenting on -- for this conference, the life expectancy goes down by more than a decade. Three miles, in Maryland, where we have some of the greatest health care in the world, where we're one of the wealthiest communities in the country, where we have more PhDs in Bethesda than in any other zip code in the country. I go three miles that way, cross over a street, and the life expectancy, due to chronic illness, goes down by a decade.

Next slide, please.

So again, this talks about the fact that we're aging a little faster than the rest of the country. And we are facing both, you know, in economic communities across the spectrum, pre-diabetes is a major issue in Maryland. It is not just a poor person issue or a socioeconomically driven issue. It's

worse in underserved communities. Dramatically worse. It's something that's touched my family directly in that way. But it's prevalent across the board here in Maryland, rural, city, socioeconomically.

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So, I don't do any presentation without reminding people, you all know this on this call, on this Zoom, but you know, the workforce crisis from physician to aide to non-care workers was going to be a crisis. Pre-pandemic, we knew of this crisis. We've been focusing on it as a community. The pandemic shone a bright light on it. But we haven't fixed that yet either. We have not dramatically increased the number of nurse educators in our country. And as a result, we haven't dramatically increased the number of nurses that we need.

That first statistic about Maryland is from the Maryland Hospital Association, and the second one is a national statistic about nurses' aides. And of course, I could have just as easily put up one with regard to physicians, right, where medical schools get tens of thousands of applicants for hundreds of

slots.

Next slide, please.

As a recovering politician, this slide always bothers me the most. We have known that we needed to reform financially Medicare in this country. Social Security, a little less, but Medicare much, much more. We have a national post-acute payment system in Medicare. We still don't have a nationally responsible system of providing for long-term care. It's largely a Medicaid system, relying on our friends, neighbors, and family members to plan and/or go broke in order to have their long-term care paid for in a center-based environment. In a country of more than 300 million people, we have only 15,000 nursing homes and just a little over a million beds. So, this is just a tiny part of the continuum of care.

Next slide, please.

So, getting to that point that Katie was making, and I want to reinforce, and that is that whatever success we have today and going forward, or success that we had in the past in fighting the pandemic, comes from collaboration. And what people, providers, and

payers all seek, in fact, families in our care seek as well, is they seek predictability. They want to know when their family member is going to be better and how much better and where and when and what's going to be their new normal.

And understanding predictability happens at that intersection of having shared goals and buy-in that are both driven by the financial necessities and the clinical necessities of the situation with regard to bending the curve on chronic care in our country. So, it begins with shared goals and predictability.

Next slide, please.

Now, I think, and I -- and also, this first point is one that I always make when I speak publicly post-pandemic, I think it was a huge advantage that Katie and I had each other's cell phone numbers going into the pandemic and that I had the cell numbers of the hospital CEOs and of the long-term care providers and then eventually the National Guard commanders. We all knew each other because of the work we did on the total cost of care and evolving it over that time period. We

all knew one another. We all worked together. We all had tough conversations together. That collaboration, I'm convinced, saved lives during the pandemic. And it elevates the difficulty, the type of -- the kind of difficult conversations that providers can have, both clinical providers and physical spaces, hospitals, nursing homes, assisted living, home health care. Having those relationships and working -- having a history of working collaboratively kind of gives us permission, gave us permission, to have what the authors of the book Critical Conversation speak of, you know, tough conversations where we could get to some meaningful agreement.

Next slide, please.

So, you know, success going forward means that we need to work to establish clear shared parameters for quality, cost, utilization, and outcomes across all payers. Now, we did a really good job in that in Maryland, but where we can advance that work is moving from collaborative sense to an ownership sense. Providers are willing to own upside and downside financial risk, but they have to know what the measurements are and know what the

rewards are and be in a position on the decision-making side to decide how they can affect that with regard to dollars or care going forward.

And it's something that I think Katie and I eventually started laughing about, but moving from a transactional vendor relationship to a long-term strategic continuum of care partnership ownership, you know. So, we so often look at the cross sort of professional on-care being the physician and the nurse caring team and the platforms, let's say, being hospitals, nursing homes, assisted living, home health, and those levels of care. We look at them as upstream and downstream and kind of vendor relationships.

And instead of looking at them as upstream and downstream, looking at them as one stream, where we're not actually vendors, but we are full ownership partners, that's sort of what the future looks like. And that's why I'm really excited to learn more about the Vermont ACO Model, and that's why I'm excited to continue my work with Katie on the AHEAD Model, because I'm convinced that that's part of the success of those models.

Next slide, please.

So again, you know, one of the things that we have going for us in our various sectors right now, and I'm really proud of in my current position with Marquis Consulting Services, is the disease management programs that various operators across the country, including Marquis, have put in place. So, physician-led chronic disease management programs that are managed across the continuum of care with our acute care partners on congestive heart failure and pulmonary disease and diabetes. And I'm just excited that -- on the work that we do. And I'm excited that that work has been augmented by those providers, but only about 20 of them in the country that have instituted I-SNPs[56]. Again, I'm a huge fan of I-SNPs, but one of the barriers is, is the state-by-state regulation on the insurance model and the cost of putting capital up front, which excites me more about, sort of, the ACO Model going forward, right.

Now, right now, I'm also excited that in our sector we're using AI pretty dramatically to determine risk and clinical

56 Institutional Special Needs Plans

match with regard to patient selection. But that's only one use of AI, and I'm excited about expanding the use of AI across the entire continuum of care. But most specifically in the post-acute long-term care environment.

Next slide, please.

So again, this is, I think, getting down to the near -- second to the last slide. You know, we have to serve as true partners at the intersection of quality and cost. It can't be quality, period. It can't be cost, period. It has to be quality and cost. We have to commit in advance to shared opportunities and shared risks, and getting back we have to collaborate to define what success looks like in advance with regard to metrics, financial accountability, and reinvestment strategies.

Next slide.

And then, this is just a synopsis of my methodology and sources for the slide. So, with that, I look forward to hearing my fellow presenters and to the Q and A period.

MS. HARDIN: Thank you so much, Joseph. Again, really rich content. Looking forward to asking questions after each of the presentations are over.

Next, we're very pleased to welcome Ms. Ena Backus, who is a Senior Consultant at Freedman HealthCare. Ena, welcome. Please go ahead.

MS. BACKUS: Thank you so much. My name is Ena Backus. I am a Senior Consultant with Freedman HealthCare. Freedman is a focused independent consulting firm dedicated to improving health care access, affordability, equity, and equality. And in particular doing so by empowering our clients with actionable data.

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While I am a Senior Consultant with Freedman HealthCare now, I was previously the Director of Health Care Reform in the State of Vermont. And prior to taking on that role, I was the Chief of Health Policy at the Green Mountain Care Board in Vermont and played a role in negotiating and implementing the state's All-Payer ACO Model agreement with CMMI.

We can go to the next slide.

For my conversation with everyone today, I'm going to talk first about the All-Payer Accountable Care Organization Model

agreement and give you a high-level overview of its multi-payer parameters. Then I'll take a step back and talk about the State Innovation Model grant and how these funds, which were awarded to Vermont in 2013, helped to lay the groundwork for the All-Payer Model. I'll touch on a lot of the themes that Katie and Joseph covered in their presentations relative to governance, buy-in through strategic engagement, collaboration, and the state's role in supporting multi-payer alignment. And then I'll talk about implementation of the ACO Model agreement and some of the challenges and opportunities in that work. And also circle back to some of the structures that the SIM grant and the state initially supported and may have promoted continuous improvement and alignment across payers and state partners, had these structures been utilized more consistently through the performance period. So, we can go to the next slide now. And I'll provide an overview of the All-Payer ACO Model agreement.

Vermont certainly followed in the footsteps of Maryland in working with CMMI to develop a state-specific alternative payment

arrangement. We worked collaboratively with CMMI over a number of years, informed by the work that was going on in the State of Vermont with the SIM grant to put together a statewide transition to value-based care that was really based in these pillars. Moving away from fee-for-service reimbursement was a key component of the agreement. Aligning payer programs for ACOs in the value-based model was another critical component of the all-payer agreement.

As well as scale targets. And scale targets were both necessary for ensuring that enough people were attributed to the model for there to be benefits for providers in terms of alleviating the administrative burden, having a common incentive across payer groups. But the scale targets were also very ambitious and were a component of the model agreement that was difficult to achieve, given the state's regulatory purview over the self-insured payers in the state in particular.

The model agreement also included all-payer and Medicare total cost of care targets, and these were consistent with the state's overall total cost of care targets. There was a per capita expenditure growth

target of 3.5 percent over the model agreement period, with a ceiling of 4.3 percent. And then there was a specific Medicare growth target included in the agreement, as well, so that the state's Medicare spending would stay slightly below the projected national average over the five years of the agreement. The agreement also included ambitious population health outcomes targets, which included increasing access to primary care, decreasing deaths due to drug overdose and suicide, and lowering the prevalence and morbidity of chronic disease, specifically COPD, diabetes, and hypertension.

We can move now to the next slide.

And as I said, the State Innovation Model grant was a really key component for providing the groundwork for the state to enter into the All-Payer Model agreement and to develop its aligned priorities and requirements for participation -- for participating in such an ambitious model. The SIM grant for Vermont provided $45 million for the state. And these funds were utilized to create a pretty comprehensive system of work groups and initiatives that were really testing value-

based payment arrangements, and also providing a convening structure for stakeholders across the continuum. These stakeholders, including payers, health care providers, community providers, state officials were overseeing the convening, and these were critical pieces into developing aligned structures for -- and these would ultimately inform the all-payer agreement. So, these included work groups that were focused on payment reform and incentive structures. And these work groups really delved into ACO infrastructure development, shared savings programs alignment, value-based payment models, and the eventual evolution into the ACO Model.

SIM structure also supported care integration and care coordination. And this included practice transformation support, care coordination capacity building, regional infrastructure strengthening, linkages with the existing blueprint for health in Vermont, the patient-centered medical home. And the SIM infrastructure allowed for clinical and economic data, health data infrastructure expansion, the adoption -- supporting the adoption of electronic health records for those

practices that had not adopted them previously, interfacing, building analytics capacity, and building standards for data, data standardization efforts.

And just some examples of what was accomplished through these work groups. And there were, like I said, multiple simultaneous work groups that were being supported with state officials, contractors, meeting on a regular basis, working collaboratively and in partnership. And they were focused on government -- governance requirements for ACOs, payment methodology and calculation of shared savings and risk payment for ACOs, patient attribution for ACOs, and financial stability provisions for ACOs, as well as significant work on quality and performance measures to align across payers participating in ACOs. The standards were developed initially for the shared savings program, which was also implemented in Vermont with alignment across Medicaid, commercial, and Medicare. And this really was the springboard for aligned standards for the ACO Model.

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So, I just covered some of the

standards, but here we can see in more detail there -- these standards were developed. They included governance, payment methodology, payment attribution, financial provisions, and quality and performance metrics. What I think is really important about this work was that the work was convened, supervised, encouraged by the state. There were funds available for contracted support through the State Innovation Model grant, and everyone was at the table to align in these standards and requirements. That means that commercial payers were at the table, providers were at the table, as well as the state Medicaid program. And this is really what fostered the state's ability to then pursue the All-Payer Accountable Care Organization Model agreement.

And we can go now to the next slide.

The regular work group participation funded through the SIM program created shared understanding, collaboration, and an opportunity for payers and providers working together in the state to move away from fee-for-service, to workshop one another's ideas, and to troubleshoot and engage in continuous improvement. These structures were not in

place for the entirety of the agreement. And those structures may have enabled more coordination and more ability for addressing some of the challenges that came up, had they been maintained throughout.

Some of the challenges -- and I know that my colleagues at OneCare Vermont will likely talk about these challenges as well, but there were some critical challenges with the implementation of the model. One challenge was fidelity to fee-for-service. The model was really rooted in moving away from fee-for-service. When we were doing the work to negotiate the agreement, we understood that Medicare would be offering the Medicare Next Generation ACO program, and that program would move aggressively away from fee-for-service. However, when the payment methodology was finally specified, there was a full reconciliation still for Medicare to fee-for-service. And that was more rigid than what we had expected and was certainly a challenge for aligning across payers, whereas the state and the Medicaid program in the state had moved fully to an unreconciled prospective fee-per -- prospective payment.

Another component that posed a challenge for implementation of the agreement was stakeholder participation and the scale targets. And these scale targets, as I indicated, were very ambitious, but there was also, I think in part due to the way that the model was being implemented, perhaps there was not enough stakeholder engagement to support the scale targets throughout. Keeping the payers at the table was a really important component. Bringing the payers to the table is also a really important component to implementing the Vermont All-Payer ACO Model agreement, and the structures were not maintained throughout the entire performance period to keep everyone at the table.

Scope creep was another challenge for model implementation, meaning that the All-Payer Accountable Care Organization Model agreement, which was being implemented with one ACO participating statewide in the state, was really looked at as a solution to all of the issues for the health care system at once. And that was a difficult piece for the ACO to negotiate in terms of being able to maintain focus, on improving value, delivering higher-

quality care. And also, another challenge was the patient perception. This was a very high-profile implementation in the State of Vermont. Many people were aware that health care reform was happening through the All-Payer ACO Model agreement, but we're unable to understand how those changes in care delivery were impacting them.

And so, those were challenges for implementation. There were many opportunities as well, and there were many good outcomes to the implementation of this model. I think that my colleagues at OneCare will talk more in detail about the savings that were generated for the Medicare program in particular, the quality improvement gains that happened through the implementation of this model. And I also think that this scale of participation does speak to the state’s support for collaboration over the period of time leading up to the agreement, and then throughout as well.

But eight hospitals out of 14 participated across all-payer programs in the agreement. The primary care model that OneCare put into place was extraordinarily successful. It aligned multi-payer payment reform and

provided predictability and flexibility for primary care providers where there had not been previously. The data and analytics, in part accelerated through the SIM process and the work groups focused on data analytics and also through the ACO's implementation, really provided for improved data and analyses for transformation. And there was better access through the implementation of the agreement to more appropriate levels of care, particularly facilitated through the waivers that were available to the ACO. And those waivers similarly allowed for OneCare to leverage its very large statewide network across the continuum of providers.

And so again, I'll close my presentation by emphasizing that in order for there to be success with all-payer or multi-payer reform, there really does need to be, I think, a very clear focus on multi-payer alignment, the carve-out of time, and time and focus on work group activities, state supervision to bring people together and keep people at the table in terms of staying aligned over time.

Thank you. I look forward to the

discussion.

MS. HARDIN: Thank you so much, Ena. Again, really valuable content.

We'll be diving into questions after this next session. And I'm very honored to welcome OneCare Vermont's Chief Medical Officer, Dr. Carrie Weigand, and Chief Executive Officer and Chief Financial Officer, Mr. Tom Borys. Welcome, Carrie and Tom. Please go ahead.

DR. WEIGAND: Thank you very much. We appreciate this opportunity. Like Lauran said, I'm Dr. Carrie Weigand. I'm a family physician. I've been seeing patients for more than 25 years in the same practice in Vermont and still love it. And I'm also the Chief Medical Officer at OneCare Vermont. And I asked Tom to join us today, too. I'm so glad he has. He's going to go first -- more about the operations of the ACO. And I will go after him and share more about the clinical aspects of the ACO that we've been working on in the past few years.

I want to say thank you to Ena. I think she did a great job of setting the stage for what we want to talk about. We were told

we had 10 minutes, so we may not be as detailed as you would like. I think we will be able to answer questions in the question session later, and always happy to come back if you have more questions. I think you are going to hear some repeat themes that were shared by our Maryland friends, and I'll turn it over to you, Tom, to go next.

MR. BORYS: Great. Hi, everybody. Nice to speak with you today. So, a little bit of context for OneCare Vermont. OneCare is an administrative entity that manages multiple Accountable Care Organization or ACO contracts on behalf of provider organizations. We've been referred to as the ACO in Vermont for years. I actually don't think we're the ACO. The provider groups are really part of the ACO, but our job is to run and manage the complexity within ACO contracting.

Organization was formed in 2012. And we simultaneously manage Medicare, Medicaid, and commercial arrangements throughout our history. And our market was really the State of Vermont, a little bit of New Hampshire as well, so we had a broad reach in the region. In 2018, the Vermont All-Payer

ACO Model initiative began. It's a complex arrangement, but when you really boil it down, to me, it's a test of scale. And ask the question, if ACO participation is spread across a region, will cost growth slow and quality improve? So, that was, kind of, the hypothesis of the program itself. As such, we positioned OneCare as a come one, come all ACO, in spirit of the APM's, All-Payer Model's, goals. Ena spoke of the scale targets, which were targets for a number of attributed lives. So, in spirit of that statewide goal, we really invited anybody to come in, as long as they're willing to contribute and put in the effort.

What's a little bit unique is that we're technically not a signatory or a party to the Vermont All-Payer Model agreement or contract, but our work slotted in underneath that. And happy to talk about those dynamics a little bit more. The All-Payer Model in Vermont ran through the end of 2025. There are, I think, thoughts of transitioning to the AHEAD Model, but that didn't happen seamlessly in the State of Vermont. And OneCare is actually in the process of winding down business operations now, so we're just going to

-- concluding our '25 business and then we'll turn off the light sometime later this summer.

Next slide.

Multi-payer alignment, is it worth the effort? Yes, with an exclamation point. I think it's a great goal to pursue. The benefit of aligned ACO or really other value-based care arrangements is that it gives providers a more holistic operating paradigm. That's really important. And when these initiatives are aligned across payers, the care delivery approaches will be more patient-centered rather than insurance-centered. And if a provider has to look up a patient's insurance to know what to do or what to prioritize, I think we've missed the mark. And really just to, kind of, move those dynamics of who's insuring the patient to the back and moving the patient forward is a good goal to aspire to achieve.

Once you get some multi-payer alignment, other opportunities start to show up. There's new opportunities for collaboration and relationship building between separate provider organizations, especially if you're under one ACO umbrella. There are opportunities for pilots and innovations that

start to make more sense when everybody's all -- you're all in the same programs and have alignment across the different payers. Opportunities for payment reforms. We designed and operated a program for primary care that blended their Medicare, Medicaid, and commercial revenue into one monthly fixed payment. And that was a really successful initiative for us and simplified revenue generation and management for primary care practices. And then you can also redirect funding within the system, move it to high-value areas like primary care or skilled nursing facilities or home health care, to help build the foundation of a strong and high-functioning health care system.

Next slide, please.

I think this visual is really important. Structure matters a lot here, and I think a centralized entity is recommended, if not essential to do this. One of the barriers to multi-payer alignment is contracting. The visual on the left shows the contracting model without a central entity where every payer needs to independently contract with every provider organization, and it becomes this

super complicated matrix of contracts that is burdensome everywhere. For the provider organizations and upstream for the payers as well.

So, when OneCare installed itself in between the payers and the providers for this type of work, we simplified the contracting model, and it enabled us to grow and build a broad network very quickly. So, we would have every year one contract upstream with Medicare, one with Medicaid, and then one with each commercial insurer who wanted to do business with us. And then we would singularly contract downstream with the provider organizations, and it made it much easier for especially small or rural provider organizations just to sign up once with us, and we would, kind of, manage the details with the payers on their behalf. A huge administrative burden relief for small organizations who just don't have the time, expertise perhaps, capability, to engage in negotiations with each payer. So, I think this is a really important concept, and I like this visual to show how it can really be streamlined and much more efficient if there's an entity like this in the middle.

Next slide, please.

So, challenges. First, is it takes significant administrative effort to do this work, and the work shouldn't fall to the small practices or organizations delivering the care. So, that was really the idea behind OneCare Vermont is it's an administrative entity, would take the burden of those contract negotiations and all the details within so that the provider organizations didn't have to manage that themselves. There needs to be a broad willingness to commit, invest, innovate, and collaborate. This is hard. First, you got to fund this work. Because as I said before, it takes a lot of effort. It doesn't happen for free. So, there needs to be a funding model and a commitment to support the organization. I think it's really important that insurers, that's all of them, Medicare, Medicaid, and commercials, flex and customize in spirit of alignment. This can be really hard, but when, you know, a payer has a very rigid idea of what they want to do, and it's different than what another wants to do, that -- that's a barrier or problem.

Buy-in from all sectors, that

includes payers, providers, regulatory entities, state government, is really important so that everybody's working towards the same goals. And I think to get to this space, it might require a push from state or federal policymakers to just, kind of, nudge everybody there. I mean, these aren't really novel ideas in a lot of ways, but sometimes a little push is really important to get everybody on board, put aside their own personal priorities a little bit, and focus on the greater good.

Next challenge is consistency and stability over time. We found it's really important. If you're constantly changing, it's a distraction and hinders progress. And I think that was actually a value of having OneCare as a centralized entity is that we could push back a little bit on the payers from constant change and say, no, we actually want to stay the course and continue focusing on high-priority areas in Vermont. One being hypertension, for example. That was something that we really wanted to stick with over time and ensure that that was in the suite of quality measures that we passed down to the providers, rather than changing them every year

or two.

All right. Next, I'm going to hand it over to Dr. Wulfman.

DR. WEIGAND: Thank you. I changed my name recently, so you can call me Dr. Wulfman or Dr. Weigand. I -- I'll answer to both. Thank you, Tom.

So, we certainly don't have all the answers. And again, some of this will sound like a repeat, but we want to share some more of our experience and observations with you. First of all, gaining alignment is a big lift. It isn't easy, as everyone else has already said. We made progress in this regard. We convened some multi-statewide conversations on controlling hypertension, for example, and social needs assessment. And those were very successful. But in my opinion, we didn't really reach our ideal state. I wish we could keep going and working with this model because we did make some progress on alignment for sure, but it takes building trust and building relationships. And that takes time.

We cannot underestimate the factor that motivations to do this work differ. So, they differ from the payers, who focus a lot on

money. The government, who focuses also on money and hopefully quality. Very important to them, too. But also, on policy and who's in charge, and sometimes that gets in the way in my opinion. Patients also. Somebody else mentioned this already. Patients need to understand this. They need to understand that we are trying to make the system more affordable for them and more accessible for them. And I think we have a ways to go on educating the patients about what health care reform is and how it can benefit them.

And then let's not forget the clinical care staff, all levels. They also really, in my opinion, didn't come to a full understanding about this work during the last seven years. They are focusing on providing the best care possible while trying to maintain their work-life balance, not become burned out. And then also, they want to receive a livable and fair income. So, those are some of the factors behind what motivates people in the different sectors.

Building trust and relationships, again, takes time, and I think we have to be consistent. We found that the consistency is a

little difficult to achieve when roles change frequently. You know, programs change, priorities change, there's policy turnover. So, like others have said, consistency, shared priorities, coming together and collaborating on a regular basis, those are required.

Attribution was a difficult factor for all parties in my experience. So, patients, clinicians, administrators, EHRs, it was, kind of, confusing to know who was attributed and who wasn't. And then how to look that up was also cumbersome. So, I recommend that aligned models minimize this confusion. Clarify the attribution. Make everybody attributed. Somebody else already said this too. Busy clinicians don't want to look up whether somebody is attributed or not or what their insurance is. We need that to just be in the background. And so, we worked on this, and we achieved it, but it was a little clunky, and I think it could be smoother.

How does a multi-payer plan share data and analytics and who pays for it? That's another big question. I think we made progress on that. I know most states have a highly

functioning HIE[57]. I personally feel like ours has made progress and could be even better. Sharing data sometimes feels conflicting. I think clinicians, in particular, are very protective sometimes of their own data, their own patient data. And so again, that takes building trust and understanding the reason behind why we need to share the data. The data has to be secure obviously. That's expensive. Who owns the data? Who governs the data? And again, who pays for all of that? Technology is very expensive. And besides labor, I think that was our most expensive component in running the ACO.

So, I would like to speak a little bit about oversight of the ACO, or lack thereof. I think that also really matters. And I'm happy to say we had a very supportive board of managers throughout, as far as what I could see. I think our leadership was excellent. Parent companies need to believe in and support this work. And I think we were also fortunate in that UVM[58] Health Network and Dartmouth, who were our two parent companies in

57 Health Information Exchange
58 University of Vermont

the beginning, were extremely supportive and eager to work with us on this project.

In Vermont, we have a unique entity that Ena already spoke about. And in fact, she worked with the Green Mountain Care Board in the past, and that's a unique case for us. They oversaw our budget, and they also required a very detailed annual certification process, which I think is pretty normal for ACOs. And we spent a ton of time on that every year. And I think it's fair to say that we would've appreciated more positive support from our oversight governing entity. All of these leadership entities should ideally believe in the structure, understand the requirements of the operation, be willing to back it financially because it is expensive. You cannot get experts in the field or the technology you need, you know, on a little bit of money. It's expensive.

And I think it would be ideal if people working in leadership to oversee ACOs and models like this had some kind of background in the health care delivery setting. I find that firsthand health care work experience can bring valuable insights. So, I

would love to see more experienced clinicians participating in health care reform. I think if you're explaining, you're losing. And if you're explaining, you're certainly wasting time, so it would be great if, you know, we had even more health care experts who wanted to work on the health care reform.

I think we're ready for the next slide.

So, during our tenure, we did witness benefits in value, and I don't want to underplay that. We gained alignment, we gained efficiency, and we were able to innovate. So, over time, the providers did collaborate more and more. We had the visiting nurse associations, mental health associations, area agency on aging, primary care, whether that be hospital-owned, independent, or FQHCs[59], all collaborating.

And in some of these multi-state collaborations, we had the Department of Health, we had Medicaid leadership all at the table talking about how to work on hypertension control, for example. And so, that was wonderful. That was unique. And probably in

59 Federally Qualified Health Centers

my experience, the most pleasurable part of this work.

We did get payer buy-in, but you heard already that that varied, especially in the commercial space. But I want to say that Vermont Medicaid was a part for the entire seven years of the All-Payer model. And we really enjoyed working with those people.

Patient confidence struggled, I think. More education is needed for the patient population at large on what we're doing. And we need simple ways to explain the benefits to them.

We did have a patient and family advisory committee, and so we got some input from our patients and families, but I think we just barely scratched the surface as far as educating the patient population.

In quality, also mentioned earlier, we were able to gain alignment across the payers in the list of quality metrics that we wanted to work on. And I think because of that, we made progress. So, some of the areas we made -- especially made progress in are chronic disease, conditions such as diabetes control and hypertension control, as well as

preventive visits across the board, all ages. We improved in all those areas over time.

In the area of efficiency, we made some progress in shared data and analytics. Again, more progress could be made, but we were able to move the ball and our quality effort consolidation, I already mentioned. And Tom talked about our unified payment streams. I think he did a good job. I love the slide showing how we diminished the number of contracts required.

In the area of innovation, we were able to -- as we gained alignment and efficiency in the areas listed above, we had more time and energy to work on innovations and try new things.

And you heard about our waivers earlier. I'll mention an example, the skilled three-day -- the three-day skilled nursing facility waiver that allowed us to admit patients to rehab without a three-day hospital stay was an amazing focus of ours. And since the end of the pandemic, more than 300 patients got admitted to rehab without a three-day stay. And that saved we calculated at least $2 million. So, that and many other waiver

projects were exciting.

And we also were able over time to really hone our population health model into a streamlined model. So, we integrated our care coordination requirements, mental health care screening, and provision of care, and social needs assessment as requirements into our quality program. And so, our members had to be focused on those areas in order to have access to any of the incentive funding through our population health model.

So, those are just a couple of examples of the innovations that we started and we got involved in closer to the end of our model, because we had freed up some time and energy, so we could work on those. Much more we could say, but I think our time is up, and I'll turn it back to you, Lauran.

MS. HARDIN: Thank you so much, Carrie, and some really, really valuable information and also personally, really interesting. I'm sure we all crossed paths at the beginning of the SIM model, so it's really exciting to see all the development.

So, now we're going to open the discussion to Committee members to ask

questions for the next 20 minutes. And for -- in the interest of ensuring balance for our experts, we just want to encourage you to keep your comments to a few minutes so we can get to as many questions as possible.

So, I want to open it up to Committee members. Encourage you to raise your hand if you have a question. I have many. So, if you don't jump in right away -- oh, Krishna, please go ahead.

MR. RAMACHANDRAN: Oh, this is fantastic. No. Thank you for hearing -- your comments and the presentation, really fantastic perspectives there. So, appreciate it.

I think the one thing that stood out was this sort of the we are moving at the speed of trust to some extent, right? Like, it's a -- the alignment always has, like, the human and trust elements within all the stakeholders there.

Any sort of, like, guidance or recommendations on how do we speed up that alignment and trust? And I'd love some perspectives on that. I know it's, like, a hard question, and this is such a human behavior thing, but curious to see if there's

any -- if you could do this again, like, what would you do to make it faster? I'd love any perspectives on that.

MS. HARDIN: Tom, please go ahead.

MR. BORYS: Yeah, great question. I have a few thoughts. So, first is at least in our experience, having the Vermont All-Payer ACO Model program come to life was that policy push that I think helped tip those who are kind of on the fence say, all right, we'll jump in.

And when we were growing our network, I remember, you know, talking to hospitals or primary care practices, and they'd finally say, okay, we'll jump in. But, you know, don't tell us what to do kind of thing. But over time, the trust built up once they understood our intentions.

But I do think that that policy-level push, to get those who are on the fence who might otherwise kind of sit back and wait to see what happens to others, was really helpful for us to grow and get more participants in our network.

MS. HARDIN: Ena, please go ahead.

MS. BACKUS: Thank you. I was just kind of looking back on how long ago we started

on this work, which really was around 2013, where we said in Vermont, we want all payers at the table for payment reform. And we want to understand which payment reform models are going to provide the most bang for the buck and move towards the Accountable Care Organization Model because of its inclusiveness across the continuum of providers.

I think that we struggled with trust building in some ways, and also we benefited in other ways. The state political climate when we were getting going, had just been really focused on single-payer system for the State of Vermont.

And I think in the wake of that single-payer effort, there was a lot of excitement and willingness for providers and payers to come to the table together to do something other than single-payer that could provide some savings and improve quality and access for the people of the state. So, I think that there's also that overlay of the political climate that is very important in terms of what kind of trust and how you accelerate that trust building.

And I'll emphasize again that

meeting regularly with the stakeholders is incredibly important. We had a series of meetings in Vermont that were called the Monday morning meetings. And it meant that every Monday morning, the payers, the providers, state officials, and community agencies were all together around a table, working on those standards for the Accountable Care Organization.

And that -- it had to be very consistent. It had to be a very regular interval of time, one week in between, and progress had to be shown between all of those meetings. And when there was less of that intensity, I think that that's when we started to see more drift.

MS. HARDIN: So valuable to hear the specificity.

And then Katie, you hand your hand up, and then Joseph, and then we'll go to another question.

MS. WUNDERLICH: And so, this is just a real quick add-on to what the other two just said is transparency. Consistent transparency, even when there are challenges, even if there's a challenge to what you're

trying to do, being consistently transparent to the extent possible, really helps to continue to build trust and relationships so that they don't -- people don't think you're doing something in the background or not really bringing everyone along. Thank you.

MR. DEMATTOS: Yeah. Katie nailed one of my five that I was going to share. The five that I would share would be regular formal and informal discussions. It goes back to the idea of being transparent across all settings, across all conversations. But you sometimes -- you want to share concerns and process them if -- privately, if they're going to derail the group discussions. So, formal and informal touches.

Being data-driven is huge. Huge, huge, huge. Focus on being driven by the data. And I've already quoted the book, Crucial Conversations. I'll quote Getting to Yes by Ury and Fisher. Reinforcing conversations that are based on shared interests and not individual position.

MS. HARDIN: Valuable advice.

Let's go to Larry.

DR. KOSINSKI: Great session. I'm

always learning in every one of these sessions. Multiple members talked about data. And Joe, you just -- Joseph, you just mentioned data in your answer.

There's a new term out today and it's called SaaSpocalypse. We are in -- AI has created a situation. We are in the apocalypse of SaaS[60] providers. You have to own the data, you have to control it. The data has to be, you know, data by consent. That's the most valuable data. So, in your models, who owns the data?

MS. WUNDERLICH: Well, so Larry, I think that's a really -- I'll just take a quick one.

And I'm sorry, I didn't put my hand up, Tom, so I jumped ahead of you.

But, you know, I think that's really part of where the governance structure comes in, because there's certainly state-based all-payer claims databases or HIE that can get funded through and the cost absorbed through the state or some kind of broader mechanism, broader state mechanism. But the data is so important, and it's so important to share the

60 Software as a Service

data.

So, I -- you know, I am with you in terms of how do we make sure we understand who can share, who owns it? In Maryland, that was really important to have a state infrastructure and, you know, having a state health care good that could build a data infrastructure so that providers could share, especially providers that cannot build their own.

So, if they can't put together their own HIE or their own Epic, other -- you know, the providers that can't really -- don't have the kind of means and resources to have a sophisticated data system, important for the state to be able to support that.

MS. HARDIN: Super important comment.

Tom, and then when you're done, if you could pass it to Ena for comment.

MR. BORYS: Sure. I like that term, SaaSpocalypse. I'd have to remember that one, but yeah, it's a great question. I think my answer's going to come from the ACO perspective, but when you sign an ACO contract, they basically fill your life raft with a bunch of data and push you out to sea and say, good

luck. So, it's the most important tool you're given and how to use it well, and how to leverage it well, is a critical problem to address.

For us, in Vermont, we kind of became the de facto data entity because we had these contracts with all the different payers, and we aggregated them into a system, which was a SaaS system. And the data governance work is incredibly complicated and important. But also ensuring the right access is available to participants in the network is really hard and often layered and cumbersome, establishing who has that care relationship when multiple providers out there clearly do.

So I think it really should go beyond an ACO. I can argue that it would be much better to have a really strong state-level HIE rather than ACOs that can make these data available to participants in a governed way and a really thoughtful way.

Because when it's done through an ACO, it's just the attributed lives. It's just for the payers that are contracted. So what we did, I think, was effective for our use case, but it could be done better at the state level,

in my view.

MS. HARDIN: Go ahead, Ena.

MS. BACKUS: Thanks. You know, I think what Tom just said is really interesting in terms of the ACO kind of becoming the collection point for the data. And absolutely, it required it to do its work, but it wasn't -- when we were talking about having a statewide all-payer model, that was really focused on the total cost of care for the population, whether they were attributed or not attributed to the ACO, having a broader source of data was very important for that reason.

And as Vermont now transitions from the All-Payer ACO Model to AHEAD and thinking about the Medicare data that's so critical to potentially working in the AHEAD Model, there's a real difference in where the Medicare data may come. The claims-based data may come to the State of Vermont rather than to the ACO. And for the State of Vermont to then have to integrate with other data types is the question and how they pursue that work.

MS. HARDIN: Thank you.

Lee, please go ahead.

CO-CHAIR MILLS: Sure. Ena,

something you said kind of perked my ears up. We've been talking about, you know, the importance of transparency and shared interests. And I mean, that's all about how you get people to the table. And I would love to have that conversation for another hour from you all's experience, just based in the state where major payers and/or providers aren't even willing to even say what their interests are because that's competitive advantage and they're not going to go there, right?

But assume you get them to the table, and you made the comment about, you know, it was hard to keep everyone at the table. And maybe towards the end, there was less at the table than when you started. And so I would just love reflections on, with that experience behind you, what types of strategies and discussions would you use to try to keep full involvement at the table throughout the full process?

MS. BACKUS: Well, I do think learning from the intensity that we had at the outset of, again, very regular meeting cadence, the state being a supervising entity in the room for that. And then you know, I think that

was all pre-implementation, that regularity of meeting and intensity of cadence with the state's involvement.

And then I think that there was sort of an approach for implementation that was more like, oh, well, this is provider-led reform. And so, maybe the state backs off on this kind of engagement and partnership ongoing on a day-to-day basis, and puts the model into the hands of the providers to implement.

But I think what you've heard from Tom and from Dr. Weigand as well is that, you know, maybe more of a push would have been helpful over the course of the model, over the term of the engagement. And I think that that may be a key learning that the state's role really needs to be consistent, ongoing, and throughout.

CO-CHAIR MILLS: Okay.

MS. HARDIN: Would any of our other presenters like to comment on that question?

DR. WEIGAND: I would agree with that, and I felt that while I've been working at OneCare. It'd be really nice to have more support from the state and not, you know, shoving it down the provider's throat, so to

speak. But, you know, being a cheerleader -- you can do this, you know, let's work together. Being a really positive force, but also requiring it. Requiring those ongoing weekly meetings, requiring alignment, requiring the payers to stay in, I think would've contributed to more success.

MS. HARDIN: I'm going to add a follow-on question to that. So I'm going to quote your line, Joseph, that what we're trying to move people to is from transactional to partnership models. And you've all referenced some type of convening infrastructure, some kind of regular integration, some kind of regular communication, ongoing relationship building and competency building.

And I'd like to ask each of you what you've learned about what types of investments are needed to continue that sort of regionalization convening ongoing into greater role, really, infrastructure, including do you see things such as Medicaid waiver programs or others supportive to that kind of infrastructure?

I'll open that up to all the experts. How would you find the answer going

forward?

MR. BORYS: I'm happy to jump in. I actually have one other thought about the previous question, just to go back really quickly. But one of the lessons in Vermont was that the Vermont All-Payer Model is a test of scale, and that was set up based on attribution, number of attributed lives.

And you all probably know, attribution has a purpose, but it's highly flawed. There are people that fall through the cracks all the time. I actually think it should have been based on the provider participants.

So if I was setting up a new state level initiative, I wouldn't use attribution as the basis, really. I'd try to get a critical mass of providers to be in this. And had the model been set up that way, I think it would've been viewed much more successfully in Vermont.

On the finance front, I'm jumping as I'm going, money talks, whether we like it or not. So in our model, we often -- I believe this is the right thing to do anyway, but we would give out some sort of a base PMPM[61],

61 Per-member-per-month

particularly to primary care. And then we'd have PMPM opportunities that they could earn based on outcomes and results.

And we changed the blend over time, started off with more free money, if you will, and then moved it back over time. And that worked pretty well for us, but it is a heavy cost burden, and we're funded by hospitals in Vermont.

And as the hospital financial situation got worse and worse over time, due in large part to a lot of regulatory action, it just became harder and harder for them to come up with the investments. So you know, one of the many reasons I think we're shutting down operations, but I think some sort of investment is really important. It's just hard to sustain.

MS. HARDIN: Super helpful.

We're going to go Joe, Ena, Katie. We've got about four minutes, but want to really hear from each of you, your response.

Joe, please go ahead.

MR. DEMATTOS: Yeah, so I think declaring long-term commitment to process change and outcome change regardless of the

framework of the change. I mean, look at Maryland, right? We started with a Social Security Act exemption, and then we went to a relatively simple contract. Then we went to a much more complicated all-payer contract. And now we're going to AHEAD, right?

But we're still -- that's just that part of it. Not counting the Social Security Administration, you know, statutory, you know, decades of change, just the contractual evolution part of it. We're talking about, you know, the last 15 or 16 years, right? So the framework changed, but the idea that we're committed to this process, that hasn't changed, and money is always a big thing.

I would be remiss if I didn't talk about a couple more barriers though, right? So in nursing homes, one of the barriers is the regulatory mismatch, right? So for instance, in Maryland, we have a behavioral health crisis, and we have some folks, not all, but some folks that are in long acute hospital stays with a primary clinical diagnosis, that have, in addition to the clinical diagnosis, a behavioral issue or a behavioral diagnosis.

And we're set up to help those

folks. But that is a regulatory risk for the skilled nursing and rehab environment. So you have to be willing to take that risk.

We have folks that clinically, for what they were in for their acute episode, let's say they were in for a broken hip, but they were fighting cancer. And so we are set up for their rehab part of their care, but we're not paid for their cancer drug. Not appropriate in our setting, right? So again, there's a barrier for us helping that person. So going forward, identifying those barriers and figuring what the fixes of those barriers.

Another one is, for instance, by the way, within our scope of care, we can do transfusions, but there's no rate for it. So you know, nursing homes are either eating that and doing the right thing and paying for the transfusion out of pocket in our setting, or wrongly sending the patient back to the hospital for the transfusion, where it's paid for. It's within our scope of care, but there's no rate for it, right? So sorry to unload that at the end, but more work to be done by all of us.

MS. HARDIN: That's an important

point.

We can go briefly to Ena, and then we're at time.

Ena, if you'd like to comment.

Is that okay, Katie?

MS. BACKUS: Sure. Lauran, I keyed in on your question about funding, and I think relative to the conversation we were having about data in particular, that there is opportunity for states to consider Medicaid funding, implementation, advanced planning, documentation that supports integrated data models. And that promotes interoperability of data.

These pieces, particularly if Medicaid is a participant in the All-Payer Model that the state or the state is pursuing, I think is a really significant opportunity for the states to draw down that 90/10 match and support better data.

MS. HARDIN: Thank you all so much. All excellent presentations. I know we could keep talking to you for another hour, but we're actually at the break. So I want to thank you so much for joining us. And please, I encourage you, if you'd like to stay on for our

next session, it will be also going into another level on state value-based care models.

At this time, we're going to take a 10-minute break and we'll be returning at 2:50 Eastern. So please join us then. And we have another great lineup focused on lessons learned from state value-based care models that have implemented multi-payer alignment. Thank you for joining us.

(Whereupon, the above-entitled matter went off the record at 2:40 p.m. and resumed at 2:50 p.m.)

*** Session 3: Lessons Learned from State Value-Based Care Models That Have Implemented Multi-Payer Alignment: Part 2**

DR. KOSINSKI: Welcome back. I'm Dr. Larry Kosinski, one of the PTAC members. In our second session this afternoon on lessons learned from state value-based care models that have implemented multi-payer alignment, we will hear from four distinguished experts who will discuss the multi-payer models in Pennsylvania and Arkansas. You can find their full biographies and slides posted on the ASPE PTAC website and the public meeting registration

site.

At this time, I ask our session participants to go ahead and turn on your video if you haven't already done so. After all four experts have presented, our Committee members will have plenty of time to ask questions.

First up, we're happy to welcome back Ms. Janice Walters, who is Chief Executive Officer at Rural Health Redesign Center.

Great to have you back, Janice.

MS. WALTERS: Thank you so much. I count it a privilege whenever I get to speak on behalf of the work that we've done in the State of Pennsylvania, so really appreciate the opportunity to be here. So thank you for the invitation.

So yeah, hopefully, just going to hit on some high-level key lessons learned. I've been informed that most of the members are familiar with the program, so I'm not going to spend a whole lot of time talking through the specifics, but really focus on lessons learned and some other things we're learning here at the Rural Health Redesign Center specific to rural health payment reform and what it takes to be successful in those regards.

So if you could move on to the next slide, please.

Short bio. I'm not one that likes to see their picture on slide decks, but certainly, you know, have spent the majority of my professional career leading some rural health innovation. Health care is my third industry, so one of the things that I feel like I bring to this work that is unique is I'm not a lifelong health care professional. I have other industry knowledge that I bring to the table.

So when I think about some of the problems that we're trying to solve as it relates to rural health and even just broader payment reform, population health and wellness, really understanding the role that health care plays within the macro system, and how interdependent health care really is, and how the broader system really is dependent. And so I bring that industry lens, bringing in manufacturing communication and then health care and really take a systems approach to the work that we do here at the center.

If you go on to the next slide real quick.

Who we are, the Rural Health Redesign Center. Our mission is really to protect and promote access to high-quality health care in Pennsylvania, as well as the nation, all with a vision of really helping rural communities thrive.

As I just stated in some of my opening comments, health care is just vital to broader economic development, and ensuring that that access stays in the community is fundamental if we want to have thriving rural communities. So that's really our vision is to use our knowledge to help rural communities thrive.

And our team is actually made up of a number of individuals. We have over 40 individuals, plus a lot of wonderful technical partners that help us do the work here at the center. And we most recently did a survey. And while we're saying our team has over 200 years of combined rural relevant experience, based on our team right now, that number is 500.

So really, we collectively have over 500 years of experience in dealing with rural health issues specifically. Working with just

wonderful industry leaders that know what it takes to run rural health care organizations boots on the ground, and what type of change is effective and what type of change is not.

Part of the creation of the Rural Health Redesign Center, I just wanted to hit on this point, it really was part of the CMMI demonstration. So the Pennsylvania Rural Health Model, which is certainly the flagship program that I've helped run here at the Rural Health Redesign Center, really was a partnership with CMMI and the Commonwealth of Pennsylvania.

But part of that model, the Pennsylvania Rural Health Model, called for the creation of the Rural Health Redesign Center specifically, really hoping to create an entity that could be leveraged to serve as a technical assistance center, not only for Pennsylvania, but really, the country.

And so part of the vision of our work was understanding what works with rural health innovation specifically, and then being able to use that, create an entity that can then be leveraged and serve as a technical assistance organization for the country through

consultative arrangements.

So it's been just a wonderful pleasure and highlight of my career to be able to lead such groundbreaking work, not only on behalf of the state, but really, the country and see this organization come to life.

And certainly, that was before the RHTP[62] happened last year, but really to just see this organization come to life and, you know, bring to purpose, creating a center that we can take lessons learned so that other states pursuing and other organizations pursuing similar interests don't have to make maybe the same mistakes we did, but can get to better solutions quicker.

If we go on to the next slide, please.

So real quick, the Pennsylvania Rural Health Model, acronym PARHM, really was looking to achieve two things, or excuse me, three things with two pillars, two objectives. And so really, we were looking to improve rural hospital financial viability or stability, improve population health outcomes of people that lived in those communities, that the

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hospital served, and then reduce the total cost of care over time.

And we had two mechanisms within our program to really achieve that. And the first was the global budget. Paying hospitals a fixed payment to provide predictable cash flow, and then ask them in exchange for that predictable cash flow to put together transformation plans. That really the goal was moving away from volume to a value-based delivery system.

If we go on to the next slide, please.

So just some data to show that within the program, we were able to reduce potentially avoidable utilization. So that was one of the mechanisms. And one of the things that we were trying to do is provide the right care in the right setting. And so we do have data that shows that over the course of the program, for most of our hospital and payer relationships, we actually did indeed reduce avoidable utilization over the life of the program.

And just like to note that there was a pandemic in the middle of all of this. And

so the fact that we could actually achieve these objectives and manage through the pandemic was certainly noteworthy.

The most important thing, if you go to the next slide though, is really what we've learned from the demonstration. And so while nationally, you might hear that the Pennsylvania Rural Health Model or publicly, you hear that the Pennsylvania Rural Health Model is sunsetting, is coming to completion, the work does continue here in the State of Pennsylvania.

And so I continue to work with the payers that were part of the first program and many of the providers. And the hospitals as well. We've expanded that stakeholder base to say, what worked well, what have we learned, and where can we make improvements and really iterate on what we call a next generation strategy?

So the program really provided a robust learning laboratory for what worked and what didn't work within rural APM structure specifically, because again, ours was a rural-only model. And then now we're really iterating on that to take that into the future

to say, okay, how do we continue to iterate and build a next generation program? So that's the work that I'm currently leading in the State of Pennsylvania, is really iterating on the first version with the goal of getting a next generation program off the ground.

Transparently, we don't have CMS at the table right now, but we felt the work in the State of Pennsylvania was too important, that we have to keep going on it. And hopefully, we'll be able to figure out a way to get CMS back to the table as a partner with us in this work.

But some of the most important things that we've learned, relationship and trust, stakeholder alignment is fundamental if we want a change to happen. We need, in addition to payments, alternative payment, we need broader infrastructure. And of course, really, really need good planning.

I like to say this work is really, really hard. If it were easy, it would've been done. But the fact that our stakeholders are staying at the table to really continue to iterate and move forward to me is a huge win. A huge lesson learned as well.

If we go on to the next slide.

Some of the overarching things that we've learned from again, the first Pennsylvania Rural Health Model, the experiment, as I like to call it. As we think about a next generation program, what do we actually need? You know, and one of the things that first and foremost, it's got to be palatable for both our payers and our hospitals. Provides the right care within the local community. So one of the things that we're not sure the first program did was actually preserve the right care in each community, so we're spending a lot of time defining these essential services.

What does essential service actually mean? Where do these services need to be provided, and something that can be customized at the local community level? We know it has to take into consideration costs. So the first program was revenue only, and that's created some issues and an extreme inflationary period.

So figuring out how to bring costs into the equation. Something that provides truly predictable revenue. So some of the ways our program was administrated undermined the

predictability that we were trying to achieve. And so really getting to predictable revenue.

And is easily understood by program participants and reduces administrative burden. Those last two really being informed by, you know, we built a pretty heavy, cumbersome program. And so are there ways to get to the ideal end with less burden?

If you go on to the next slide.

The other thing that I wanted the Committee to know about that, in addition to the Pennsylvania Rural Health Model, we also are working with hospitals that are pursuing the Rural Emergency Hospital designation, so the new CMS licensure. And really, again, it's a step in the right direction in terms of changing payment for rural hospitals. And that fixed facility payment that the Rural Emergency Hospitals are now receiving, you know, has really first stabilized cash flow, providing predictable revenue, getting some of those hospitals to sustainability.

So while we've worked with over 200 organizations, you know, to assess the feasibility of that licensure, only around between 45 and 50 -- so there's always -- that

number's always changing as we continue to work, but I think the last publicly reported number was 44 hospitals have converted because the math worked. But the cool thing that I wanted this Committee to know is that these -- you know, through the alternative payment, through that fixed payment within the REH[63] space. We do see some of the hospitals, the early adopters, moving into population health and wellness and really starting to use that fixed payment in a different way. And so to me, that's exciting because once hospitals have a different payment mechanism, we've seen them step into the population health and wellness. And I just wanted to share that as an example of alternative payment working.

If you go to the next slide, please.

So just to wrap it up, this is really, really hard work. If it were easy, like I said earlier, if it were easy, it would already have been done. And so some of the things that it takes in order to achieve such broad, sweeping innovation, relationships, and trust is certainly in the middle of all of that. Building relationships with the

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stakeholders. Understanding that we're all pulling in the same direction and aligning on purpose. And then the leadership skills that it takes.

And so just listing on this slide for you, some of the key things that from my experience and those that I've worked with within the program, what it really takes to do this type of work: perseverance, tenacity, humility, honesty and communication, alignment of purpose. There's a lot that goes into that. But more importantly, it takes time. This is a marathon, not a sprint. And so again, I just thank you for the opportunity to be here.

Next slide is contact information, but, you know, we're really excited about the work that we've done in the State of Pennsylvania and where we're taking our next generation program. And again, back to who we are as an organization, I really do see us as the puzzle piece in the middle that holds it all together. We're a neutral convener. And so in order for any APMs or alternative frameworks to work, you've got to be able to get all of the stakeholders together and get that alignment of purpose in order to move

forward. So that's my final comment. And again, thank you so much for being here, and I just look forward to the conversation.

DR. KOSINSKI: Thank you, Janice. We are all -- we're saving all questions from the Committee until the end of all presentations.

Next, we are pleased to welcome Dr. John Bulger, who is the Chief Medical Officer at Geisinger Health Plan. Welcome, John.

DR. BULGER: Thank you, and thanks for having me. It's great to be back and talk to the group, and I think really talk about something I'm passionate about, and we've been passionate about in Pennsylvania, and give you my perspective, at least, as one of the payers involved in the Pennsylvania Rural Health Model. Next slide. Actually, you can go two slides. This slide kind of just gives you a little bit of bio on me.

If you look at where we've been over the last 10 years, and it has been -- and Janice talked a little bit about it -- it has been a journey. It's interesting for me because Geisinger's been involved in this both as a payer in Geisinger Health Plan and as a

provider. So one of our hospitals, a rural Critical Access Hospital in Jersey Shore, Pennsylvania -- which is not on the Jersey Shore, that probably story for another time -- has been involved in this model since it started. And Geisinger, we were very committed to that, really because we're committed to the communities we serve and making care better in rural Pennsylvania. But it has been a journey, and there's been just so many different lessons learned as we went through that. We'll talk a little about some of those today. Next slide.

The -- you know, what is the value proposition? And I think that's a question, and I'll hit on that a few times as we go through this. I think, first and foremost, it's about access to care, and these value propositions really align across whether you're a hospital or a payer. The hospitals are there really to provide care in these communities. And as a payer who serves these communities, one of the biggest things we're focused on is making sure our members are able to get care in those communities.

So I think it's, first and foremost, access to care. And then you roll into the

other ones of population health and being able to really think about what does the population need? I think population health is one of those terms that gets overused a lot. But I think about it in this sense is, what's needed in those communities? Not necessarily what some want to have in the communities. Not necessarily what do those communities have to do to pay for or bring in the dollars to get care in those communities in a fee-for-service system, but what's needed? What is needed in those communities, and what services do we want to get? So that's the population health piece.

It is important to remember that many times in rural communities, in all states, it's certainly that way in Pennsylvania, health care and the hospitals in those communities are the economic engine. Many of these communities have had decreases in their manufacturing base and other bases. And it's the hub of the community is the hospital. It's the people that work in the hospitals. It's the people that drive, that come into the hospitals and use other services in the community. And it's what those hospitals give back to the community. So keeping them alive and vibrant

is extremely important.

And in the end, we want to be in a learning health system. We want to be able to test and take away and understand what's happening. And that's really the other piece of this value proposition. As Janice said, a lot of this is a great unknown. It's not like there's a playbook out there that you can Google and say, you know, how do we keep rural hospitals thriving? It's on the tip of everybody's tongue from a policy standpoint. And a lot of what we've done with this program and a lot of what we'll continue to do moving forward is really trying to collectively learn so that we can make things better for future generations. Next slide.

So one of the things that were required in transformation plans and I think, you know, one of the -- you know, why does a payer do this? The payers do this because, one, when you're taking risk from a payer standpoint, the more certainty you can have, the better the process is. So this created, the global budget model created a lot of certainty around what the payments were going to be and how we were going to work with the

payers. We also want better outcomes, and we want to try to find ways to have better communication between the payers and the providers.

And one of the hooks that's part of this is from a payer standpoint, we'll change the payment model. We'll, you know, give up-front payment and have that knowledge. But at the same time, we want to do something different, and that was what the transformation plans are about.

What you see is there's some things that -- you know, care management, this whole notion of how do we get services in the community to help the most vulnerable in the community? You see access being the second one, but then you see kind of this -- and I just highlight ED utilization, which would probably be on the tips of all of our tongues. But then the areas like social determinants of health, substance abuse, behavioral health. Those are things that we know are lacking in, quite frankly, all communities, but in rural communities, it's really tough to get those things to exist and then to thrive.

And those were areas that were being

neglected, but because of the transformation plans, because of this program, we were able to get the hospitals and get the payers to be talking together as to how are we going to change those things in the communities. And really this hook of saying, okay, we're going to stabilize things, but we also need to transform. We're not just going to stabilize things and stay the same. Next slide.

So you know, this -- and, you know, Janice kind of connected on this of saying, aligning on the purpose, but -- and this was really the purpose we tried to align on is, you know, trying to preserve the right care for our rural communities. And the global budget was a vehicle to do that, but it's only one vehicle, and it was the vehicle we were using. But I think one of the biggest take-homes was, and you'll see it in further slides, is this piece of collaboration.

You can go to the next slide.

And it's interesting because when you look at -- we did a survey with the payers and the hospitals and said, what worked well, and what needs improvement? What's interesting is the top in what worked well is communication

between hospitals and payer. And the second one in what needs improvement is communication, hospitals, payer. And it's one of those things where I think there was a generally felt to be a lack of communication perceived on both ends, both hospital and payer, when we started this. And that increased a lot as we went through the program. But as you might expect, the more that you get of that, the more we were communicating, the more we wanted to communicate, we wanted more of that good thing we were creating, which is why you see that on both these.

I think a great piece of this is that every hospital that was involved in this from the beginning and further is still providing care to patients in Pennsylvania. And we all know the statistics on rural hospital closures. And to me, when people ask me, what was the biggest success with the program? From overall, but a from a payer standpoint, it's that none of these hospitals had to close. They're all still able to be vibrant parts of the community they're in.

But you also see in this that there's some lessons learned that we need to

take to the future. So the budget methodology, even though it's somewhat standard, it is -- you know, anytime you need a, I kid with people at the health plan, anytime you need an actuary to help you with something, you probably have a barrier to overcome. And, you know, the reality of the way the budgets worked and, you know, in spite of all the awesome work that Janice and her team did, it does create a little bit of, I'd say, angst with the people working with it. And that's why that's number one. You see, the other things that were the needs improvement were, you know, much smaller in that standpoint. Next slide.

So you know, as Janice said, the thing we're working on moving forward is what's it going to look like in the next generation? And we're lucky to have attendance between hospitals and payers. We're lucky to have our state involved, and we're lucky to have other interested partners that want to look at this moving forward.

But, you know, I'll finish just with saying the things we're focusing on, why our payers want to do this. Again, it's the certainty. We did see better outcomes as a

payer with this, and it really has brought everyone to the table, and I don't think we've seen payer collaboration in Pennsylvania outside of this in the same way we did in the Rural Health Program. And we haven't seen collaboration between the payers in any hospital community, whether it be rural and urban, but this program has brought them together.

I think in the provider side, it's provided stability for those providers. It's allowed them to do things that they've wanted to do, but weren't able to do, because if you're in a fee-for-service system and your survival is a reality, is a problem, then you have to go do the things that fee-for-service gets you. And many times we did a survey to say, if you look at what rural hospitals that do versus what they want to do, what you see, what they do are the things that they get paid more from a fee-for-service standpoint. What they want to do generally are the things that are on that list in the transformation model. Things like care management, things like substance abuse, behavioral health, SDOH[64],

64 Social determinants of health

palliative care. There's that mismatch there. And what this program did, is it let the hospitals survive, but still be able to do the things they want to do. And from a payer standpoint, those are the things we want to do as well. So there was just this kind of alignment of purpose was incredible with the program. Next slide.

So that's the end of my talk, but I'm really excited to continue discussion and answer questions as we move forward. Thank you.

DR. KOSINSKI: Thank you, John. Next, we are excited to welcome Dr. Dawn Stehle, Director of Early Childhood Systems, Policy, and Planning at ZERO TO THREE, and Ms. Alicia Berkemeyer, Executive Vice President and Chief Health Management Officer at Arkansas Blue Cross and Blue Shield.

Please go ahead, Dawn and Alicia.

MS. BERKEMEYER: Thank you, Larry. Appreciate that. I'm very excited to be here today to speak to the group, especially for the fact that I've heard so many similar and repetitive consistencies of today around this value work.

So in my regular job, I day to day work with the medical management provider networks, certainly our pharmacy and health economics, but really have a passion around value-based care. And as you'll see here today, Dawn and I, in our typical collaboration across the State of Arkansas, we are going to talk about this Arkansas value journey together, because it is a journey. I think what has been said by Janice recently is about finding that common interest, that common passion, and ours is really improving health care in Arkansas, and we're excited to tell our story.

Dawn, I'll pass it to you.

DR. STEHLE: Thanks so much, Alicia, and thanks so much, Larry, for the warm introduction. Rarely do people pronounce my last name correctly, so I just wanted to just give an extra special thank you for that as well, but just excited to be here with everyone today, and as Alicia said, tell you a little bit about our story. You know, we really felt like it was important that since we started this journey together, and we've continued on this journey together, that we actually share

then the story of our work together.

So as you may have noticed, I am currently with ZERO TO THREE, but I want to talk a little bit about, like, the work I did with Alicia and many of our other partners when I was with the Arkansas Medicaid program of which I served as the Medicaid Director for eight years. So excited to be here today and talk to you a little bit about our journey together.

So if you would, next slide, please.

Before talking a little bit about how we got here, we thought it was helpful to talk a little bit about sort of who we are and a little bit about the State of Arkansas because I know many people when they think about Arkansas, they probably think about rolling hills and lots of rivers and streams. And while we have lots of those as well, we also want to talk a little about the people, because at the end of the day, that's what this is about. It's about the people that we serve and the -- and our neighbors and our fellow community members.

So in Arkansas, we have a little over three million people. As you may not

know, we are a popular destination for retirees. So as you can see, we have almost 20 percent of our population is actually over the age of 65. And so that's definitely something we have to think about in terms of the health care system. On the other end of the spectrum, we actually have just over 20 percent of our population that's actually under the age of 18. So as we think about, you know, sort of what the landscape looks like, we have to think about both our youngest, as well as our oldest, and of course, all of us in between as well.

Arkansas is a very rural state by definition. That said, we have about 72 percent of our counties that are actually considered rural, but when you look at it, about 44 percent of the population actually lives in a rural area.

Taking a minute to focus on some of the economics for a second. We are slightly above average in terms of when it comes to the percentage of individuals living below the poverty level. Compared to the United States, we were at about 16 percent of the population that actually meets that criteria.

And then along with that, we also

thought it's helpful to just talk a little bit about sort of what our primary care landscape looks like. So as you can see from the map there on the right side of the screen, we are a area that has a lot of things going for us, but one of those is that we are actually a primary care shortage designation area, which means, as you can see from the picture on the screen, we only have about 9.4 active primary care physicians per 10,000 residents. So that's definitely something that helped to inform our journey, which I'm going to turn to Alicia on the next slide to talk a little bit about what this means for us and helping think a little bit about the landscape of how we got here.

MS. BERKEMEYER: Thank you, Dawn. The fun in this is we do get to tell the story, and our start of this is quite interesting. We are a state that was agreed upon that -- the governor at that time, Mike Beebe, came to Dawn's boss at that time, John Selig, and said that health care is not sustainable, we've got challenges in Arkansas, and we've got to look for some answers to fix this. At the same time, he came to my boss, Mark White, at that point, our CEO, and said the same thing. I

think that set us on our journey from the public and private sector that I think after that point, we met at least weekly, if not more often. And very quickly, we decided that it doesn't matter if it's Arkansas Blue Cross, it didn't matter if it was Centene or at that point, QualChoice, or Medicaid. We were trying to accomplish the same things. We needed better, healthy state. We needed better care for Arkansans. And so from that point on and -- you know, we -- in this model here we're showing that we really truly joined hands and became lockstep in trying to improve health care.

If you'll go to the next slide.

This is the fun slide to talk about. This -- we call it our building blocks of value because it truly is a journey, it takes time, and it's very hard. And those are all things you've heard today about these challenges. But I'd like to first of all point out the color coding on here. So the dark blue here are two initiatives that were strictly just Arkansas Blue Cross and Blue Shield. And from an Arkansas Blue Cross journey, we started in 2010 when my boss came to me and says, "what is a

patient-centered medical home, and how do they work?"

So we started a pilot, and I brought on two vendors and I had thought, well, I have one with the transformation support, one with the data support, and then we're going to make magic happen. I wish I could tell you that in 2026 that magic was happening, but what I learned a lot of things. And even though we're one of the larger payers here in the State of Arkansas, practices said, number one, Arkansas Blue Cross, if you're going to do that, you've got to be here by our side. But number two, you can't pay me enough to change my entire practice and to support those changes needed. And that's where we were very fortunate to come into the play of CPC. The Comprehensive Primary Care initiative really allowed us all to lock hands, to come together, to really join in quality measures and metrics and really have some amazing outcomes.

From there, and I'm sticking on the column here of the primary care, then we moved into the statewide or patient-centered medical home. That basically the red -- two red ones are things that are still in place, active

today. And the patient-centered medical home, what's so important in that is to be a payer on our Marketplace in the State of Arkansas, Medicaid has defined what those medical homes are and how we have to support and reimburse them. So we're all aligned in that state effort.

Then we moved into the CPC+ and the Primary Care First Models. Going back to 2012, when Dawn and I started those regular meetings, it truly was the episodes of care. And those are where we aligned in our reporting systems and other things that were very, very important to us.

Dawn, do you want to talk a little bit about the episode work? Because that really was our starting together.

DR. STEHLE: Absolutely. Yes. It was pretty novel at the time when we started down this pathway. You know, I think that people kind of questioned, like, what it was and what it could do. And we really saw it as really sort of our first, you know, sort of entree, if you will, into the world of value-based, you know, purchasing. Not that we hadn't been doing things before, but really, I

think in terms of trying to sort of all point in the same place -- that's one of the things I love that Janice said in kind of talking about some of the work in Pennsylvania was we recognized that if we were going to do this, we had to be able to do this in a way that providers felt like that they really were engaged in the process, but also that we as a payer community were all sort of pointing towards the same values and incentives that we felt like were so important.

And so that really was sort of the kickoff to us being able to kind of come together with the providers, with patients, and with other payers to really, you know, think about sort of what these could look like and really thinking about sort of where we had the most opportunity for value within the system. And so that really kind of led us on our journey of thinking about, sort of, those sort of condition-specific type opportunities versus things that were more focused on sort of chronic care or overall health and wellness in general, so -- but that was a little bit about our episodes of care work.

MS. BERKEMEYER: Thank you, Dawn. I

think throughout all of these programs you see here on our map today, we really worked hard as a state to align in our quality measures, our data and reporting to the practices, and the attribution. So really coming up with common definitions to support this work was so very important for us.

I think all-payer claims databases played a big part into that, as well as our HIE. We also carried this work through the State Innovation Model support and State Transformation Collaborative and the Multi-Payer Healthcare Expenditure Dashboard.

Dawn, would you like to add anything about that or any of the others that I've covered?

DR. STEHLE: No. I thought you did great. Thanks, Alicia.

MS. BERKEMEYER: Okay. Well, what we'll talk about here on the next slide, we're going to talk about one of the keys, I think that's been very important for us and very successful is our State Health Information Exchange. We are very fortunate that we have one in our state, and our HIE sits underneath the Arkansas Health Department.

I think with that model through our value programs, we have encouraged and really supported and driven data through that, as well as some -- in order to be a patient-centered medical home practice in our State of Arkansas, you had to sign up for our HIE. We have well over 95 percent of the hospitals that are signed up through the HIE, and also from a payer perspective to participate in some of the value work and through our exchange and things of that such, we've really tried to get as much as we can to the practices. So the admission, discharge, and transfers, the information about with the hospital discharge and things like that, has been so very important, not only to the practices, but, for example, our case managers, our nurses as well, receive that information. So really looking at use cases and driving that information. Next slide, please.

This is another little bit example of just the roster. So we as payers submit our attributed lives to the HIE, then we get the information back and this prevents -- initially we had started where the practices were having to submit that, and then we moved into all the

payers. Now we do that on behalf of the practices because some of those small rural practices really struggled with that. So trying to simplify the process to make it really successful for all of us.

So we can go on to the next slide.

Because one of the things that I'm very proud about is because of being a state utility, we actually have had many uses for this. So this is just an example of the hospitalization reports that those care managers receive every morning. We also used it during COVID. So very quickly because we already had this utility in place, our nurses, the nurses and practices had that information, could understand. When beneficiaries are losing coverage, we do some outreach and collaboration, and also some foster home children be able to have consistent care if they're in and out of different homes.

Another key project through the HIE is really immunizations. And you probably all are familiar with that sometimes we have some trouble with having baby 1 or 2, or girl or boy, and then we kind of get a name. And so we've really done a lot of work through that

and trying to clean up our data and coordinating the HIE, as well as the all-payer claims database. Next slide, please.

I think on the foundation, you'll hear the message that we try to go through this is really looking at the patient. How do we put the patient at the center of all the decisions we make around this care and collaborate around that patient? Next slide, please.

And as Dawn talked about, people like to retire, like to visit Arkansas. So many of these pictures are to entice you to come visit us in Arkansas. We'll take you to any rural practice or any rural place you'd like to see.

One of the keys to our success has certainly been collaboration and coordination. I think that is something that we are very proud of. And this is a picture of an example. Our -- one of the key stakeholder meetings that really made a difference and an impact on some of these wins we've had was in 2017. This was at the Arkansas Hospital Association, and you'll see that it included the payers, it included the employers, as well as some

patients at the table. And that was one of the things that I certainly learned when we started our patient advisory councils, trying to -- how do we onboard patients? Because we circled through a few patients before we could get them to feel comfortable in that environment to really speak up and help us understand what they needed and wanted.

It's been mentioned earlier by others too, but we really took a day and whiteboarded what's going really well in Arkansas in health care, and what do we need to improve? And so you'll see some of the focus areas then we decided to be collaborating on. We're looking at data and interoperability. We were looking at, you know, red tape. How do we empower patient and behavioral health integration?

So I've already spoken to you about the Health Information Exchange that we really put all hands on -- you know, in, and said, we're going to do this. And it's going well. The other thing I'm extremely proud about is behavioral health integration. So through this initiative, a not-for-profit, Arkansas Behavioral Health Integrated Network, was

created and spends quite a bit of time, you know, on a regular basis, having the conferences, educating and training individuals to feel confident and successful through those primary care practices. Next slide, please.

A couple more stories here on this slide. So on the slide you see right there at the Fayetteville Police Department, as I had done -- invited and hosted CMS staff and others to come to Arkansas, one of the areas we stopped -- and this is just an example to show that it goes beyond just patient-centered medical home, it goes beyond the journey, but in how do we engage the community, and how do we look at areas that are gaps that we can fill? So the Fayetteville Police Department was one of our stops on that visit because of the fact that they have done a phenomenal job working with the University of Arkansas and deploying social workers out with the squads, and the improvements that they have done and the success that they have done by including those social workers. Now, where it started out some grants and pilots, the City of Fayetteville now funds those social workers and continues to grow that social worker numbers.

The one on the bottom is an example, is a conference where we had patients, providers, as well as payers at that table. Truly hearing what having behavioral health integrated into a clinic can -- how it changes their lives.

And then the final one is looking for resources. This is very intense. It takes a lot of time. It had the convening, the facilitating, and things of that such. We started back in -- and during CPC+ with the payer, all the payers in Kansas City, as well as Oklahoma and Arkansas, we all -- it takes us about the same amount of time to travel up to our Northwest Arkansas location. And we really have had some amazing opportunities to collaborate in training practice coaches to look at resources and tools because anything we can share and spread we benefit from. We even are doing the three states. We're doing provider training and education together in these value programs. Next slide, please.

Alrighty. On this next one, Dawn, and I'll share here, it just shows that some of the things that we've done in Arkansas to help with legislation. And, Dawn, do you want to

start and talk about it?

DR. STEHLE: Sure. And so it's one of those things where -- and I know it's -- you know, it could be a bit of a double-edged sword, but at times thinking about what are the things where we feel like we need legislation to be able to move something forward versus those times where we feel like maybe it's better to not actually have legislation. And so but we do think in these instances, you know, it's been important to be able to talk a little bit about those places where we did feel like it was important.

And one of those was, you know, really, after we had made the decision that we wanted to try to implement episodes of care, you know, we felt like it was really important to be able to have, you know, that -- sort of that buy-in, but I think also that decision as a key value strategy from, you know, on behalf of the state and really having that solidified as part of, you know, some of our key legislation.

And so you know, as part of that, we actually then went ahead and began developing the episodes and then actually put them into

practice, you know, through the -- you know, through the reforms, but then also had legislation to support that. And likewise, with our patient-centered medical home, you know, once we had the support of, you know, our provider partners and patient community, we felt like, you know, in order for this to really be something that we could implement statewide, that we also wanted to go ahead and then put that in place.

You know, much like Alicia had mentioned, you know, it started out with, you know, requirements within Medicaid, but then ultimately became a statewide requirement for participation within the Marketplace and really helped to be able to set the standard for what we felt like was important when it came to implementing patient-centered medical homes in Arkansas, both what it was and what it is, but also those components that we felt like were so important to the Arkansas model.

And then Alicia, do you want to talk about the last two?

MS. BERKEMEYER: Sure. I'm happy to do so. I've talked briefly a little about our HIE and some of the requirements to participate

in the value programs, but I'll spend a little bit here on the primary care spend.

I'm very proud of our state. I know Arkansas Blue Cross and Blue Shield since 2012, we've been measuring and monitoring -- in the back of the references here we have the Milbank publication on how the return on investment and increase in primary care spend that we've been tracking. But there was recent legislation that was just passed that a working group, a committee has been established, and the report's due in April to the legislature.

What we've done to this point is gotten a consistent definition of what is primary care spend, which clinicians are involved in that, and how that will be reviewed. And then a data structure field for the -- all payers to submit the data into our insurance department and working along with the all-payer claims database.

One of the key things that we've really had to do -- much of that work today in the files do not include the value-based payment. So trying to get some fields added into our all-payer claims database files. So going forward, we ensure -- because that's

where we've really increased our money is in the care management fees, utilization, and the equality incentive areas.

We can go to the next slide. And I'll pass it, Dawn, if you start out on the challenges?

DR. STEHLE: Thanks so much, Alicia.

And I know we've told you a lot about many of the successes, as well as a lot of the things that have gone well on the journey. And there are many of those, but they were not without challenges, both then and now. And so we also wanted to make sure that we spent a little bit of time talking about those today, I think the first of which is payer participation.

I know -- and John touched on this a little bit, with regard to the State of Pennsylvania, but much like, you know, in Arkansas, we recognize in this case, we literally could not have done this without coming together as a multi-payer effort. Because, you know, as you saw in some of the data, yes, you know, we have a significant portion of the population, which is children, which, you know, in Arkansas is, in many cases,

covered through Arkansas Medicaid. But then we also have a large adult population, which is also covered through Arkansas Medicaid, but also a significant number of those patients, as well as those providers, are actually within the Blue Cross and other private payer networks.

And so as we sat down to look at it, we said we knew we couldn't just focus on the children or the adults. We had to do it together, and so that's really what kind of led us to be able to then say, yes, like, A, do we want to do this, and B, if we're going to do it, like, the only way for us to do it is together. And so that was one of the important challenges that we had to overcome, which is, how do we do that? Because as you'll see, you know, kind of as we go through some of these other bullets, there's a lot of that, that we can do together, but there's also some things that we have to do separately when it comes to the legal side of the house.

But inherent within that was being able to get the employer buy-in, because, you know, much -- there are many things in Arkansas that we're proud of, and one of those is that

we actually have a very thriving self-insured and small-business community. And so as part of that, you know, even though a lot of those do use, you know, plans and payers, such as, you know, Arkansas Blue Cross Blue Shield, to be able to take care of their members, there's a lot that also, you know, are very involved in that, you know, as small businesses or as self-insurers.

And so one of the things that was so important in this was getting the employer buy-in to do this. And so as part of this, actually, setting up, we had an employer -- employer-sponsored health council. And so we brought together the employers and talked to them about what's important, and actually getting their buy-in and helping not just to move forward with the initiative, but actually helping to design and develop it.

Like, I can remember, you know, some of you may be aware that, you know, one of the sort of flagship employers that we have here in Arkansas is Walmart, and so, you know, they were very involved in helping us be able to actually develop and support this initiative, as well as many of our other small employers --

smaller employers within the state.

And there's several others I think we can walk through, but Alicia, any that you want to add at this point?

MS. BERKEMEYER: I think you're good.

DR. STEHLE: Great.

Just a couple others that I want to hit on, that I think are very important, is, as you can see, there's simplification. There is a lot that goes on behind the scenes to make these things work, as I know, you know, many of you on this call already know, but I think there's a lot when it comes to also then simplifying, how we communicate about it. And so for us, because this really is a patient-centered initiative, we began with that, right, where we sat down and basically said, what is the patient journey?

And surprisingly, you know, many people might say, "Oh, okay, well, I know clinically, this is how you get from A to B to Z," right? And then a patient might say, "Well, this is how my experience has been." But one of the things that I think made us unique was that we came together and said,

"Let's do that together," right? Like, it's important to understand what's the patient's journey and perspective on what this looks like and how it works, and where are those opportunities to be able to improve?

But then likewise, from a provider's perspective, because, you know, the providers, you know, we heard very loud and clear, like, they didn't want us telling them how to practice medicine. But they also realized the value in us coming together and really talking about where we could identify areas for improvement, and that would increase value, but also as well as the satisfaction within the health care system. So it was very important that we developed a common language and a common way for how we communicated and really developed those initiatives together.

And then you know, John talked about this as well, and it's just so important, but really thinking about, like, what are those metrics that are most important? Because there is any number of -- there's probably 100 different things during any, you know, particular visit that you could say, well, it would be so helpful to know this or to know

that, and that this particular, you know, value has this impact on this particular outcome. But at the end of the day, it was so important for us to say, what literally are those three to five, right, that are going to -- that are most impactful, that we can come together and agree on as a community, that would best influence both the outcomes, as well as the value for this particular approach to value-based care and purchasing?

And then along those lines, thinking about the resources. You know, one of the things that we realized as we started thinking about sort of what is it that we need from a data perspective, what do we need from, you know, the hospitals, you know, many of them did not have the resources to be able to connect to the state's Health Information Exchange. And so one of the things that was important for us was to say, okay, then we will help support that, right, you know, both through our public and through our private opportunities, you know, being able to do that, to at least be able to get them connected and start to report, like, some of that basic admission and discharge data, but then ultimately being fully

connected to the systems.

And then the last thing I know that, you know, has come up, both as a challenge and then as a lesson learned, was really dealing with some of those antitrust issues, because, you know, we definitely want to make sure, like, I love all of our friends and colleagues that are attorneys. I am not one of them. I appreciate them. But I also know that, you know, we also can't let things stand in the way, right, when we're trying to focus on, you know, what's best for the health care system and for our patients and providers.

And so you know, one of the things that we had to really spend some time thinking through was then, what are those conversations and those things that we can do together, you know, versus those things that we have to do separate? And through that process, we actually found out that about 90 percent of, like, the work in developing out these models can be done together, which was so great. You know, the things that then, like, how much are you going to pay, and what is the payment going to look like, those things all have to stay separate, and it was very easy for us to do

that. But it also, I think, really pushed us to think about, like, yes, there's a whole lot of things here that we actually do have in common, and that there is a way and a path forward for us to be able to work together to do that.

Alicia, anything you want to add?

MS. BERKEMEYER: No. But I'll tell you what, if we can go to the next slide, and I -- what I will do, just for an interest of time, I'll go through these next two pretty quickly.

So from a lessons learned, one of the things that I'll call out on this slide specifically, one of the challenges, if we don't have CMS at the table, it's difficult. And I think what we've learned is, with these programs, we have attached and tried to align with CMMI as much as possible. But what happens is, like, when we were in CPC+, and the attribution for those Medicare members were in our share, our HIE, and then when we changed that program, those lives came out. Well, the doctors would go, "Well, why can't I see Ms. Smith anymore?"

And so I think that's been one of

the challenges that CMS gets tired of hearing me talking about, like, "Can I please just have all your attribution in our HIE?" So it's those type of things that, really, our providers and practices do their best work when they see everybody's patients, everybody's admissions, discharges, transfer, and can work off of that. So they're -- you've got to conform to their practice and what they do in their clinic. And so that's been a gap, or a lesson learned, certainly, is trying to figure that out. And many of these others, we've already talked through.

Dawn, is there anything before we go to the next slide that you want to hit on this? Okay.

Let's go ahead to the next one, because we want to allow time for questions here. We'll do the same thing on this Arkansas successes. I think we've talked about our collaboration and communication, our HIE. Practice participation, we've been very, very fortunate because the providers and the practices enjoy our collaboration that's coming together. I can't tell you how many times they've thanked us.

We actually have a recording of video from one of our learning and diffusion sessions that was a part of CPC+. We did a video and heard, actually, from the practices how these value-based programs have impacted their patients, their lives, and changed things for them as well. So I get excited, could talk all day long, but we're going to be very respectful of everybody's time, and we can go to the questions.

DR. KOSINSKI: Thank you, Dawn and Alicia.

Now, we'll open the discussion to our Committee members. At this time, PTAC members, please raise your hand in Zoom if you have a question for our group. Additionally, we'll want to encourage our experts to ask follow-up questions of each other. Feel free to do so. You can signal that you have a question by raising your hand in Zoom as well. In the interest of ensuring balance across different perspectives and questions, we encourage experts to keep each response to just a few minutes.

Okay. I think Krishna is first.

MR. RAMACHANDRAN: Yeah. Excellent

work. Really good to see the -- a -- have a light shined on these states and the awesome work there. I was just curious to get sort of both thoughts on just as we think about scaling this work nationwide, like, any sort of reactions, thoughts, advice, if you, like, export this, you know, to the whole country. Like, what would your advice be? So --

MS. WALTERS: I'm happy to take --

MS. BERKEMEYER: You go, Janice.

MS. WALTERS: Yeah. Certainly, as we approach our work -- great question, so thank you. As we approach our work, that's one of the things we always have in mind, is, how do you build scalability and processes? You know, one of the -- one of the lessons learned in our program was, especially our rural partners, our rural hospitals, don't have a lot of resource in terms of being able to engage. And so as we build our programs, our education, it's really built about that framework of, what's the balance between cohort-based learning, where you create opportunities for participants to learn from each other, and so, again, they're not starting, you know, from square one?

And then -- so cohort, as well as individual, and, you know, as we think about building methodology, everything that we build is with a lens of, okay, how do we start with this cohort, then how do you take it to the next cohort? And so I think -- and I would say that would be the same of how we approach the rural emergency hospitals. So like, running that technical assistance center for the country, it's very much about building repeatable processes, and then -- so it's not, every time you go into an engagement, you're starting from square one, whether it's templates or talking points or education. It's 80 percent of it is already prepared, and then you go in and you tweak it for the 20 percent that might be site-specific or community-specific.

So going back to one of our lessons learned, you know, was planning. How do you plan well? And part of planning well is, how do you build scalability into that planning? And leverage, you know, broad tools, broad think, wherever possible, and then allow for the customization that might be needed within the program. So that's how I would answer that

question.

Alicia?

MS. BERKEMEYER: And I --

MR. RAMACHANDRAN: Okay. Thank you.

MS. BERKEMEYER: -- I'm very aligned with you, Janice, on those answers.

And I say health care is local, but when I say, health care is local, it's almost down to the county level. So even within Arkansas, we couldn't do it consistently. We had to understand the different counties or different areas. And so understanding the community, what resources are in the community, who are your champions in that community, and how do you get that playbook and adjust it for that community?

So that's example I mentioned earlier with the Oklahoma, Kansas City, and Arkansas. There are some things that Kansas City does really well, there were some things that Oklahoma does well, and there's some Arkansas. So when we all came together to get our best practices, as well as payers, then we can kind of make a bigger impact and a faster impact with that work.

MR. RAMACHANDRAN: Excellent. Thank

you.

DR. KOSINSKI: Any other comments from our experts?

Okay, Lauran, you're next.

MS. HARDIN: Really excellent and exciting work. It's great to hear about the diversity of application. So across the day, we have heard consistently from our presenters that it's really important to have some kind of convener role that's financed, so -- and then that infrastructure is involved in capacity-building, trust-building, most importantly trust-building, and shared metrics across stakeholders, practice change, and then also, really, some of those integrated system improvements that it's no one's specific job to do. But having that kind of convener role is really important.

So I'm curious, when you -- for the Rural Health Redesign Center, when you talked about the behavioral health integration network, how you're seeing those roles financed. I get to work with a lot of different communities, and sometimes the payers financing it, sometimes funding out of Medicaid waivers has financed it, sometimes it's another

stakeholder. So I wonder if you could speak to the financing of that and the importance of that convener integrator role in the community.

DR. STEHLE: Yeah.

And Larry, if it's -- if it works, I'm happy to help kick it off for Arkansas, and then I know others will have things to add, too.

But it's just -- it's such an important question, because yes, you know, people often think, like, oh, that work of, like, planning and convening, like, people recognize the importance of it, but they don't often think about the fact that it's like, that's people's time, right, that they're coming together to be able to do those things, but also the infrastructure, right, to support that.

And so you know, for us, it was so critical. Like, we -- when we began this work here in Arkansas, you know, we really had to think about, like, what can we do? Like, we're kicking this off. This wasn't something that had gotten a lot of attention at that point. And so we actually used some of our own resources between, like, Arkansas Medicaid, and

then between Arkansas Blue Cross and Blue Shield, actually, to pay for some of that initial convening work, right? Like, we brought in a consultant to be able to help us, you know, think about sort of, what does this look like? You know, what -- you know, what are some of the different design features and options that we have to think about?

And then you know, kind of once we got going, we said, okay, we need to be able to think about where we can, you know, secure other funding, because we couldn't, you know, separately or collectively, like, continue to finance this all on our own. And so thankfully, at the time, you know, CMMI had the State Innovations Model program, and particularly the grants, and so we applied, and thankfully, we were one of the, you know, handful of states that were initially selected to do that. And so that brought a major infusion into the state to be able to then support the design and development and the implementation of that work.

But I think the other part of it was also, then, to your point, being able to think about, how can we actually then change our

payment models to support that? And so for Medicaid, yes, that was very much thinking about what state plan amendments, what waivers, what other types of authorities could we use to be able to then actually sustain, you know, the work of these different models? And likewise, you know, I know, like, you know, with our friends from, you know, Arkansas Blue Cross and Blue Shield, it was also thinking about, okay, how do we sustain this, right? And thinking about through payer contracts, thinking about, you know, the work with providers, as well as then what those reimbursement and payment models look like, you know, because that was a big part of the change.

And then I think the last thing that I think is important to mention is, you know, as you said, kind of that infrastructure piece. And, you know, I think one of the greatest things that I feel like that we were able to do was to actually develop and then utilize, like, that shared infrastructure, like, for data, for reporting, you know? And so for a long time, like, when, you know, practices were reporting information to us, it was actually through, like, a shared portal that, you know, from a

payer perspective, we use together, and we sent out our reports together, like, through that. And so -- because if we're asking them to do some of the same things, it didn't make sense to say, okay, we'll go over to this portal here and enter your information there, and then likewise go over here and do the same thing.

So it was so critical that we be able to do as much as we could together, and would definitely encourage that as people think about sort of looking at, you know, taking some of these models to scale across the country, thinking about where can we find that consistency and that shared infrastructure, so that way we're not asking providers or patients to do -- you know, to do the same things time and time again that's just, you know, adding more, you know, waste and inefficiency to the system.

MS. BERKEMEYER: And I'll add as, we've work through that. I think it's been brought up today about the trust and building the community and the trust, how you know, if you're transparent, you understand where you're going. So throughout our different programs with CMMI, sometimes it funded conveners and

sometimes it didn't. And so we, as a state, really rallied together, and I'll give you an example of -- show you how thick. So Dr. Richard Armstrong that was with QualChoice at the time, one of the kickoff meetings that CMS was having for us in D.C., he was not able to attend.

And so I'll never forget this conversation where he told me, it's like, hey, Alicia, you're not just Arkansas Blue Cross. You're representing QualChoice at this time, too, for this trip.

It was that -- we knew things we could talk about and could get out of line with, and there were things that we couldn't talk about, and so it's truly building that trust and collaboration.

DR. KOSINSKI: Any comments from our Pennsylvania team? John, Janice?

MS. WALTERS: Yeah. I would just add similar as, you know, good planning, funding for this work has to be part of the planning. So as part of the Pennsylvania program, you know, CMMI recognized the need for the convener, and so that was part of the seed

funding, was to create the RHRC[65]. As we're doing our next generation work, you know, funders like the Appalachia Region Commission, you know, going to other types of funders that are willing to pay for that planning.

And so -- but it's good planning. It's a function that has to happen. Somebody truly, in order to advance it, needs to be there, service that convener, do all of the heavy lift, because again, it's -- it -- there's a lot of work that goes into this, and that has always -- has already been mentioned, you know, the infrastructure and the planning and how to be efficient. And so just good planning, and then there are folks willing to fund this.

And so our next generation work, a bulk of it is being funded by the Appalachia Region Commission, as well as the PA Senate. So as we're continuing to evolve, you know, leveraging that, and then getting specific funding to advance the planning, and then certainly, where we sit with Rural Health, we're hoping that our implementation will be funded by the Rural Health Transformation plan

65 Rural Health Redesign Center

specific to Pennsylvania. And in other states, I think, you know, there's a lot of money there that, if planned well, can be leveraged to do this work.

DR. BULGER: Yeah. And I just would add, too, I think long term, and it gets to a little bit of the first question, too, you know, from a payer perspective, all the payers were not involved. So some of them were. I think it -- you know, making this work will, I think, work better if all the payers are involved. And obviously, that includes the state and federal government.

And then I think the savings, if you will, that you end up getting when this is done right, you know, can be pushed back into some of that infrastructure payment as well. And again, I think that ends up being all-payer, including state and federal government. So you know, those are kind of, I think, looking-forward opportunities and thinking how it could look.

MS. WALTERS: But it's a great point, because all of our work is to get to the point of it being self-sustaining. So in order to do the work, you need that investment of

capital, you know, the financing mechanism, as I think you coined it. We need that up front, but the goal is then it's self-sustaining within the program. And to Dr. Bulger's point, it really is, you know, the savings that are generated are then helping to fund the infrastructure and some of the platforms that are needed to be successful.

MS. HARDIN: Great comments. Thank you.

DR. KOSINSKI: Thank you.

Lee?

CO-CHAIR MILLS: Yes.

Janice, like, you had made a comment that providers really emphasized, when you're doing your multi-stakeholder engagement and pulling at everybody's interests, that they were mostly interested in reliable cash flow, reliable revenue, they can count on. And then you also commented about, you know, simplification the need to easily understand the program. That's certainly important when you get lost in the world of quality metrics. Just ask you to comment further, and then everybody else, what, you know, actionable, concrete pieces did you find the provider

community most emphasized in your stakeholder engagement, that wind up being, you know, kind of contracting avenues to design a program that brings everybody alongside?

MS. WALTERS: Yeah. So I'm just going to answer with a little bit of illustration first. So within our first program, the Pennsylvania Rural Health Model, we had two payment mechanisms. And you'll see some of this language even in the AHEAD framework, again, because our work directly informed that. But we pay from the state side of the program, or the commercial side of the program. We use something called virtual cap, versus on the Medicare side of the program, the payment was truly facilitated in biweekly payments. We calculated a budget, we divided it by 26, and every two weeks, the hospital knew what their check was going to be.

Key lesson learned is that, by far, was far better than the virtual cap, because the virtual cap was still providing a lot of fee-for-service payment. So in the virtual cap, we calculated the global budget the same way, but the payment mechanisms were different. A lot of the payments still came through the

fee-for-service claims, with then true-up payments along the way, and our hospitals have really found, you know, being able to count and know what that biweekly payment was going to be.

So that's a key lesson learned, as we iterate -- it's like, we truly want to know what our payment is going to be, and we don't want a lot of surprises at the end of the year, because there were some reconciliations that are done that, based on market shift, you know, you never quite knew what your final payment was going to be until after the program year was over. And so really trying to minimize all of that retrospective reconciliation, and getting to more of a straight-lined approach to -- and that's also for the payers too, you know, be an accountant.

So my formal training was an account, and at the end of the year, you've got to do accruals and all of that. And so really, moving away from their retrospective reconciliations, getting to a point where we know what our payment is going to be, and then we move forward, so any adjustments to the budgets would be made moving forward, versus

any type of a retrospective type of a calculation. So that's the thing that we've heard both from the plans and the hospitals, is, like, we want predictability, we want to know what the payments are, and we really want to move away from reconciliation.

Also, I would say -- and again, the trust, you've heard that theme, trust and relationships. Our hospitals, and even probably some of our plans, there's still a lot of black-box magic. We send stuff in, you know, to us, the TA[66] Center. They don't necessarily know how. They generally know the frameworks, but really, getting to just straightforward, this is how we calculate it, and again, doing away with the retrospective reconciliation, the market-shift adjustments, and some of the things that we had in ours, will just make it much easier for both payers and hospitals to understand, and then hopefully other partners.

Because one of the things that we've recognized is, you know, we're -- our first focus is sustainability, preserving, but we recognize we've got to bring in primary care.

66 Technical Assistance

We've got to align more holistically across the continuum of care. And so using easily-understood and really reducing, I would say, the black-box calculations that are happening, that folks just don't understand. And to reiterate a point that Dr. Bulger made, anytime actuaries are needed to explain things, it becomes really different -- difficult. So taking just a much more straightforward approach to calculating the fixed payment, as well as the actual payment mechanism, is really where we're landing.

DR. KOSINSKI: Other comments?

MS. BERKEMEYER: I'll come at a little bit different area, the providers feedback perspective, the -- what we've heard. In the programs where we've offered the care management fees and allowing them the flexibility to meet the patients where they're at, we've seen some really good examples of success.

Allowing those, when we talk about being, you know, local care in the communities, you know, one of the examples to this day that still resonates very well with me is that there was a physician that was having a lot of

trouble with the care coordinator, reaching the patients and getting to the patients in some of the different chronic conditions. So he set up, next to his little clinic with some of the funds, a little gym. It wasn't too fancy, but it was a gym, and offered it to the patients for free. And then the care coordinator was able to wander through the equipment as the patients would come in and talk to them about their health conditions.

Another one, very, very rural part of our state, very poor part of our state, the practice bought a washer and dryer because these children were going to school with their dirty clothes, and it just didn't feel really good. But when the patients would come in to wash and dry their clothes, the care coordinators go in there and talk to them. So really trying to find those patients, meeting those people where they're at, and having the flexibility of those value dollars to do those type of very unusual things.

The other thing I think a big discussion is around, the burden of the quality measures. And we all talk about reducing the burden for the providers, and we can reduce the

measures in our value programs. We support that. We -- you know, we're trying to get some systems up and create that efficiency and interoperability. But at the end of the day, for example, myself as a payer, I have over 120 quality measures that I have to report upon, be it state or federal government requirements. And if I have to report those, I have to get them from somewhere. So they might not be in my value programs, but I still have to go get them, and so that's still creating that unnecessary -- frustrating burden for those practices. So a couple different perspectives of feedback from providers, but it's different.

DR. STEHLE: Yeah. And a couple of things I would add to that, I think that was so well said, I think is really thinking about, much like to Lauran's question earlier, about sort of what does it take to be able to do this work? You know, we also have to think about that at the practice level. And so it was so important, you know, one of the feedback we -- you know, some of the feedback we heard when we started doing some of this was, you know, this is great that you're, you know, paying for experts to come together and to be able to have

these discussions, but, you know, here in my practice, when I have to actually implement this, like, you know, I need tools and resources to do this, too.

And so it was so important that we did that, right? Like, we actually invested practice transformation dollars in helping support practices to be able to do that work. You know, it was one thing we heard loud and clear, like, when, you know, at the time, there was a lot of pressure for us to say, well, adopt, like, the Medicare model, or adopt the NCQA[67] model, or, you know, whatever it was. And, you know, we heard loud and clear from our practices, like, hey, we want to do this. Like, we want to be able to help, you know, figure out where there's value and efficiency, but we need some help and support to get there. And so that was a big part of, then, us hearing them and being able say, like, yes, we can do this, you know? So I think that was a big piece of it.

And I think the other part, and Alicia touched on this a little bit during, you know, our opening comments, is, health care is

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local, right? Like, I mean, it is so much about, like, what we do, and the patients we serve, and our neighbors and our communities. And so the other thing that we heard was, yes, tell us what it is -- you know, be very clear, you know, as Janice said, like, be very clear about sort of what it is you're asking us to do, but then let us also figure out how we do that, right?

And so it was just -- it's just so amazing, like, I think about, you know, like, between, like, the different groups and the patient councils and stuff like that, where practices would come together and say, this is how we figured out how we're going to do this. Like, I remember, you know, different practices would say, well, we have the blue team, and we have the red team, and we'd have all these different sort of ways that they would then actually make it their own, which was so great. Because at that point, you know, just like any of us, right, when I have the opportunity to make something my own, it's more likely that I'm going to actually do it and I'm going to stick with it.

And so I just offer that as you're,

you know, thinking about, you know, both whether it's how to take this to scale or what is it that's important to the providers, I think it's definitely just like the rest of us, right, to be listened and to be heard, but also to be able to actually be part of the change and not just be sort of impacted by it as a downstream participant.

DR. KOSINSKI: Well, thank you. I have a question myself. I was really intrigued by the prospective payment to the hospitals in Pennsylvania, where you allow them to craft a budget around it. I really think that's a fantastic idea. What about the physician? Do they get prospective payment?

MS. WALTERS: So not yet. So again, our first program was hospital-specific, but one of the lessons learned that's coming out is we've got to figure out how to align this with primary care. And so as part of our next generation work, that's -- and I don't know if it's going to be a budget or if it's going to be incentive-type payments, but that's certainly part of what is we're iterating with, you know, our stakeholders. Like, we know so much of this work needs to be done in the

outpatient space with primary care providers sitting at the table, and so trying to figure out what that alignment strategy looks like and take that into consideration as we're building the budget.

So for example, for a lot of our rural communities, you know, they also employ the primary care and maybe even specialty providers. And so if we need more primary care within a community, as part of that development of that global budget, should we be assessing what we're going to need within that community to get to an adequate level of primary care? And do we take that into consideration as part of the budget in order to recruit the providers to the community, cover all of that cost?

So that's the type of conversation we're having. I don't have the answer to your question, Larry, specifically, but certainly, as we iterate, we know it's got to be more than hospital-focused. Our goal is to continue to stabilize, and then really big, I would say build a broader-continuum payment infrastructure that's going to meet the needs of the community. I certainly would ask Dr. Bulger his thoughts on that. He sits at the

table with me, engaging in these conversations.

So anything you would add to that, Dr. Bulger?

DR. BULGER: Yeah. Briefly. It's a great question, because and as Janice said, it's a shortcoming of the original program, it was only hospitals, and I think you got to figure out a way to have, you know, clinically integrated network or something else that's baked into it. And then that organization, whether it's the same, you know, it's a hospital and it's CIN[68], or it's the hospitals and a larger CIN, because we have some statewide clinically integrated networks. Like, for example, the Pennsylvania Medical Society started a clinically integrated network statewide a few years ago.

But there has to be a way to get the providers involved, and many rural hospitals don't have -- the providers are independent providers that are, you know, they aren't associated with them, which is sometimes different from large academic medical practices that might be in other places. So then figuring out a what -- and you have to bring

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those together. You can't have them separated.

I think there's also a question of -- to say, you know, other types of providers in the community, whether that's physical therapy, or home nursing, or skilled nursing, you know, all those, how do you wrap those in as well into one model? Because sometimes, they're all under the same payment umbrella within the community, but many times, they're not. But you really need all those people that are swimming in the same direction if you're going to make this work.

DR. KOSINSKI: How about Arkansas? Any prepaid models there for providers?

MS. BERKEMEYER: Yes, we do. And so I can add, on the value programs, we talk about, you have multiple programs you have to coordinate. So we have our Patient-Centered Medical Home, our Primary Care First, like Blueprint Primary Care, but we also have our ACOs, our risk ACO products, that are kind of the hospital contracts. They've got your providers. And so we've really had to work hard to combine and coordinate those efforts.

One of the things that we were hearing from the physicians independently in

the primary care specifically is, hey, the hospital is getting that payment, and I'm not seeing it in my practice where I need to get changes, or I need the funding in my practice to buy this or to do that. And so we just kind of work through that with some transparency tools.

So with that, each time we do a performance summary for the year, a thank-you letter goes out to that individual physician, thanking them for participation in the program. It tells them their attributed lives, it tells them how much care management fees, as well as their utilization quality incentive. So it's kind of a thank-you note, but it's a report card too, that goes out. And then two weeks after that, the similar goes to the CIN or the hospital with a whole summary and listing of all of them, of the performance and how that went for that participation. So what it did is it allowed conversation between the providers and the hospitals and how they can negotiate and coordinate that funding on those value dollars that they had earned. And, you know, it's been a -- I will tell you, I still to this day get a text when it's about value time.

About, hey, Alicia, where's my letter? Can I get my heads up? And so it's definitely important for us to coordinate those dollars and to ensure that they are being used in areas of need. And so the pre-funding is really in the primary care area, but because so many of our clinics are being purchased by the hospitals around here, it had -- we're moving to that tipping point where more are employed versus not employed.

DR. KOSINSKI: With some of those same services you just mentioned that you're able to provide by having a prepaid model is one of the major stimuli for prepaid concierge practices --

MS. BERKEMEYER: Yeah.

DR. KOSINSKI: -- developing all around the country. And I know it's region- -- city-specific, and it might not be as applicable in the rural areas of Pennsylvania -

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MS. BERKEMEYER: It is.

DR. KOSINSKI: -- but certainly in the major cities, you could see where a model you have with prepaying physicians could actually provide the mechanism for a hybrid

type payment model between prepaid value-based payments tied with, you know, fee-for-service --

MS. BERKEMEYER: Yes.

DR. KOSINSKI: -- payments with it.

Any other questions from any of my other PTAC colleagues?

Well, I guess we're going to get some time back. Excellent. Thank you, Committee members. If you have any other questions for our participants, you know, feel free to bring them. But I'd like to thank our four experts for joining us this afternoon for a robust discussion. You're welcome to stay. Oh, no, we're done. If you want to listen to the rest of the meeting if you want, but at this time, I think maybe we go to an early break.

And Lee, do we want to meet earlier after the break or keep it at the same time?

CO-CHAIR MILLS: We're going to go to a standard 10-minute break and return earlier. Say --

DR. KOSINSKI: Okay.

CO-CHAIR MILLS: Yeah. Say 25 after.

DR. KOSINSKI: Okay. You're all free until 25 after.

MS. BERKEMEYER: Thank you.

DR. KOSINSKI: Thank you.

(Whereupon, the above-entitled matter went off the record at 4:20 p.m. and resumed at 4:25 p.m.)

*** Committee Discussion**

MR. RAMACHANDRAN: Welcome back. I'm Krishna Ramachandran, one of the PTAC members. As you know, PTAC will issue a report with the Secretary of HHS that will describe our key findings from this public meeting on improving multi-payer alignment in value-based care.

We now have time for the Committee to reflect on what we've learned from our sessions today. We will hear from more experts actually tomorrow, but we want to take the time to gather our thoughts before adjourning for the day.

Committee members, I'm going to ask you to refer the potential topics for deliberation documents during this discussion. To indicate you have a comment, please raise your hand in Zoom. Yeah, I'd love to start

with some volunteers here.

Lauran.

MS. HARDIN: I'll get us started.

MR. RAMACHANDRAN: Thanks for being the first one. Yeah, thank you.

MS. HARDIN: So I'm really struck today by the universal lesson. So one quote that sticks out to me is what we're really trying to do is move communities, integrated systems from a transactional relationship to a partnership model. And that involves deep trust building amongst partners and providers to have shared values, a payment model that works or a way of doing that and metrics that work. But also, a really important role that continues to come up is that convener role, the investment and the practice change, the capacity building, and also some of the work around systems change and redesign of systems of delivery.

The funding of that kind of role is really critical. We saw that in OneCare Vermont. We heard that from the last sessions. I think really thinking about how do we continue to invest in those integrator roles? I've seen on the ground in practice what

happens when we do early investment and then take that infrastructure away, how difficult it makes it for the change to continue. So very important for success in multi-payer alignment and roles. And then also thinking about shared infrastructure, what a difference that makes. So the difference in multi-payer alignment in states that had one HIE and support for the data analytics, advanced payment to really equalize the table with who's at risk, and also thinking about integrated care coordination structures and how that can be disseminated, especially for rural outreach can equalize the table with access to specialty.

MR. RAMACHANDRAN: Yeah. Well said, Lauran. Yeah. I think the convener, the infrastructure, I think key elements that we heard as well, like a sort of through line across many sessions, too.

Lee?

CO-CHAIR MILLS: It was well said, Lauran. I one hundred percent agree with everything that you said. I was struck by -- really what these experts who have all been there and done that in the real world emphasized is this isn't really about a metric,

a program, an incentive. This is operating at a level way larger than that. This is culture change in a community with community leaders, employers, government agencies at multiple levels, and providers at multiple levels. And so I think that just really struck me that it's clearly not -- you can't issue a program and think it's going to be successful, right? You've really got to take it and do the hard work of culture change management throughout a community, which is, when it's as large as a state, is a multi-year process. So that was very striking.

Again, as I'd commented earlier, within the first session especially, was really struck by the unanimity of the opinion that Medicare Advantage has to be part of the portfolio, because only when it's included do you get to, you know, the 60 or 70 percent of a patient population that's required to get engagement, get health systems and providers willing to change what they do. So I think that was really striking. And I guess this last session, just kind of talking about what were the elements that were necessary to get providers to change, and they spoke -- looking

for my notes, but they spoke to reliable revenue, multi-year projected reliable revenue, they spoke about simplification and making it easy to understand by the practicing doc and the patients, both. You have to have an actuary to explain it, it's not simple enough, right? So the programs have to essentially insulate both providers and patients from that level of complexity, decrease the burden of program administration, and emphasize the criticality of just predictabilities, which speaks to, you know, a one-year plan with changing metrics and/or benchmarks every year is just probably not going to move the needle. It takes a longer time horizon to affect culture change in a practice environment. So those were all things I took away.

MR. RAMACHANDRAN: Great addition.

DR. KOSINSKI: I can go next.

MR. RAMACHANDRAN: Yeah. Go ahead, Larry. Yeah.

DR. KOSINSKI: I'm going to just pile on to what Lee just said. We heard simplification all through the sessions today from multiple speakers, even one saying we should abolish MIPS and revamp the Star

program, and I couldn't agree more because from my provider days, I mean, when you've got multiple ACOs, you're participating in multiple health plans you're trying to hit measures with, it's just, it's crazy. So that came out loud and clear. The second point -- oh, and on that simplification, I love the line, whenever you need an actuary to calculate something, you have a barrier. So simplification was one of them. The second line was push from above. We heard that multiple times. And one person even said, if we don't have CMS at the table, it's difficult.

So again, that power from the top pushing down on this thing to make sure everybody's participating and we're all going towards the same end. And, you know, the line, believe in it, understand the nuances, and fully fund it, you know, somebody's got to have that kind of influence over it. And the final thing I was intrigued about was in that Pennsylvania program giving the hospitals -- abounding their budget. Now, I didn't ask whether they got extra payments for, you know, high-risk, high-intensity services. I'm sure there was a reconciliation that brought all

that into the end, they did mention reconciliation, but what was the line? You need predictable revenue to build infrastructure. And so that applies to the physician side, just as well as it provides to the hospital side, though I think, you know, there's infrastructure necessary for the change we're talking about, you need predictable revenue. So you know, in the multi-payer environment here, those three pillars, simplify the system, have push from above from the biggest entity, meaning Medicare and Medicaid, and then revamping the structure of prospective payments. I thought it was a good day.

MR. RAMACHANDRAN: Yeah, well said, Larry. Other thoughts, comments?

DR. BHANSALI: I can go next. So I really like the way Mike outlined the five key components that need to be simplified around attribution, quality, risk adjustment. I can't remember the other two, but those five key pillars I thought was a good summary of how we need to think about simplification. Fewer programs was another one. And the attribution piece came up again when Karthik spoke, is even if we want to allow Medicare Advantage payers

to have creativity around how they create their programs, there are certain components of the program that can be made standardized without necessarily impacting their ability to be creative or innovate, like attribution, for example. And I remember Karthik saying that one of their payers does attribution really well, others don't, and that has a huge impact on how they're able to manage their population. And if Nicholas was able to take a couple of those key things away is that we don't want to stymie innovation and creativity but, at the same time, having certain standardization will allow for better population-based management I think was a good takeaway.

MR. RAMACHANDRAN: Great, Henish. Thanks.

Other thoughts, folks?

DR. LIAO: Yeah, I can jump in. Yeah, I agree with a lot of what's been said. I think one of the grounding things, and I'm glad this was our first session today, was really about kind of like being, kind of entering with humility and being humble about what we're trying to achieve and what we can achieve here. I think it's a little bit more

than that. I think as I've listened today and heard responses from our subject matter experts, it strikes me that, you know, where we're talking about alignment, there's kind of this pull towards, like, standardization, what we've called in the PCDT kind of more exact alignment, and then flexibility, which might be -- you think of as, like, directional. You know, as long as you're working on quality in a chronic disease way, we don't have to line up around the details and the specifications. And I don't think they are opposing principles, but I think they're kind of complimentary design levers, what I would call them.

And, you know, I think standardization promotes comparability. It helps with oversight. I think flexibility allows innovation, responsiveness to local needs, which is what you want. I think MA provides a really important example of that. I think -- you know, Larry mentioned things around mandatory versus voluntary. I think all these things that we talk about lives on the spectrum of do we want to standardize or promote flexibility? I think I mentioned this a little earlier, but I continue to grapple

with what is the policymaker's role in that then? And I think perhaps the best word I can think of, at least today, is calibration, right. So changing flexibility affects certain things and vice versa. There's always a trade-off there. So I think simplification's good, but it has its limits, right? With greater standardization, reduces administrative noise, it makes things simpler. This is good. But it also limits choice and limits ability to be flexible to local needs to kind of map the culture that Lauran and others are talking about.

I think we just need to be humble and acknowledge that there's a trade-off there and not pretend it doesn't exist. And I think our speakers helps us kind of realize that today in a kind of real world way. I guess the last thing I would say here is just that, you know, I think we can simplify things. I agree with Henish. I think I agree with Henish. I think we can simplify and align attribution, risk adjustment, quality measurement, et cetera, but I would humbly push back on this idea that, like, these models that we're talking about are inherently hard, right. We

just, like, need to acknowledge that, like, fee-for-service works because you know time and materials, parts and labor, and you can kind of map that out as a clinician or as a group. When you're, like, risk-adjusted for what the spending should be for these populations that may or may not be -- it's hard. So you're going to need actuaries, you're going to need statistics, and that's just an inherent part of this. And so I don't want the simplification to overlook that point. Can we make it more rational and standard? You bet. I think it's a dial to calibrate against flexibility and local needs, and I think some of these things are just inherently complex and that's the world we live in. But anyway, great day.

MR. RAMACHANDRAN: Yeah --

DR. KOSINSKI: You know, Josh, on what you just said, it would really help if what CMS did was to set all those risk adjustment rules, because they're different. Whatever payer you're getting a risk adjustment from, they all have their nuances. And you always suspect that they've created their special nuance just to decrease what they have to pay you so, you know, some standardization

there would really be welcomed by everybody.

DR. LIAO: Yeah. And I think Larry, I know of all people, you know this, it's like -- I think we all know this, to some -- it's not, like, a yes or no, standardized or not, but it's like what would you standardize and to what degree? And, you know, I thought we started with the easier task today. In the morning, we were talking about insurance vehicles for the elderly in America MA versus – fee-for-service in different flavors of MA. We're wading into much harder case of, like, you know, children and women against seniors in America against employee populations. As we do that, I just think this trade-off is going to be hard, right. Like, acknowledging some complexity is structural and that you can't undo the net cons without losing some of the pros I think is the point here. So --

MR. RAMACHANDRAN: Yeah, well said, I think, both of you. I mean, inherently, I think it's harder to simplify it in my mind, where we can align, and these models are just complicated, as Josh has said. Like, when you think about anything that does that global budget, it's like, well, like, how does it

compare to my fee-for-service? What's the comparison? What's the adjustment? How do I set the rate for the population? There's a ton of, like, complexity just built in, especially coming from a world where I've had to design some of these models. But I think can be aligned better, can be streamlined better. There's still some, like, good nuggets, I think, today we had. Other folks' thoughts? Happy to share mine, but I figure I'll give you all more room just to share thoughts.

DR. LIN: I'd be happy to jump in.

MR. RAMACHANDRAN: Yeah, thanks.

DR. LIN: Yeah, I agree. It's been a great day. No, I think my big picture takeaway from today is what PTAC has been saying for a long time now, namely that multi-payer alignment is essential to scaling value-based care. But I think what today shed light on is that this alignment must be very pragmatic. So from today's morning session, it's clear that CMS' convening role and/or regional conveners have the potential to accelerate collaboration, yet durable progress really requires standardization around timely data, clear attribution, ideally a concise core

quality measure set and equitable payer cost sharing, so providers aren't forced to cross-subsidize transformation. No, I think it's also evident from today's session that a primary care focus seems to be the common linchpin. Strong PCP relationships and reliable attribution methodologies enable early engagement and lower utilization.

From the morning session, I was struck by the extent that Medicare Advantage often outperforms Medicare ACO, I think primarily because of better attribution, timelier data, and an expanded toolbox, including, I think as Karthik mentioned, utilization, management, and narrow networks. The afternoon sessions demonstrated valuable state experience showing how to operationalize this Multi-payer reform seems to succeed when a strong mutual convener and inclusive governance facilitates sustained engagement from payers and providers. Also, predictable prospective payment structures and allowing primary care funding seem to reduce provider burden and enable transformation, as well as shared metrics, interoperable data, infrastructure, and up-front investments in

practice transformation and analytics are also essential to scale and sustain progress. Some of the unanswered questions for me include how to operationalize Medicare Advantage engagement at scale when managing MA plan heterogeneity. That was mentioned this morning. Which kind of specific core quality measures should be standardized across Medicare project lines without stifling innovation? What kind of legal waiver or market flexibilities are needed to enable sustained payer collaboration and long-term financing and convening? You know, I look forward to hearing how our subject matter experts think about addressing these challenges and others more in tomorrow morning's session.

MR. RAMACHANDRAN: Excellent. Thank you, Walter. Lindsay, I think I thought I saw you go off mute, so --

DR. BOTSFORD: Yeah, it was a competition there for a minute. Yeah. I mean, I think some of the themes we heard today, while not necessarily specific to multi-payer alignment, warrant probably repeating, and maybe this is repetition again, if I missed it. But, you know, from Michael Chernew was talking about, you know, what do you need to succeed

and talking about, you know, systems need stability, not for next year, but for 2030 and years into the future for systems to actually transform. And I think the quote that stood out to me from him was, you know, do less more simply for a longer time horizon. And it seems like we're starting to learn some of those lessons but, you know, maybe it's not just a complex new model as refining existing ones with doing less.

I think we heard a couple times just themes around HIE-enabled data sharing, helped increase communication and reduced low-value care by understanding what's been done before and the broader health care ecosystem. And I think also themes of it as the HIE is a public good and how might that further some of the multi-payer alignment, if there were common data. And then I think, you know, when explicitly, kind of, talking about what's the role of the state or the federal government for that matter in multi-payer alignment, you know, it sounds like, and from the Vermont learnings at least, a little more push would've been helpful. And it's not just performance, but it's actually meaningful help along the way and

not just quality metrics or whatever it may be. And then similarly, that requirement that payers stay in. So maybe not dictating the exact terms, but there has to be participation and communication for success. Those stood out to me. Thanks, Krishna.

MR. RAMACHANDRAN: Yeah, well said. Well-rounded there. Any other ones? Any other folks that haven't gone? I have some comments to add, but I think I'll -- okay, wonderful. I think the challenge of going last is that you've covered much of my own observations as well during the day, but in the spirit of rounding it out, interestingly, I think this whole, you know, back to sort of the speed of trust comment I made in our ask -- one of the questions on it, comes back to that trust alignment, I think, was still such a key piece of this as well. And so that was -- yeah, I thought it was another sort of through line that stood there. And I think there was a comment made on just, like, stakeholder motivations. There's just, obviously, you know, you know, bringing people together, but also making sure that the various parties, payers, providers, other stakeholders, are

actually aligned, and we have the motivation to actually align, I thought that was key there.

Similar to Lauran's observation, the role of a convener I thought was helpful and needed, whether it's regional or broader, particularly the contracting example, because that's the true reality, right. When these things happen, that multi-payer to multi-provider, there's just sort of a mess of contracting. And certainly the convener has the opportunity to sort of align the contracting, maybe less about reducing complexity as much as just, like, same but different variability. I think the interesting opportunity there from a contracting data, the core dataset, some of you have mentioned as well, I thought that was helpful. And then the shared infrastructure, Lindsay, you and others mentioned that as well from our data reporting. How can technology be a -- consistent technology be an enabler, whether it's an HIE or some other methodology there?

Certainly the advancing payments stood out. It just is one of those challenges we've had with just fee-for-service value-based care, particularly the ACOs. It's so delayed

and time delayed, and so where we can front load, I think is good, and certainly will help with the engagement and alignment. Particularly, it was good to see the global budget work in Pennsylvania as well on this space there. I also appreciated some of the speaker's comments on just planning as a strategic sort of function there as well. How do we make sure we can create the artifacts that we can reuse to scale I thought was just a sort of under-emphasized, but I thought it was helpful. Be like, you know, it's good governance and good organization can be helpful. And then the sort of push from state policymakers that nudge, I think, was key, as well as just continued stability from our payers and policy folks as well, that it's funding or measures and other things as well. So yeah, those are things that stood out for me, and I think many sprinkled in with all -- any of your comments as well. So I appreciate you all.

David, I don't know if you were able to get off -- if there anything else you wanted to add as well, so -- we can't hear you if you're saying anything. No, we still don't

hear you, David. But maybe just if you want to send out your thoughts via email too, that would be good. We can incorporate it.

Yeah, there's no other thoughts, team, yeah, thank you all for obviously your contributions and your, you know, sharing your insights and observations during the day as well. I loved this session a lot just because I feel like you all just look at the world so differently and bring such unique perspectives from your worldview. So it is just always awesome to see how you all see the day and how you bring it together. So one of my favorite parts of these meetings, so thank you all. Maybe I'll give it to Lee for just logistics about tomorrow or other things as well.

*** Closing Remarks**

CO-CHAIR MILLS: Very good. Thank you so much, Krishna. This time, I want to thank everyone who participated today. Our wonderful session experts, my PTAC colleagues, all the amazing staff that make this possible, and those listening in.

We will be back tomorrow for our next session at 9:00 a.m. Eastern time. We'll be joined by four more incredible experts who

will share their perspectives on addressing challenges to advance multi-payer alignments. There will also be an opportunity for public comment tomorrow morning at approximately 10:50, that's five, zero, a.m. before the meeting concludes with the Committee discussion.

*** Adjourn**

We hope you will join us then. We look forward to continuing the conversation tomorrow. And thank you for today. The meeting is adjourned. Be well.

(Whereupon, the above-entitled matter went off the record at 4:50 p.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: 02-23-26

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