PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

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PUBLIC MEETING

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

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Tuesday, September 9, 2025

PTAC MEMBERS PRESENT

TERRY L. MILLS, JR., MD, MMM, Co-Chair
SOUJANYA R. PULLURU, MD, Co-Chair
LINDSAY K. BOTSFORD, MD, MBA
JAY S. FELDSTEIN, DO
WALTER LIN, MD, MBA
KRISHNA RAMACHANDRAN, MBA, MS

PTAC MEMBERS IN PARTIAL ATTENDANCE

LAURAN HARDIN, MSN, FAAN*
LAWRENCE R. KOSINSKI, MD, MBA*
JOSHUA M. LIAO, MD, MSc*

PTAC MEMBERS NOT PRESENT

HENISH BHANSALI, MD, FACP
JAMES WALTON, DO, MBA

STAFF PRESENT

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

*Present via Zoom

A-G-E-N-D-A

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

9:01 a.m.

*** Welcome and Co-Chair Overview - Using Data and Health Information Technology to Transparently Empower Consumers and Support Providers Day 2**

CO-CHAIR MILLS: Good morning. I call the PTAC to order. Welcome to Day 2 of the public meeting of the Physician-Focused Payment Model Technical Advisory Committee known as PTAC.

My name is Dr. Lee Mills. I'm one of the Co-Chairs of PTAC, along with Dr. Chinni Pulluru.

Yesterday, we had a number of experts share their perspectives on using data and health information technology to transparently empower consumers and support providers.

Today we have a great lineup of experts for two separate sessions. The first session is focused on data-driven approaches to enabling patients with chronic conditions and enhancing secondary prevention.

And the final session will be focusing on payment models and benefit designs, improvements to enhance patient empowerment.

The Committee has also made considerable

effort to include a variety of perspectives throughout this two-day meeting, including the viewpoints of a previous PTAC submitter.

Later this afternoon, we will have a public comment period and welcome participants either in person or by telephone to share viewpoints and to share comment related to the meeting's topic.

As a reminder, public commenters will be limited to three minutes each. If you have not registered to give an oral public comment but would like to do so, please reach out and email PTACregistration@norc.org.

That's PTACregistration@norc.org, prior to the public comment period at 1:05 p.m. Eastern Time.

Then, the Committee will discuss our comments and recommendations for the report to the Secretary.

*** PTAC Member Introductions**

Because we might have some folks online who weren't able to join yesterday, I'd like the Committee members to please introduce themselves.

Share your name, your organization, and if you'd like, tell us about your experience with

our topic. And I'll cue each of you in turn.

I'll start. My name is Lee Mills. I'm a family physician and currently serve as Chief Medical Officer of Aetna, Better Health of Oklahoma, one of the state's managed Medicaid plans.

I have served in, after starting private practice in rural Kansas, started in multi-specialty medical group and health system leadership, and have had the pleasure to practice in or help lead operations in five or six different CMMI[1] models over the past 20 years.

Chinni?

CO-CHAIR PULLURU: Good morning, Chinni Pulluru. I'm a family physician by trade, have practiced about 15 years in suburban Chicago.

Led a large multi-specialty group, as well as served as the Chief Clinical Executive at Walmart Health, having spent about 20 years in implementing value-based care.

Currently, I serve as the Chief Medical Officer of Stellar Health, a value-based care enablement company, as well as have founded a company in genetics, and most recently consumer-

1 Center for Medicare and Medicaid Innovation

based AI[2] navigation tools. Thank you.

DR. FELDSTEIN: I am Jay Feldstein. I'm originally trained as an emergency medicine physician, practiced emergency medicine for 10 years. Then was in the health insurance world, both the commercial and government lines, for close to 14 years. And have been the President of Philadelphia College of Osteopathic Medicine for the last 11. I have been a PTAC member for six years.

MR. RAMACHANDRAN: Thanks, Jay. Krishna Ramachandran, Chief Information Officer, operations and experience for United Healthcare. Health care for 23 years, tech payer/provider segments.

Data and technology have been topics close to my heart. So, I'm excited to be the lead for the PCDT[3] team here for this meeting as well.

Lindsay?

DR. BOTSFORD: Thanks, Krishna. Good morning. I'm Lindsay Botsford. I'm a practicing family physician in Houston, Texas, where I care for patients, including Medicare beneficiaries. I

2 Artificial intelligence
3 Preliminary Comments Development Team

also serve as the Medical Director for the Midwest and Texas with One Medical. I have been a participant provider in multiple CMMI models, and I'm currently the Chair of the governing body of our ACO[4] REACH entity for One Medical.

DR. LIN: Good Morning. Walter Lin, the Founder of Generation Clinical Partners, independent medical practice based in St. Louis that cares for the frail elderly in nursing homes and assisted living facilities.

I'm also the Clinical Strategy Officer for LTC ACO, as well as Medical Director for various programs, provider-based programs, including a PACE[5] program and institutional special needs plan.

CO-CHAIR MILLS: Larry, go ahead.

DR. KOSINSKI: Good morning. I'm Dr. Larry Kosinski. I'm a retired gastroenterologist. I practiced for 35 years in the Chicagoland metropolitan area, helping build the largest GI[6] group in Illinois that is now part of the GI Alliance, the largest independent GI practice in the country.

4 Accountable Care Organization
5 Program for All-Inclusive Care for the Elderly
6 Gastrointestinal

Ten years ago, I started a value-based company named Sonar MD, which actually was started in the commercial space following a PTAC presentation. We were actually the first PTAC recommended physician-focused payment model in April of 2017.

Currently, today, I'm the Chief Medical Officer for Jona, which is an AI-powered microbiome company. And I have another startup, VOCnomics AI, which is a company built around a wellness product that uses AI to enable patients to monitor their soluble fiber intake to control their weight. It's deployed in the obesity space.

I've been on the Committee for four years. I'm happy to participate today.

CO-CHAIR MILLS: Thanks, Larry. Go ahead, Josh.

DR. LIAO: Good morning, everyone. I'm Josh Liao, internal medicine physician and professor at UT[7] Southwestern Medical Center. Over time, I've had the privilege of conducting research, doing evaluations, implementing and leading programs, thinking about strategy, and working with a number of state and federal

7 University of Texas

decision-makers on issues related to payment models and delivery models.

In the course of doing that, obviously, I've grappled with data in its multiple different forms, claims, EHR[8], patient-generated, multiple data sources.

And so, I'm excited about continuing this conversation today.

CO-CHAIR MILLS: Thank you, Josh. Thank you all. For today's agenda, we're going to explore a range of topics on using data and health information technology to transparently empower consumers and support providers.

The background materials for the public meeting, including an environmental scan, will be posted online at the ASPE PTAC website meeting page, which is publicly available.

The discussions, materials, and public comments from this meeting will inform a report to the Secretary of HHS[9] on our topic using data and health information technology to empower consumers and support providers.

Lastly, I'll note that as always, the

8 Electronic health record
9 Health and Human Services

Committee is ready to receive proposals on possible innovative approaches and solutions related to care, delivery, payment, or other policy issues from the public on a rolling basis.

We offer two different 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.

And now I'm excited to hand it over to Krishna to welcome and facilitate our first session. Krishna?

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

MR. RAMACHANDRAN: Thank you, Lee. As I mentioned, I'm Krishna, I'm one of the members and was the lead for the Preliminary Comments Development Team, so PCDT for this meeting.

For this meeting, in this session particularly, we have invited four esteemed experts to discuss their perspectives on data-driven approaches for enabling patients with chronic conditions and enhancing secondary

prevention.

You can find their full biographies and slides posted on the ASPE PTAC website and the public meeting registration site.

At this time, I'll ask our session participants to go ahead and turn on video if you haven't done so already. Thank you all.

After all the experts have presented, the Committee will have plenty of time to ask questions and engage in what we hope to be a robust discussion.

We actually have two speakers on video and then two in person as well. So, thank you for joining us live here in D.C.

Presenting first though will be Dr. Charles Senteio, an Associate Professor in the Department of Library and Information Science at Rutgers University School of Communication and Information.

Charles, welcome to PTAC.

DR. SENTEIO: Good morning and thank you. Thank you for the opportunity to share this perspective and this very important work.

My work focuses on how we can center the patient's lived experiences, collecting

information, and using it accordingly, especially psychosocial and social needs information in the care process, and how respectful AI-enabled tools can help make this information accessible before, during, and after clinical encounters.

Next slide, please. As a health equity researcher and licensed clinician, I examine how patient experiences such as stress, perceived discrimination, and caregiver burdens affect chronic disease care.

As an information scientist, I study digital tools that elicit and summarize this data for clinical use. My work complements other panelists by focusing upstream at the point of patient engagement, while platforms like CareCo support downstream coordination. Next slide.

Whether in primary or specialty care, we understand that there is more to patients than just in their diagnosis. Actually, we've known this in care delivery for quite some time.

Patients live with much more than just their diagnoses and their clinical conditions. But that lived experience is not fully captured in the EHR.

When we think about reasons why patients

don't fill a prescription, for example, that information is not as reified, not as defined as say, their height, their weight, their payer status.

So, simply, that information, even if it were collected routinely, is not easy to collect in our current tools. And that's been the case for quite some time, but new technology is making that information more accessible. As many of us can relate, there are many different reasons, and those reasons can be updated almost daily in why or why not, we may take a medication or not, or why our dietary practices or our physical activity may be what it is.

So, I think most of us can relate to some of the challenges, and some of the decisions, and some of the information that informs decisions that patients, particularly patients with chronic decisions make, or chronic diseases make. And disclosing that information happens more fully when we are in respectful, trusted environments. And AI tools can help with that. There's some early evidence on that. Next slide, please.

We have two promising paths. First, pre-visit AI avatars or chatbots enable private,

stigma-free disclosure of sensitive experiences like why patients may or may not take medications or even fill a script, disclosure of sensitive experiences such as trauma in a care delivery setting or outside of a care delivery setting. This has been validated in several care settings, including emergency departments.

Generative AI tools tailored with social determinants of health-aware prompting, such as in heart failure dialogue models, have shown that they can in fact enhance the quality of dialogue through empathetic engagement.

It still lags behind human interaction, but I think that the trends are headed in that direction if we keep these things top of mind in terms of empathy and simulating that, or to the degree we can, simulating that approach.

Second, in-visit AI prompts, like those piloted at Stanford, support clinicians in addressing these needs during care.

They report that ChatEHR is a conversational AI-enabled tool that's integrated into Stanford's EHR system. It enables clinicians to query patient records and generate summaries.

These kinds of tools complement

downstream platforms like CareCo by enriching the upstream data that care coordinators and other clinicians can act upon. Next slide, please.

So, when tools are designed with empathy, and dignity, and respect in mind, in terms of language, in terms of tone, even in terms of appearance, patients tend to engage and disclose to tools.

When providers are given brief, relevant summaries or AI enabled prompts, they are more confident in tailoring their care. What can result is better chronic disease management, fewer missed red flags, and enhanced, increased trust.

There are indicators that under certain circumstances, the use of technology-enabled tools can result in reduced emergency use and increased follow-up care. And this is true for communities that are historically underserved. Next slide, please.

So, to manage chronic disease or to better manage chronic disease, we must treat more than symptoms. And we've known this for quite some time.

We must treat people and keep people at that center. That requires understanding their

lives, their lived experiences.

We already have the data, the tools to gather this data and this information at scale. What we need to do is keep top of mind the importance of empathy and what that has to do with disclosure of information, as well as how that information may be used.

Respect and technology are not opposing forces. They can be part of a formula that results in better outcomes, a noble objective, which unites us all.

And I have references should you choose to follow up. Thank you.

MR. RAMACHANDRAN: Thank you so much. I appreciate it. We'll save all questions from the Committee until the end of all presentations. But, thank you.

Next up, let's move to Dr. Gianni Neil, who serves as Chief Medical Officer for ChenMed. Gianni, thank you for joining us. And please go ahead.

DR. NEIL: It is my pleasure to speak to the PTAC Committee and my colleagues in the space today on a little bit about what we're doing at ChenMed, how we're using technology to empower our

patients, and leave you with some thoughts about where the gaps may be that we can lean into for our patients to experience better care in the future. Next slide.

And so, this is a little bit about me. I won't spend too much time. But I've been with ChenMed for about 12 years.

I started as a primary care provider. I'm internal medicine pediatrics trained. I'm now focusing on the adult and aging population and also making sure that we are providing for our patients that we serve in 111 states, 111 centers across 12 states. Next slide.

So, this is a little bit about the company's set-up and our snapshot. For those of you who are not familiar with ChenMed and how we operate, it's really important to understand the people that we serve and the structure of the model, to really begin to understand where the gaps may be and where technology can be improved to help us deliver this care.

And so, we started as a family-owned company, and we still are to this day. For over three decades, we've served the underserved population. And we have a bold and lofty vision

to be the most influential primary care provider in the cities that we're serving, transforming care for seniors while strengthening their communities, achieving better outcomes, and lowering total health care costs at the same time.

And so, across our footprint, we employ about 4,000 team members that rally around the PCPs[10] to serve patients that are medically complex. Our average number of chronic conditions is about five.

And then, we have 30 percent of our patient population who are partial or full dual. And, in addition to that, about another 40 percent of the remainder of the population are LIS[11] eligible.

So, needless to say, we are serving people who are truly underserved, and many of whom are given about $30,000 or less than that on which to live for the year.

We operate again in 111 locations across 12 states under three brands. Our flagship is Chen Senior here in South Florida. JenCare Senior Medical Center and dedicated Senior Medical Center

10 Primary care providers
11 Low-Income Subsidy

are our other two brands. Next slide.

And so, for this slide, I really want to start with a little bit of imagery about a real patient that I recently saw on one of my trips to visit the centers in New Orleans.

So, imagine a woman, she's a grandmother, she's in her mid-seventies. And she's actually at the visit with her granddaughter. Why? Because she is the caregiver while her parents are working. She, however, has COPD[12], and it's not well-controlled. And while the clinic is working very hard with her to be able to help her to control her COPD, she has trouble affording those very expensive inhalers.

And so, we're working with her to try to see how can we help her with the cost, help her with her chronic illness, and allow her to exist and be present for caring for her family.

Now, you can begin to see how we believe that caring for these patients also leads to strengthening these communities.

In these communities, the elderly patients, those grandmothers and grandfathers, they are the ones that are doing the work of home,

12 Chronic obstructive pulmonary disease

while their children, their relatives, their neighbors are out actually working in the space.

And so we believe that these patients really do need us to be there for them and give them more good days.

You'll see at the top, the urgent pursuit of more good days. That is the first line in our big vision. And by more good days, we mean that the patients are doing what they like to do, with agency increasing not only their lifespan, but their health span.

We want them to be healthy. We want them to experience that quality of life. And so, I'll draw your attention to the wheel that we have there.

And this is essentially a pictorial representation of our model. At the center is the patient, which is the focus of everything that we do. And it begins with detecting what high-risk disease situations do they already have, and how can we predict and prevent the next thing from happening?

And so, we have a detective hat that we wear. And, we want to be ahead of and not behind chronic illnesses for our patients, and want to

make sure that they are managed exquisitely well.

And we do this through surrounding a PCP, who has a reduced panel, with care team members that are supporting them as they care for that patient. They coordinate not only what happens within our centers, but they also need to coordinate what happens outside of the center, external to the patient, so when that patient is engaging, for example, with ERs[13], hospitals, specialists, we need to make sure that that's a highly coordinated event to decrease error and make sure that we're not experiencing fragmentation of care for that patient.

And then we have ongoing patient engagement, education, and empowerment. We are trying to build communities.

And so, we make our centers a go-to place for the community. They come in, they're not only able to receive a cup of coffee or a little something to eat on their way in, but they can also come for exercise classes, for cooking classes, for, you know, an expert advice on a relevant topic for seniors.

And so, we make our centers a beacon in

13 Emergency rooms

the communities. And, because they experience, I told you a little bit before about the socioeconomic status of our patients, we also need to provide for them real needs that they have, so transportation to the centers.

We need to help them with affording their medications. We are aware that they have housing instability, food insecurity, and these are the factors that we are trying to go after as we build these communities in the places that we serve. Next slide.

And so, this is a busy slide, but I'll walk you through it. This is the patient care journey at ChenMed.

And so, I mentioned before that our patients are assigned to physicians, and they have a reduced panel compared to our fee-for-service counterparts.

We expect our physicians to empower and build immense trust with their patients so that they remain top of mind for those patients should any medical problem arise or they experience any change in their health.

And so, we give our patients, for example, their PCP cell phone number. And we

actually lock it into their cell phone at the first visit that they have with their PCP so that they can know this is my doctor calling, or they can text their doctor if they have any issues.

We have a comprehensive care approach where we're really seeking, as I mentioned before, not only to manage what's there, but also to prevent what's coming as much as is within our power.

And so, we do a robust set of screening. We see them often to monitor for even subtle changes in their health.

We want to make sure that we're checking on them. We have folks that live in the cold, for example.

When it is really cold outside or if they don't have the means to be able to heat their homes, we want to be a source of heat for them. So, we go and get them and bring them into the center, and keep them there to keep them well throughout those times.

The patient and the PCP really act as team members and the family extenders as well. And we call ourselves copilots, because we really want to be holding that patient and their family's hand

through their experience with health care.

As you know, many of our patients, if they -- our average age is about 72. And so, we're actually holding their hand with them through the last decade of their lives in most cases. And so, we take that very seriously.

And then, of course, we are going to have to refer them outside of our care model at times to receive specialist care, specialist intervention, or even emergency services.

And so, we want to make sure that when we're doing that, that we're getting the information in a timely manner so that we can also make updates to their care plans without any delay or confusion or overlap, you know, for the patient that could be bad for them.

For example, when they go to the hospital and they get a new medication, we really need to reconcile that medication list pretty quickly, because the patient will take duplications if they're not careful.

And if there's not a system that really reconciles that between the outpatient and the inpatient, it really leaves a lot of room for error.

And so, we see our patients, aim to see our patients within 24 to 48 hours to do that reconciliation, to prevent those errors from happening.

Of course, we want to make sure that we're with them no matter where they are in the health care continuum. Whether that be in receiving a home health within their home, or at a skilled nursing facility, a rehab facility, or a long-term chronic care facility. Next slide.

And so, the way in which we empower our patients, really is illustrated in the previous demonstration of the model. But there are gaps there that technology and improvements in communication could really help us fill.

Obviously, we empower our PCPs and equip them to have really strong relationships with their patients.

But we do need to be able to have them be able to interact with us and even detect when there are changes in their health while they're at home. Preventing them from having to have the stigma or the hesitation of calling to say, hey, this is going wrong, I need help with X or Y.

And so, we interact with them frequently.

But we know that this is a way in which we can help empower them. And there are many AI tools that are arising, and we want to be able to decrease the barrier for the patients to be able to access those tools into the future.

Internal care coordination and infrastructure really helps us to ensure that the specialists that we have internally, whether they're contracted or employed, are serving those patients in a timely manner. It becomes more difficult when they have to go outside of our model.

And so, separate EMRs[14], separate systems that don't really coordinate with each other or talk to each other, has truly been a barrier for us.

Health Information Exchange information, state to state, varies in the timeliness that we are able to receive it and act upon it. And it truly helps us immensely when we can get that information in a timely manner.

And so, removing some of these barriers to communicating with Health Information Exchange on behalf of our patients, it really does help us

14 Electronic medical records

to keep care coordination tight and prevent the patient from experiencing an error in medical care.

And lastly, our PCPs are basically our chronic disease health coaches for our patients. And so, if we have technology that we can deploy to the underserved, removing those payment barriers that whether they be wearable devices or ambient devices, really will help us to get more information into our clinics to prevent that ER arrival in the future. Next slide.

So, these are basically, I think I talked through most of this slide, and the other slide that I have is really in response to the questions that have come up.

But I'm happy to continue to talk through them as we go into the dialogues, the dialogue portion of the session. But, really, you can kind of see with the continuum of care that we provide here at ChenMed, how it's truly important for us to have more integrative resources, getting more information at our fingertips, truly being able to quarterback the care for our patients and decrease fragmentation.

I thank you for your time, and I'll hand

it back over to the host.

MR. RAMACHANDRAN: Thank you, Gianni. Next, we are happy to welcome in person Mr. Mendel Erlenwein, who is the Founder and Chief Executive Officer of CareCo. Welcome Mendel.

MR. ERLENWEIN: Thank you so much. First of all, good morning and thank you to the Committee members and to the Co-Chairs.

This is really an honor to be here. And I had a chance to talk with Khue a little before. And hearing the other two panelists today, there seems to be a lot of similarity and synergies around some of these concepts that we'll talk about today.

And so, my name is Mendel. I'm obsessed with value-based care and very specifically care coordination.

I've spent the last, let's see how this clicker works. Nice. Today I'm the CEO[15] of CareCo, which we'll talk about.

But CareCo was built off of the last eight years that I've spent building a service-based care coordination company. And so, we talked to thousands of patients a month doing programs

15 Chief Executive Officer

like chronic care management, transitional care management, and annual wellness visits.

The seven years of building that company and seeing the impact that really good care coordination can have on patients when done correctly, really gave me, I think, two things.

First of all, a really deep appreciation for care coordination. I know that in health care, every part of health care is the most undervalued and underappreciated part of health care.

But I think from within health care, care coordination I think takes that prize. And that's because when care coordination is done correctly, it really becomes the foundation for the entire patient's experience with health care.

We would have patients that would go to their primary care doctor, and it would be a whirlwind. They'd go in, doctor would come in, doctor would go out, they'd go home, they'd call their care coordinator, and they'd ask them to look at the visit note and explain what in the world just happened.

And so, if you can do a good job with building that relationship, care coordination is not just a service, but it really becomes the

relationship that can carry across the entire patient's health care experience. And so, I think that it's critical if you're going to win at value-based care.

And the second thing that that time building the company gave me, is a really deep understanding, a nuanced understanding of the behaviors of both the folks that provide these services, care coordinators, health coaches, care coaches, there's like 14 million names for these wonderful people, as well as the behaviors and processes of just care coordination, the way that patients respond, the way that it's really effective.

And so, about two years ago, I started thinking about how I can augment our team using generative AI.

This was towards the beginning of 2023. The gen AI boom had just happened a couple months prior.

And I had been augmenting my own workflows, and I thought, we've got to build something that is really, really perfect for the workflow of care coordination and maybe even larger care teams, what I'm starting to call

middle earth, all the folks between the patient and the doctor.

And so, looking at the market, I saw that there's a couple of different approaches. There's an approach that is being touted by some that's kind of AI is going to allow us to, if we see it, we're going to automate it.

We'll create AI bots. They're going to talk to patients. They're going to do diabetes management and education.

I have yet to see that really play out in today's world. I think that everyone that has done care coordination will agree that if you had a, today, if you had an AI bot just calling your patients than talking to them, you'd probably have no more patients to talk with by the end of the day.

And so, we really believe that you have to look at the inherent advantage that technology has over humans. And then, look at the inherent advantages that we have over technology.

And the way that it makes sense to me is that technology is simply inherently better at the brain of care, analyzing endless amounts of data, surfacing insights.

And we are better at the heart, the actual delivery, the empathy. It's not just about empathy. It's that it's that human to human connection.

And so, our motto at CareCo became, we want to build the brain to amplify the heart. If we could build something that took over all the tedious parts of care coordination, the pre-call prep, the post-call documentation, task creation, task management, communications, and then we allowed the care coordinators and the care teams to just care, just care for the patients, how incredible would that be?

And so, we started this experiment. At this point, I call the official date maybe February of '24. So, about a year and a half in.

We launched formally in January of '25. And I will go to this for a moment. And so, far we've finished, I remember in April, we had about 10,000 patient conversations on the platform in the month of April.

And I'll explain what the platform is in a moment. And in August, we completed the month with 45,000 patient conversations on the platform. And we're continuing to grow quite rapidly.

And so, the thought process and what we really built was, the first thing is we put all the old school communication systems built directly into one platform.

And so, as crazy as this was, here's a quick tip, don't build a phone system. It's not fun. But we built a phone system specifically designed for care coordination.

We then built texting capabilities, video capabilities, and an ambient recorder. And the idea was that we have all forms of communication flowing in and out of one platform.

And the reason why we really wanted that is not just to have everything on one platform, and not for that to be fragmented, but because I believe that the most underutilized piece of data in health care today is the entire patient interaction.

I find it incredible that so many health systems and so many health care organizations today are already using ambient recorders. They're using these technologies to listen to the conversations, technically analyzing the conversations.

But then, we slice this tiny, tiny little

sliver off in the form of communication, and then we throw that in the chart. And then, the chart becomes, it's a collection of what's left. And then, that's what you're now analyzing for further AI tools.

At CareCo, we want to grab the entire patient interaction. And we want to analyze that entire patient interaction and bucket it accordingly, and kind of build a brain on every individual patient.

And that's why we built all the forms of communication on one, so that we're always there enabling and analyzing at every point of the conversation.

Now, from that, that's all meant to power our call guide. And I love that one of the points that Charles mentioned before was, it was one of those small little bullet points that I'd really like to highlight it.

You talked about in-office guiding and prompting. And that's really an extension of what we're doing on the care coordination side. And I love that.

What we're doing is we're taking all that context and then we stack it on top of an objective

for any given conversation. And we say, what's everything we know about this patient from this entire brain that we've built?

What are we trying to accomplish today in this very specific conversation? Much deeper than a care plan, much deeper, it's really, really hyper personalized.

And then, our call guide will spoon-feed the human care coordinator, the exact talking points and discussion items that they can discuss today with the patient. And the beauty is that every single thing is citationed back to the source data. And that's, once again, why we want all that data on one platform.

And so, that's what our call guide looks like. And then, post-call, we just do -- and this is what you're seeing on the screen here in addition to the gorgeous UXUI[16]. When you get off your conversation, whether it's in person, a phone call, or a video visit, you would get the full transcript of that conversation together with audio. You get your clinical documentation, which is a standard at this point, fully customizable to any template that you'd like for documentation.

16 User Experience User Interface.

You then get your tasks, which you could kind of see at the bottom there. And the tasks are probably my favorite part because it gives you just the actionable items that you actually have to do for the patient.

And we even take it a step further. And, if there's a message, if there's a communication that is necessary as part of that task, we'll generate that communication.

And I think a lot of folks don't appreciate this, but one of the most stressful parts of care coordinators' jobs is sending messages to doctors.

I know there's a lot of doctors around the table. It's intimidating, sending you guys messages. And when you have to do that dozens of times a day, and you want to make sure that you're really constructing the perfect message, that really creates a lot of stress. So, with that small feature, we were able to delete that stress.

And then, finally, there's a patient message as well that you can direct, immediately reengage with the patient.

And so, I have a lot to talk about as we go through the discussion. But I think that I would

encourage all, see if there's any, yeah, so our mantra became, we want to build the brain to amplify the heart.

And, if you are, and I'd like to call out actually AdventHealth, I know is doing a tremendous job with this and setting some of the infrastructure here at a health system level.

But, starting to think about grabbing this data and starting to analyze the data so that we can really do things like Charles mentioned before, and like we're doing at CareCo, of analyzing that data and then surfacing the perfect insights at every time and making the actual process of care better, not just for the patients, which is the end goal, but for the care teams as well.

Thank you.

MR. RAMACHANDRAN: Fantastic. Well, thank you, Mendel. And last, we're happy to welcome in-person a previous PTAC submitter of the Advanced Care Model Service Delivery, and Advanced Alternative Payment Model Proposal, Dr. Khue Nguyen, who is the Founder of Emprise Health.

Please go ahead, Khue.

DR. NGUYEN: Good morning. Thank you to

the Committee and to my esteem co-panelists. I think we're going to have a really great conversation.

I think we're all coming at this in some way very similarly. And there are definitely synergies. So, I'm definitely looking forward to the discussion.

It's an honor to be back at the PTAC. Years ago, I came before this Committee to propose the Advanced Care Model, a high-touch, person-centered approach for the high-needs population.

Since then, I have, through the experience of helping CVS ACO, from scaling from concept into a national platform, I have witnessed first-hand both the opportunity, as well as the persistent challenge, that we all face in making truly effective care coordination scalable and sustainable.

While today is a discussion, I can't help but view it as a call to action, a chance to put new ideas on the table. So, thank you for this opportunity.

In the last decade, I have been on all sides of this challenge, building from the provider level, designing payer strategies. We've

leveraged EHR, interoperability, dashboard, risk score, registry, team-based resources.

And, while we've made progress, it simply hasn't been enough. Progress is too slow, too incremental, and we have largely maxed out on, you know, what's possible with the current sets of tools and approaches.

Today, we have mountains of data, but they don't work well together in a simplified way. EHR claims, registry, by the time insights can be surfaced, it's too late, the patient is already in the ED[17] or maybe back in the hospital.

We built a system that looks backward, when what patients need is foresight. And that is the divide between data and impact.

We've all talked a lot about team-based care. Care managers are the backbone of care coordination, yet the system burdens them.

Every day they spend countless hours searching the EHR, reviewing claims data, doing documentation, and unfortunately leaving voice messages for patients and doctors.

They rarely have time to truly synthesize insight or connect with patients in a meaningful

17 Emergency department

way. Burnout is inevitable, and the model is just simply not sustainable.

So, sorry for that, kind of a depressing opening. But I think we have all experienced it, and the exciting news is, we are entering what might be the most consequential technological breakthrough of our lifetime, artificial intelligence.

AI offers the ability to go beyond retrospective silo data to create real-time, adaptive, personalized support for both patients and doctors. Imagine a system that not only looks backward, but can continuously learn and anticipate.

For patients, AI can turn complexity into simplicity, translating medication changes, lab results, multiple care plans into a simplified, just-in-time, what does this mean for me?

For care teams, AI can be a copilot. It can triage high-risk patients, it can execute simple routine workflows, it can surface next best action.

It can even make phone calls to check in on patients routinely so that we're now giving back time to the care team so that they can focus

when it really matters the most.

For health systems or for delivery systems, the benefits are going to be compounded. Finally, the mission that we're all after, higher quality at lower costs.

So, Committee, my message for today is this: we can continue to iterate with the existing tools and approaches, and we'll continue to get incremental results.

But if we embrace AI with urgency and deliberation, we can realize the impact of improved lives right away. My call to action is why wait? Let's dive in.

So, thank you for this opportunity and looking forward to the discussion.

MR. RAMACHANDRAN: Thank you, Khue. Thank you to all of our experts for those three presentations too.

Let's get to Committee questions now. The PTAC members, please flip your name tent up, or virtual Committee members, please raise your hand in Zoom if you have questions for our guests.

In the interest of ensuring balance across different perspectives and questions, we encourage experts to keep their response to a few

minutes. All right, who's up first?

All right, maybe I'll kick us off here. You want to go? Jay?

DR. FELDSTEIN: Sure. A couple of questions for each of you that are a little different. I think for Dr. Neil, I'm curious as to how you're doing your curbside specialty consults. Are they phone, are they electronic, are they through your care coordinator?

Because one of the issues we've been talking about for the last several days is leveraging technology for informed patient decision-making, but really, what's going on between the primary care physician and the specialist? So I'm really curious as to how you're leveraging, or not leveraging, technology for that?

DR. NEIL: Absolutely. Thank you for the question. We have two sets of specialists that we engage with right now. We have a small focused employed series of specialists, and then we have a third-party specialist, or consulting firm, that we have a vendor relationship with. And so I'll talk about that first and then bring it back to our home.

So through them, we're able to access curbside consultations that involve the PCP sort of giving a little bit of a snippet of what their patient scenario is, what their question may be. And we get a response in writing, and in video, from that consultant within about four to six hours on average.

The SLA[18] is much longer than that, but we are able to share that and view it at times with the patient where necessary. Whether that's synchronously or asynchronously. Meaning, we'll bring them back into the center, and we'll sort of review it together with them. Or we can call them and let them know what the consultant said.

Perhaps a greater source of pride is the internal ability to have PCPs be able to curbside specialists that are employed. And we do employ about 10 sub-specialists within our practice.

And they have immediate, sometimes synchronously while the patient is in the room, access to curbside consultation via a tech platform that is almost like an instant messaging device or a texting device if you will. And then that's how sort of we've engaged with patients.

18 Service Level Agreement

What we want to do more of is engage with specialists who are value-based care experts and really understand the model, understand our patients, and are able to give us advice that we can reasonably follow that are cost-effective and continue to drive quality of care for the patients. And so we still put the onus on our PCPs to make that call.

Whether or not that specialist is giving aligned advice, or they're giving advice that's really not practical to deliver to the patient and the scenario that they're in. And so, does that answer your question?

DR. FELDSTEIN: Yes, that's very helpful. And I was curious, have you seen a reduction in ER visits and admissions along those specialty lines, whether it be cardiac or pulmonary and so forth?

DR. NEIL: Absolutely. When we, for example, cardiology is probably our most robust service line. When we have cardiologists that are engaging with the PCPs in the market, we can see up to a 50 percent reduction in hits on external cardiology providers, hospitals, unnecessary tests. For example, repeating tests when that

cardiology is engaged. And so it's absolutely a game changer for patients.

DR. FELDSTEIN: And my question for Mendel is, are you contracting out as a third-party vendor, you know, on a PMPM[19] basis for health plans, ACOs? I'm curious to hear your business model.

MR. ERLENWEIN: Yes, appreciate that. We have a couple of different pricing models. It is a SaaS[20] platform so we are giving it to folks that are doing care coordination already. We want to upskill them tremendously.

Absolutely spot on, ACOs, payers, health systems, there is also quite a number of just third-party care coordination companies that are doing this work pretty extensively. And that's who we're licensing it out to. And we have a couple different pricing models either per user or per patient.

But when we do per patient, we do per active patient. So actually patient engaged with on that platform for any given month. And those have been pretty effective.

19 Per Member Per Month
20 Software as a Service

MR. RAMACHANDRAN: Great, thank you. I'll go to maybe Lauran next, then Lindsay and then Larry. So the three L's. So, Lauran, go ahead.

MS. HARDIN: Thank you. Good morning. I'm sorry I wasn't on at the beginning I was actually providing some complex care coordination urgently.

My name is Lauran Hardin, I'm Chief Integration Officer for HC^2 Strategies and a nurse by training. I've spent the better part of the last twenty years really focused on model innovation for complex populations. So I have a really broad lens around coordination. I'm fascinated by your presentations.

A couple of questions. I am curious, in your work, so this is a question really for each of you. There is a lot of different disciplines engaging in care coordination. Physicians, nurses, pharmacists, social workers, community health workers. I'm curious what you're seeing as which disciplines are most successful at this work, and what are you learning about that?

And then my second layer of question is really around the importance of anticipatory disease and symptom management. What are you learning about that and the competencies that are

held by the people delivering care coordination versus what can be covered by AI and some of these predicted models?

DR. NGUYEN: I can just maybe get started here. Thank you for your question. So I believe the first question is, you know, is there a certain discipline that is better than others?

I'm curious to hear from others. You know, I've, CVS ACO was managing over a million Medicare beneficiary, fee-for-service lives. And, you know, prior to that, worked at other health systems.

And so, I would say that I don't even know that we would even be approaching that question, it's more of, what are the resources that are available. And each discipline do bring their own focus.

And so it's very important to the extent that you're in a marketplace where you can bring in a full multidisciplinary team that's going to include your nurses, your social work, your nutritionist, your pharmacists. And even a lay care coordinator. You have that full suite. Then you, you know, you're very well-rounded.

And the strategy often is, you know,

there is always going to be sort of your, your quarterback. And typically that quarterback is best served by a generalist such as a nurse or social work depending on the kind of case. If it's a case that's more medically oriented, we would assign that to a nurse. And then to really leverage your other discipline for very targeted intervention.

And so to the extent that you have that kind of a budget, to the extent that the resources exist, then that’s definitely the ideal picture. But often times, we're working with much more limitations.

And so, I don't think any of us here are questioning what needs to be done, it's more of, how do we do it, how do we do it in a cost-effective way, how do we make this sustainable? And so that continues to be a challenge.

I think there was a second question, Lauran?

MS. HARDIN: I'm so curious with, you know, we know that in best care, anticipatory disease management and symptom management is really --

DR. NGUYEN: Oh --

MS. HARDIN: -- important. And I'm curious what you're learning with --

DR. NGUYEN: Yes.

MS. HARDIN: -- what can be covered by AI, NLP[21], all of the technology versus what's health and the person providing it --

DR. NGUYEN: Yes.

MS. HARDIN: -- and how are you teaching that?

DR. NGUYEN: Yes. I mean, we're all here very passionate about how to make care better. And care management is really that, you know, foundation to how we can make care better.

But as you said, I think we're asking our nurses, we're asking our social work to do a lot. These are complex cases. Often time, those are the cases that get assigned.

And so we get great anticipatory care with a very experienced clinician. Now that very experienced clinician may be very limited in using technology, right?

So there is, there are these barriers and, you know, we all try to optimize them. This is where I'm now, you know, someone who has been

21 Natural Language Processing

so deeply committed to doing this work and have seen it at scale. I just, I just see so much barriers. And I think this is where AI is going to really just change the equation.

You know, Charles, you talk about, if we approach engagement with empathy and dignity, right, a skillful clinician can do that. And even on a stressful day, they'll get it right 90 percent of the time. Now, if you have that skillful clinician with an AI, and you instruct the AI to always approach the engagement with dignity and respect, that AI is going to get it a hundred percent of the time.

So this is where AI is going to be superior in the sense of being able to anticipate because AI has that ability, right, to really comb all of the information that you can give it to it. And then quickly within three seconds be able to synthesize that and put in place, you know, an analysis of anticipation, what are we predicting is going to happen next.

DR. NEIL: Dr. Nguyen's answer was so eloquently worded. The only thing I'll jump in to add here is, in response to your first question, which is care coordination, where is it super

successful.

I think we will continue to have a challenge with care fragmentation so long as we have a different payment model or different incentives. Hospitals are driven by volume. You have full-risk providers that are driven by outcomes. And those two inherently don't really connect with each other.

And so, them providing a specialist, providers a, you know, in ChenMed, providing us with timely information with which to help the patients to actually decrease the volume that they want to see, I don't know that we'll ever get on the true same page with that. And so, where AI really does step in is that it empowers the patient and the PCP to be true advocates for health span to be able to get ahead of a worsening disease state way before it becomes at the point of no return.

One of the most proud sort of projects that we have here at ChenMed is, how often do patients, for example, crash into dialysis? When a patient crashes into dialysis, meaning they have a hospital event that initiates dialysis, their mortality rate almost quadruples. If compared to

if you were able to start that patient in a controlled outpatient setting with the family very, you know, very -- maybe even starting peritoneal dialysis versus hemodialysis, and we were able to use tools that help us to detect, when is that deterioration impending, and how do we intervene in a proactive way?

Now the possibilities are even more astronomical with AI on the scene. They're able to really even comb the medical record every time that patient interacts. So we're not actually just waiting for the GFR, the glomerular filtration rate, to drop, but we're actually looking, hey, is that patient gaining weight, are they sleeping less, are their health patterns changing, are they coughing more, are they more tired, right?

And so these are ways in which we can get ahead for the sake of the patient. But we have got to get a line on the incentives because unless the volume is disincentivize, then we'll always be sort of fighting the two sides of the battle.

MR. ERLENWEIN: If I can add just a couple points. Really well said about the incentive structure and the downstream effects and the fragmentation of communication. I think

though, there is also, even within every organization, there is still fragmentation of those communication platforms, and that is something that we can tackle today.

And so, to kind of go back to your first question of who is using, in our scenarios at CareCo, it's, we started with just like traditional care coordination, and it's expanded to, we've got pharmacists, therapists, we've got home health nurses, we've got hospice nursing. There is quite a few of these verticals.

And the more interesting ones are the ones that use multiple different forms of communication. So I like the home health example because 80 percent of that operation, so to speak, is in person in the patient's home. But then you've also got a call center.

And so, if you've got one hub that is analyzing all of that, and it doesn't matter whether you're on the phone or in person or video or texting, all that data goes to the same "brain," you're then able to pull out the insights that you need. And you're taking into account everything, even from the other kind of care team members of the other team.

And so, it's a really interesting way to kind of build one brain that feeds all these different care team. And so that's been really effective.

The other thing is, going back to your second question, my framework for when is AI effective, I think anyone that's going to give you a definitive answer of exactly where AI should be is either not visionary enough or is just trying to be opinionated. Which I generally am, so.

But my framework for thinking about it is that the way that it makes sense to me is there is two types of patient conversations. There is what I like to call one-way conversations and two-way conversations.

How I define a one-way conversation is, if a patient is calling you because they need something. And in those scenarios, typically speaking, they don't actually care who is on the other side of that phone. Whether it's an agent, a person, on-shore, off, they don't care, just help me, that's what they want.

And there is also a version of that for when you're calling a patient. Different various assessments where you've just looking for

information. That's all I need. Did you update your insurance, yes, no?

And so I think we'll see, and I don't think we're even there yet because I think there is quite a stretch even between the health care kind of examples of this and even what's available from kind of the main models from a friendliness perspective, and there is still a lot of work to be done, but I think that's very different than what I call a two-way conversation.

A two-way conversation is when you're reaching out to the patient because you're actually trying to affect something in their life. You're trying to change their behaviors. You're actually trying to change their health outcome around a certain chronic condition.

And to do that, you really need, not just to be inspirational and almost like a coach and, you know, obviously the various tactics and motivational interviewing and all that good stuff, but I think that inherently there is something about human-to-human connection where because we've all gone through something in our life there, we can connect each other. And we can say, hey, I'm going through this rough time and maybe

I'll actually listen to you and change my diet and change my exercise habits and things like that.

And that's something that I don't think will ever go away. And so I think, you know, we can even improve in the empathy, we can improve in various different aspects when it comes to AI and agentic voice. But that kind of core connection of, I know that I can kind of trust you and I can connect to you because we've both gone through something I don't think will ever go away.

MR. RAMACHANDRAN: -- Helpful, thank you. Lindsay, do you have questions?

DR. BOTSFORD: Yes, thanks. So it sounds like we haven't totally figured out how to pay for the various forms of good care coordination that we talk about here outside of maybe total cost of care models where you plan to reap the benefits of it and decrease total cost of care or improved quality or things like that.

I think when we're thinking about potential payment models or ways to value this important work, I'm curious around how each of you might be thinking about how you quantify impact or how you show that it's working outside of waiting for those downstream markers we all care about.

Like lower cost, higher quality improved all-cause mortality, whatever it may be.

And so I'm curious, in each of your domains what are some of those surrogate markers you're using, how are you measuring or quantifying the impact of what good care coordination might look like?

So what SLAs are relevant, what are some of those things we might think about as you design a payment model that values it, absent total cost of care, or maybe that is the solve. But yes. But curious your thoughts on how are you looking at it along the way, how are you measuring success, what are those surrogate endpoints you look for to determine what good looks like?

And I think maybe just some of the background is, as we get more data, more AI, there is always this pressure of, well, let's just pay for it, it sounds like a cool tool or it sounds like a cool thing to coordinate care. But how are we showing that it makes a difference in that this added investment works?

DR. NGUYEN: Lindsay, I'm so glad you asked the question. I know it's going to be in the next session to talk about payment models, but I

have been in payment models so thrilled to be, thrilled that we get to discuss this.

You know, I think we're here at the PTAC. And we really have an opportunity here. You know, AI. One of the most promising breakthrough for AI is going to be medicine.

You know, medicine has been so difficult because it's clinicians, it's human-to-human interaction, communication. And so AI is finally going to be able to crack that with, you know. The language of AI is human communication with the ability to synthesize.

So all of that is to say, we really have an opportunity here with the PTAC, with CMMI to really foster innovation. We've done a lot. We've done a lot in the last 10, 15 years with value-based care.

I think no one ever debates now that we need team-based care, we analytics. We're all doing that. So I think we can check, put a checkmark on that. And now we need to go further.

And so the only way to go further is through incentives. New payment models. So I would urge that, you know, one of the things that just occurred to me today is we probably need, I

probably need to gather other collaborators and submit an AI native approach to value-based care because we really do need to start innovating, piloting.

Create the incentive for health systems, for primary care providers to really incorporate AI into their workflow and for us to measure the impact of that. One of the, you know, if we take transition of care, it's a core intervention across all value-based care. We pay for it today.

There are discrete ways, right? If we incorporate AI into a transition of care workflow, what can we expect?

We should be able to expect that AI plus human is going to be able to do a better job with all of the surrogate measure. Whether that's primary care visit within the next three days for high-risk patients, medication reconciliation, readmission rate. We can look at team capacity. There is just so many discrete measures where we can begin to really understand how does AI bring in that efficiency and effectiveness.

MR. RAMACHANDRAN: Thank you. Anybody on the phone have any thoughts?

DR. NEIL: Yes, I'll just jump in to add.

I think the question is an amazing one. And it truly is difficult because we've been, we've been sort of after, hey, we get the outcomes numbers, and to your point, all cause cardiac mortality, how do we get upstream from that to help our PCPs and centers know whether or not they have succeeded at today's tasks and the week's tasks, et cetera?

And so now we're actually, it's a timely question, because we're on a journey now on, how do we help, you know, get ahead of that arrival in the hospital?

For example, we pay attention to no-shows very simply. We make sure that, hey, if the patient is not coming in, there is a reason for that.

We pay attention to missed medication fills. We pay attention to, hey, did we actually administer urgent care-level medications, when do we see that patient next?

And so we have a number of systems that help us to notify the PCPs ahead of time, hey, this patient is high-risk, we want you to change the plan of care to one that's more urgent and timely. Ultimately that end measure is super important.

And it's going to be a mix of a calculation of those end outcome measures, as well as what is the, what is the cost or the business case for avoidance that we see. And the quality of life that gets added to that patient where their family member doesn't now have to take off of work or spend money missing days to take them to get a number of tests where we could have done that upstream.

And so it's an interesting sort of conundrum. I do think that AI will help us to solve quite a bit of it. But we're going to have to enter very cautiously because AI is even better when the users know what to do with the information or can equip it with the information that they can actually generate new learnings and new insights.

But until we are able to do that in a robust way it, you know, it could be a tool that we pay for, and we don't know how to really manage or operationalize its outputs. And so that's sort of from our perspective here at ChenMed.

MR. RAMACHANDRAN: That's great, thanks for sharing. Yes, Larry, thanks for your patience. Yes, I'll go to you next.

DR. KOSINSKI: Great session. The gears

are spinning in my head here. Mendel said something that's got me thinking deeply. His statement was, build the brain to amplify the heart.

And although I think that is absolutely fantastic focus, I want to ask a question about a little pivot from that. And I want to tie it into something Lauran asked.

So my question is, can we build the brain to anticipate the care? Are any of you doing anything to move to more of a proactive use of AI to get to that symptomatic patient with a chronic high-morbidity chronic disease using AI to anticipate their deterioration rather than acting on it once it occurs?

MR. ERLENWEIN: I guess I'll start with that. I appreciate the question and the pivot.

That's definitely -- what we're doing today is one, is definitely still reactive. Even though, even with our call guides, which we think is quite advanced, and we have a generation two, that's coming out soon. That's going to be a lot more in the direction that you're wanting it to.

We believe that we're laying the infrastructure to be able to do that kind of thing.

And so, I'll also kind of tie back some of Lindsay's question, and some of the points that Dr. Neil mentioned.

You know, we talked about upstream. There is no further upstream, unless I'm missing something, than the actual patient conversation, at the point of conversation. Everything from that point is downstream. Everything that comes out of there. And the furthest downstream is claims data essentially.

And today what we do is, and so this is going to kind of tie to both, also about reimbursement from Lindsay's question. Today what we do is, in order to prove any kind of efficacy, you're basically running claims data and you're hoping to see reduction utilization based on claims data which is so far disconnected from the actual original point.

And so if I were to think about reimbursement for these tools, or for an idea, what I think is going to be super transformative, and what we are already seeing already at CareCo, is that if you are analyzing and retaining and trying to be intelligent about this data, again, that you probably already are analyzing, you can

now get such a more intelligent answer. If I'm the payer, that's what I would want to see.

Because with CareCo today, you can just ask the question, how have I accomplished X, Y, Z objective with this patient, go. And it will give you an intelligent answer, citation back to the point of conversation where that happened.

And so, there is obviously carrot and stick versions of doing this, but if you want to talk about reimbursement, I think that submitting, you know, objectives and submitting kind of data and things that you've done with your patient's citation back to the point of conversation. And using gen AI in that process would be a really, really, really practical and not that difficult way to start.

And so, back to what you were saying, that is definitely the vision. I think by analyzing and building this kind of brain that we're implementing on every patient, we're building the infrastructure to be able to do that, because once we've got all those points of conversation, and to Dr. Neil's point earlier, there is still definitely issues with the fragmentation at the end of the day. No one health

care organization will, you know, get every point of a patient's interaction. But the more and more that you can get, you can start running that data to start anticipating more and more and more, better and better and better. And so, I hope that answers slightly.

DR. KOSINSKI: Well, where my head is going with this is exactly where I think you have already gone. And that is that, all these ambient recordings are going to allow you to build the AI agent that is going to take the super highway that you've created already with your infrastructure and replace the human-driven cars with Waymos. And hopefully that will allow us to get to the deterioration before it actually occurs.

DR. NGUYEN: Yes. Yes, I think the tools exist already. And I think it's going to be here. We do need CMS[22], CMMI, PTAC to create the incentives. But as you said, I think, you know, the AI not only will be able to just do a much better job of just synthesizing real-time historical large chunks of data and be able to really predict what's going to happen next.

And let's just say that we agree in our

22 Centers for Medicare & Medicaid Services

protocol that this is a high-risk patient, this is someone that we want to see same day. Gianni, I'm sure, you're nodding your head here, this is probably very similar to a ChenMed.

You know, the AI, you know, you can instruct the AI to call the patient. And if the AI knows that this is someone who is, you know, who's going to have transportation barriers, and here is the transportation, you know, here's the transportation plan, the AI can execute on that so that we get that patient back in the office within that same day appointment.

So that technology exists. And it's being piloted. And, you know, I think we're going to begin to see a lot more of that. And as the government, we need to do everything to continue to push for testing because that's how we're going to learn, that's how we're going to optimize. And that's how we're going to quickly be able to get to greater improvement.

DR. NEIL: Awesome. The only thing I'll add is, long before AI was sort of, so ever present in our lives, we attempted to do this with humans. And so we would have what we call the love call approach.

And this started during COVID. We were not hearing from our patients. They were scared, they were isolated. And so we actually developed a, an outreach tool that said, okay, ask this group of questions.

And they are seemingly random, but the idea was, how do you start to gather enough information and detect subtle changes that you can then act upon? And we developed a scoring system that would, you know, develop the next steps or escalate to the next steps for that particular patient. Now AI can do that.

If you speak to a patient, you can tell that they're breathless. Or that they're not able to complete that sentence even before they get there.

If they're, you know, if they, if their pattern is different, for example, an ambient listening device can say good morning, and when they don't hear the patient, hey, what's going on, you didn't sleep well last night, oh, why is that, I slept in the chair, not in the bed, ding, ding, ding, they got to come in, right?

So there is, there were a number of ways in which we attempted to do what I'm super excited

that AI can do for us because it just equips a PCP in an ever burdensome environment to decrease the burden of decision-making for them that they can say, yes, that's a patient that I need to see now, or this is a patient that we can see for you, or the nurse can be deployed, or somebody can make a call. A pharmacist can fill a medication.

And so it really helps to truly empower the PCP to feel as though they have control over the outcomes that I think can be successful in the value-based care model. Is what we see when people opt out is that they're like, I can't, it's too many, there are too many moving parts I'm not, I'm not able feel and see the success.

Well, thankfully we've been able to bring that sense of progress to the PCP where they can actually feel like they're making an impact because we're decreasing that decision-making burden, bringing information to their fingertips, actually helping them to get upstream. And then they can be held accountable for the outcomes as a result.

And so, I am excited about the innovation that's coming down the pike. It's going to be amazing for us.

MR. RAMACHANDRAN: That's great. Charles, do you have any comments to add?

DR. SENTEIO: No. I just wanted to weigh in that, and I know Jim Walton was part of PTAC for a few years as well. And Jim and I did a lot of work in Dallas around care coordination. And before, I guess before we learned how to spell AI, and it was everywhere. And this is going back 15, almost 20 years now.

And one of the things that we learned is, one thing that we learned is that, you know, patients, particularly patients who are vulnerable, either clinically, socially, or both, tend to have these episodic issues that may push them to the ER or ED and present barriers to care. And it was a very dynamic process to try to keep up with them and coordinate their care.

And managing a group of community health workers and MAs[23] that went out and did home visits, I learned that that information gathering was necessary to be sort of regular. Just to kind of check in and figure out what those barriers to care might be and coordinate that care. And it was a very humanistic sort of endeavor and exercise.

23 Medical assistants

And I think, and I agree with my other panelists that AI present, and the computational power, the collection and analysis of information presents a huge wonderful possibilities for us to look for patterns to try to understand where and when that intervention needs to occur because providing extra care to all vulnerable patients is still not, is not feasible. But to try to catch them in those moments or days or hours before they need to seek emergency care can be quite valuable from a human and a financial standpoint.

And the computational power data collection presents us the opportunity to do that. But it's still, at the end of the day, is going to rely on our ability to connect with patients so that we can understand what their experiences may be, as dynamic as they may be, and then respond to them in turn.

And I do think, as my other panelists indicated, and as the previous question alluded to, I think that the incentive structure can help lead that, and lead that way. But I know that there is a lot of work to do with that still.

MR. RAMACHANDRAN: That's great. Thanks for the perspectives. I'll go to Chinni next.

CO-CHAIR PULLURU: Thank you to everyone. Mine's a two-part question. The first part is, you know, what strikes me about the work that's being done to incorporate AI into chronic care management is that it also presents an opportunity to narrow the band on the sort of competency, I would say, or skill of the person doing the outreach to the patient.

So, you know, almost being able to study what is successful, what kind of word is, words are used. You know, how do patients respond to different things? And so driving that success. And then translating that and coaching other folks to speak the same way and making that successful.

So one, you know, I'd love to get your thoughts on how you're doing that. I know that, Mendel, you're probably, I see both you nodding.

The second part of the question, which I'd love to hear from Dr. Senteio and the rest of the panel, is, if on today's structures, on the ACO structure, MSSP[24], you know, today's value-based care organizations, if there was a waiver or a quick change you could make that would better align reimbursement to support, not just chronic

24 Medicare Shared Savings Program

care management in its current form, but being able to use technology to further incentivize that use, what would it be? And I know it's a two very different questions, but I do think that they're important.

MR. ERLENWEIN: I guess I'll talk, I'll talk for us. So to the first part of your question, there is one layer that we're accomplishing today. And then I'll tell you kind of where we're going with this.

And so the idea of queuing up the right things for someone to talk to the patient about based on, not just their own conversations but just best practices, whether that's motivational interviewing or other forms, is exactly what we're doing. So we're kind of prompting them, like you said, upskilling the people.

And we're already seeing that in longer conversations, more valuable conversations because unfortunately there is quite a bit of care coordination that either like super quick touch points, just like, hey, how are you, do you need me, no, goodbye. Or they're just very talkative patients, and you end up talking about the patient's pet for an hour, and that doesn't

necessarily go anywhere from a clinical perspective.

And so giving them the right questions to talk about and making it, you know, in the right way, with the right wording and framing without at the end of the day being a script, is what we're doing today. But I think the real power here and kind of our vision is to start including, as we build this out more and more, psychology and persuasion, behavioral science into these questions and into, not just what to talk to the patient about, but exactly how to talk to this very specific patient knowing their social terms of health, knowing all the context that we know about that particular patient.

I feel that in all other aspects of our lives, we're being bombarded. Whether it's, you know, fashion and purchasing and fast food, and all these different areas of our life, that there are entire departments that are trying to figure out how to make us purchase those things. And we don't do that enough in health care, and I think we have the opportunity to do that. So that's as far as the first part of your question.

When you ask what is kind of the barrier

or something that we would change to chronic care management, I wrote down one word with seven exclamation marks. And that word is copay.

So I know this has come up a bunch, but is always, is astonishing to me that there are copays when it comes to preventative care programs. I think it's make a decision.

If the point of this program is to save money, why would you inhibit literally 80 percent of eligible patients from joining? And that's what we're seeing because of an $8 copay. If it's not going to save you money, rethink the program. If it is going to save you money, why would you block people from taking a part of it?

And so that is by far the biggest, the biggest issue. I think that if you take away the copay and then you realign the incentives a little bit, so like I mentioned earlier, maybe intelligently proving some of the outcomes instead of just billing and hoping for the best. But actually citation that back to source data for the conversational data and giving more intelligent responses as part of maybe submitting some of those quality reporting, I think that would be a really, really good mix.

DR. NGUYEN: Yes. So one of the biggest benefits of AI is going to be upskilling the clinician. I think, you know, we're -- right now we're, you know, we're somewhat pretty generic in how we engage with patients. But AI has the ability to really do that adaptive learning and really understand each patient in a really personal way and really figuring out what is it that's going to really matter. Is it, you know, is it certain motivation, what would be those motivation?

And so, we're finally going to really learn about all of the different sort of nuance engagement strategies. Why does it work for one patient but it doesn't work for another? So we're going to be able to be much, much more customized. Much, much more personable.

And the clinicians, the human that are sitting, overseeing the AI is going to benefit from that. We're just going to get smarter, right? And so I think this is definitely going to be one of those, you know, another transformation that's ahead of us.

In terms of payments, I don't even think we need to create a lot. I think maybe perhaps CMMI would just need to go out and just make a

statement to say, look, you can incorporate AI assistance into your value-based strategies if that's, you know, if we're talking about, you know, value-based care, value-based payment models such as MSSP, or even in the fee-for-service. Even in the transition of care, the TCM[25], the CCM[26] fee-for-service. If we just make a tweak there.

Right now I think the, you know, there's guidelines that said, you know, it doesn't have to, it can be a clinician, a non-physician who is doing the assessment. You need the sign off of a physician. Not if we incorporate in, you know.

You can also incorporate AI, as long as the human is in the loop. That's going to sort of give that permission to the marketplace to really start innovating. So I do think that a little bit of tweaks is all that's needed to really get that piece going.

And I'm going to sit back for the second conversation here, but I also then think that CMMI and PTAC should really also be testing an AI native approach. That's not taking the human app. But if we were to redesign this, if we were to pilot a

25 Transitional care management
26 Chronic care management

care coordination without any limitation instead of building upon what we have, right, we need to continue to re-incorporate it in, test that. I think we need to do that.

We need to also create an innovation pathway where we said, look, start from scratch, innovate, pilot, and we're going to support you on that. I think we're going to need both tracks.

MR. RAMACHANDRAN: That's a great point. Folks, virtually, any comments?

DR. SENTEIO: Yes. I'd just like to add that we had, and I'm just thinking about this, that we had Meaningful Use incentives. We had incentives to incorporate EHRs into what I called, and learned at the time, I was doing my doctorate at the time, the sort of last bastion. You know, health care delivery where we had manila folders with colored tabs on them.

And we had incentives, right, to incorporate, to implement electronic health records. Wow, electronic health records. And it worked, right? It incentivized, accelerated. It sort of, we didn't rely on the market, we relied on incentives to incorporate EHRs into care delivery. And it had an effect.

So I wonder if similarly when you're at HHS, so I wonder if similar, there could be incentives for responsible ethical use of AI? We already know, unlike EHRs at the time, we already know the huge investments that are being made in AI already.

And I just thought, well, why not incentivize meaningful, ethical use, steer it to say, hmm, let's learn what we did with the Affordable Care Act. Let's leverage the good and sort of leap out some of the lessons learned from that and say, how can we also incentivize responsible AI for patient care in the goal of improving outcomes? Maybe there is something there to consider.

MR. RAMACHANDRAN: Doctor --

DR. NEIL: I'll just add in here. There is a beautiful saying where a provider and a patient can share the same, or similarly lived experience from a culturally similar life experience. And I don't know that AI can replace that totally. But I think we can come close.

And so, as we learn from a patient what motivates them, what approach motivates, motivates them. In this environment, we talk a lot about

patient autonomy and patient-centered care. There are cultures that the patient seeks to have a relationship with the doctor, that it's a little more paternalistic even, or --

And it's, and for me kind of walking that walk as a clinician where I was learning as I went along, I found it very easy for me to connect with patients who are from the island of Jamaica where I understand that when they say they ate oatmeal, that means they put condensed milk in it, and that's why their sugar was high. And my colleagues didn't really understand that, right?

And so, there is something that AI can do though to help us bridge that gap because we do have to serve these communities, and we can't always wait for that unicorn, in some cases, to come in that particular location to serve those patients. And so I do think that there is an opportunity for AI to train and help physicians, nurse practitioners, care coordinators, all of us interacting with a patient directly to understand whether or not our language actually landed with a patient based on their response and how we continue to get better.

I do think there is some universal things

that can be translatable all throughout. And that is what we're trying to focus on, training everybody to be nice, to be courteous, to be timely. And those are things that can be respected all across the continuum.

I don't have much to add to the comments about payments, but I love the copay underscore exclamation, Mendel. It is very frustrating, for example, that things like physical therapy have become simply out of reach for patients because of copays in favor of allowing some other parts of the plan to benefit.

MR. RAMACHANDRAN: Great perspective, thank you. We have about five minutes left. Maybe I'll give Walter the last question honor.

DR. LIN: Thank you, Krishna. And thank you for a fascinating discussion.

Now I always find it a bit ironic that we are looking to AI to help train us to be nicer people. But often that is the case.

I did want to pick up on a theme of this discussion around maybe taking a more AI native approach and exploring that a bit. Maybe pushing the envelope a bit there.

So it's been said here and elsewhere that

AI plus human interactions are better than human interactions alone. And I think that's, or AI interactions alone, and I think that's probably true.

Although I guess, I'm wondering if any of you have had experiences where AI interactions alone is sufficient?

I think, Charles, you mentioned that this idea of pre-encounter chatbots and avatars allow for kind of private empathetic discussions and social interactions with patients. Do humans need to be involved with that, or can the AI chatbot or avatar just take that on by itself?

Another example might be, Mendel, you mentioned you do CCM. Maybe instead of the monthly call from the medical assistant, you have an AI chatbot do that. Maybe that might be an interesting use of a waiver authority, I'm not sure.

And then in terms of the high-needs population, how does this get operationalized in that population?

And so as a Medical Director of a PACE program, a lot of our patients don't even have cell phones, much less computers to access

chatbots. Can't AI just, you know, what's the bare minimum technology that, like a high-needs patient might need to have in order to participate in this AI revolution?

MR. ERLENWEIN: Thank you. So, kind of some of the points I mentioned earlier, and I'm really passionate about this. I really believe there is a difference between those one-way and two-way conversations.

I think that there will be more and more opportunity for AI to be effective. And that's the only question that matters. Like no one's opinion matters. Is the patient actually getting better, are they managing their conditions better? And so I think there is a massive difference between, first of all, in-reach and outreach.

When a patient is looking for help, they're looking for care, even in the context of chronic care management, the calls that are being placed to the care coordinator are a world of a difference away from the calls that need to be placed from the care coordinator to the patient.

And so I think the framework for thinking about it is, if the patient is reaching out to you, do they just need a thing to get done, and

can that thing be done faster, better, and more effective with AI than human?

And I think you'll find that's very different, once again, then me trying to reach out to the patient, to really build the relationship with them. They're not in a place where they're looking to, you know, get, make changes to their life, and it's my job to actually effect that change.

And then just one interesting note. I think that all the quantity and time savings things around AI are pretty much going to become table stakes. Many of them already are.

So I think that the interesting parts of the conversation are not so much like the documentation and task creation and stuff like that. I think that's all going to be in every platform. The interesting thing is the quality, like you mentioned. Can a human plus AI.

And what I'm finding is that, which kind of logically makes sense, really depends on the volume of patients that you're seeing. So if you're seeing like there are therapists that see the same patient every day, you're not helping them by giving a cheat sheet of exactly what to

talk about with that patient versus if you're dealing with hundreds of patients a month. So there is also volume kind of difference when it comes to, what can I remember as a person.

But yes, my main point is just earlier, I think there is a massive difference between one-way conversations and two-way conversations. And I think if you're actually trying to effect change with the patient, there is a really core element there that I believe is human that I just think is inherent to being effective.

MR. RAMACHANDRAN: Helpful. We have time for one comment, and then we better get to closing.

DR. NGUYEN: So, you know, I think the difference here in terms of AI native versus non-AI native is simply just two different development approach. A non-AI native approach would be to take the current workflows, the current ways that we do work and look at what part of this can AI substitute. So that, to me, would be sort of a non-native.

A native solution doesn't necessarily leave out the human. I do believe that the clinician is always going to need to be at the table. But a native approach would be, instead of

just let's look at what we do today, a native approach is to say, we have these challenges, we have these resources, we have this new capability, how do we put it together?

And I think, you know, those are just two different ways of building things. And we need to test for both high needs is something that I'm very passionate about.

I do think that AI can play a role there, although it's going to be harder because this is definitely a very high-touch population. But a lot of the support is to the caregivers, and that's where AI can play a role.

And AI can even have conversations. Telephonic conversations. So you can simulate that conversation. And so, there is definitely places and opportunities there as well.

MR. RAMACHANDRAN: Thank you. Charles, were you going to add a comment? I don't know if saw you unmute.

DR. SENTEIO: Yes, yes. I was just going to add that it's an interesting question about supervised versus unsupervised encounters with patients. And I guess I would like to see AI unsupervised in other settings before I saw it

unleashed unsupervised with patients like, I don't know, driving our cars, maybe flying us around maybe before we get to the unsupervised mode with patients.

MR. RAMACHANDRAN: I know, put us in traffic first, great.

(Laughter.)

MR. RAMACHANDRAN: With that, you get the last word. Thank you, Charles, appreciate it. I'd like to thank all of you for joining us this morning. It's great to have this be the kick-off session for Day 2. Great discussions, great insights. Obviously stay if you can for the next half as well.

At this time we'll have a break until 10:50 a.m. Eastern. Join us then as we have a great set of experts for our final session today, which is on payment models and benefit design improvements to enhance patient empowerment. I want to thank you all.

(Whereupon, the above-entitled matter went off the record at 10:42 a.m. and resumed at 10:54 a.m.)

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

Empowerment

CO-CHAIR MILLS: Okay. And welcome back from our break. I'm going to go ahead and turn to Dr. Walter Lin for the next session.

DR. LIN: Thank you, Lee. Dr. Walter Lin, PTAC Committee member. At this time, I am excited to welcome our panelists for our final session of the day. Four amazing experts will share their perspectives on payment models and benefit design improvements to enhance patient empowerment. 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. After all four experts have presented, our Committee members will have plenty of time to ask questions.

First up, we are happy to welcome Mr. Robby Knight who is the Co-Founder and Chief Executive Officer of Soda Health. Robby, welcome.

MR. KNIGHT: Hi. Thank you for having me. Awesome. Well, thank you guys for taking the time to, for me to share today a little bit more about what we do here at Soda Health and the opportunity

ahead.

Soda Health is a company, a technology company focused on reimaging government benefits to work for everybody. We do that by administrating what we call our smart cards that restrict purchases down to the SKU[27] level, primarily working with Medicare and Medicaid plans to administer benefits for those recipients.

What we do is we send cards to members, and then those benefits are going to restrict it down to the individual SKU level. Whether it's things like transportation, bill pay, utility assistance, or certainly things like OTC[28] and food kind of benefits as well here.

We've been operating for a little over, about five years now, and have best in-class knowledge to provide that SKU-level restriction technology here. So let's look at it at a high level.

I think if you go to the next slide, one of the things that makes us quite unique in this space is our view in the marketplace as sort of what these benefits should be and deserve to be

27 Stock keeping unit
28 Over the counter

versus what they are today. Today what you'll see is there is about $20 billion to spend roughly in this category today for supplemental benefits for Medicare Advantage.

And our view is that these benefits should be viewed as medical benefits as they are included in the medical loss ratio versus as being viewed as the marketing cost. Which is today primarily what they're actually viewed today. And so, our perspective here is that when we evaluate these opportunities, we should be closely partnering more with providers.

And in this case, what you'll see here is an example of how we do precisely that to reduce the overall cost of care. And so, overall, we send the beneficiaries cards in the mail. They engage with us digitally with our app[29], with our call center, and also with text messages.

We encourage the members to get care gap closures, whether it's A1C, HRAs[30], or other kinds of clinical measures performed at their local pharmacy that we have integrations with at their point of service. And then we make it really easy

29 Application
30 Health Risk Assessments

for patients to understand what care they're eligible for and how to do things that really drive overall improvements there.

What I'll say here at a high level is that to date, we have some pretty remarkable engagement rates to date. We have a pilot with a national Medicaid plan. Over the first six weeks have over a 60 percent, or almost a 60 percent completion rate of A1Cs, again, taking this multi-sort of low approach of not just engaging them with a reward incentive but also engaging the provider in this case, the pharmacist.

So, that's a little bit about what we do here at Soda Health. And then you can see on the next slide here some of the patient experience pieces here. The last point I make here is that we're dealing with beneficiaries that have a lot of things going on in their lives. We need to make it really simple.

And as I think about the benefits that we're offering here to our beneficiaries, our view is to make this a really streamlined experience to help them understand what's in, what's out, and how do you really drive value for everybody. And so for context, typically members call, this is

actually one of the top reasons that members call their health plans, to see what benefits are in, did the card work or not.

On average about 30 to 40 percent of the calls that health plans receive are about these kinds of benefits. For us, about two and a half percent based on the member experience we built out. So that's a little bit about us. And happy to share more or any questions. But thank you for your time.

DR. LIN: Thank you, Robby. We are saving all questions from the Committee until the end of all presentations.

Next we are excited to welcome Dr. Clay Johnston, who is the Co-Founder and Chief Medical Officer of Harbor Health. Please go ahead, Clay.

DR. JOHNSTON: Thank you very much. So yes, I'm just going to talk about aligning member incentives as well from the perspective of payvider.

So next slide. So my own personal journey, I'm a stroke neurologist. I kind of rose up through the research ranks frustrated with how little we knew at UCSF[31]. Then came to the

31 University of California San Francisco

realization that it was really the health care system that was preventing us from being as innovative as we should be on focusing on the key problems.

And so left to start the Dell Medical School at UT[32] Austin. This is now 11 years ago. And we, and what we did was we took individual conditions, and we rebuilt them and using human-centered design approaches and technologies and really focusing, ignoring future services and focusing on how can we improve outcomes, improve experience, and reduce cost. And that was largely successful for a whole bunch of different conditions.

You know, we could save quite a bit. You know, muscular skeletal costs anywhere from 30 to 80 percent less. But also from bipolar disorder, breast cancer, a variety of things.

But the problem with that model was we couldn't get paid differently. So we even like bundled payments around conditions was just a huge lift with all the payers. There was only actually one insurer that saw what we were doing, was excited about it, leaned in. It was called Bind.

32 University of Texas

It's now become Surest.

And the problem was, they actually didn't make it into Texas in time for me to get frustrated with the fact that that wasn't going to solve our problems. So I left. And actually the CEO of Bind sold that company to United, and so it became available. And so the two of us started Harbor Health. So he's Tony Miller, and he's the CEO of Harbor Health. So that's kind of my journey.

So next, really what this is about is it's the money. This is meant to be animated, but it's fine.

If you don't control the dollars, if you don't really have control of all aspects of those dollars, then you really can't design the ideal program underneath. Particularly because all the incumbents that are controlling the dollars are strongly incented to keep the system where it is today. They've already optimized their systems to create maximum benefit and profit for themselves. And so if you don't control those dollars, you can't get it done.

So really this is, you know, the driving notion about why we need it to be a payvider in control, the insurance premium whether we were the

insurer or not.

Next. So what can you, what did we try to do? So here we're starting in Austin, we'll grow from Austin, here mostly around Texas, but really design around people. Again, around health journeys around conditions because those are sensible to people but also sensible to us and capable of redesigning.

And then we use a whole variety of players. We don't just have to use a biller. So we can use coaches and other things. Including technologies.

And then we can smartly subsidize the things to get people to do the right bang. And it could be health promotion type activities, but it also could just be who you go and see. And I'm going to kind of illustrate that really quickly. And then deliver it in the communities that we live in obviously.

Next. It really is about surrounding the member with the things they need. And then also recognizing that many, many things around, health, they don't occur in an office visit. And so, how do you create a system that's really responsive to people in and outside office visits? And not just

with people, but again, also with technologies.

Next. And part of this too is flipping everything on its side. And I've mentioned this a couple times already, but really organizing around condition. And our whole, all our data systems are built this way so that we can track conditions, condition outcomes. We can use that for prioritization. And we can use that to optimize care pathways for members.

Next. One of the ways we do that is to figure out where people should go. We're not trying to own everything. So as opposed to Kaiser, we're not going to try to own all the specialists, we're not going to even try to own hospitals. That makes it more feasible to do what we're doing, which is already extremely difficult.

And so, one of the things we have to understand is where we should send people. So this is an example from real data from a local HCA hospital system. Health Grades is online. It's what our members see. It's actually what most physicians feel. You know, oh, they, people like it when they go to see that person so then what else can we know.

Next slide. And the reality is, we have

a ton of information.

Next slide. That tells us more about the quality of their work, there are a variety of different ways that we can sense and determine quality. For us, we just ingested a ton of claims data, all that we could get. So 60 percent of commercial claims, a hundred percent of Medicare data over multiple years across Texas.

And then we can also look at average costs, not just for their pro-fee piece but the whole thing. The whole arc of care for specific conditions, for specific procedures.

So this is an example for a specific procedure. Huge differences in costs for these providers. Small difference in quality. Obviously why would you send somebody to somebody that costs, you know, two, two and a half times more?

Next slide. And in fact, there is a whole range of quality and costs for providers, and they're not associated, you don't, obviously a point that higher quality doesn't mean higher cost. In fact, often it's the opposite.

And so, next slide. So what we can do is start to subsidize good decisions. So then take those providers that we identified as being, this

is different from a neural network, we're allowing people to go anywhere, but we're saying, if you go to these folks, there is no copay associated with your making that trip.

So this is an example of how the benefits then align with our care model, that aligns with eliminating waste and then developing partnerships with these folks to focus even on enhancing quality for their, and also in coordination.

Next. And then what that looks like. It doesn't have to be just on referral, it can be on any, any point in the care pathway. And again, having them sensible along these care pathways and conditions makes this doable.

And so then timing of things. What's right for you at this time. Those kinds of things can then become things that are encouraged by eliminating copays associated with them.

Next. We're not alone in this. I mean, that's obviously the case, but a couple other examples in Texas, they're doing, aspects of what we're doing. One is, curative, they basically just say, you get an initial onboarding visit, that's really important to understand, you know, your benefits and how they work and where you should

go. And also plug in a primary care. And if you do that, there is zero deductible for everything downstream.

Another is Everly. And it's a company that uses a rewards cards to incent good behavior. So obviously these are just a couple other examples to throw them out. I know there are many others, but I didn't want to pretend like ours was the only one out there.

Next. That's it for me.

DR. LIN: Thank you, Clay. Next we are pleased to welcome Paul Berggreen who serves as the Chief Strategy Officer of GI Alliance. And is the Founder and President of Arizona Digestive Health. Welcome, Paul.

DR. BERGGREEN: Thank you. Good morning. So yes, I'm Paul Berggreen. I am a gastroenterologist in Phoenix. And also a Chief Strategy Officer of Specialty Alliance.

Next slide please. I want to talk a little bit today about how this ecosystem would work, not only from the patients' standpoint but from a practice standpoint. And I'm going to start off with my favorite slide here.

It's not just designing a payment model,

it's how do we improve the clinical value that we are delivering to populations of patients. So in this center is a population of patients in the blue, surrounded by the typical care that we deliver. Whether it's an office visit or procedure, et cetera. Very traditional.

But when you wrap other services around that, I'm going to start up at the 1 o'clock position with our physician leaders throughout the entire GI alliance. And by the way, it's a very large group we have. Just under 1,600 physicians. GI and urology right now. So we have a lot of experts.

Those providers have developed care pathways in all of our relevant disease states. And those care pathways then lend themselves to a development of a population health dashboard.

That dashboard is vital for us because it enables quality improvement projects. And quality improvement projects then transition naturally to a population health management system throughout the entire corporate organization.

The dashboard has some nice corollary benefits as well. It can serve as a research patient finder tool. It enables real-world

evidence data projects which are very valuable to our practice to shape direction of the practice and the care.

Importantly, it powers our chronic care management program. We're currently managing about 50,000 patients every month in our program around the country. And that includes remote patient monitoring.

And interestingly, that also enables services to be delivered to our patients that typically are not covered by Medicare or commercial insurances. And that includes nutrition counseling, which is vital for us. Behavior health, pharmacy tech services for patients through polypharmacy. Really vital services delivered to a patient.

Once you've wrapped all of those services around your ecosystem, then you can confidently engage in a strategy of a value-based contract. But it also works well in a fee-for-service world.

Next slide please. I want to show you the dashboard. So this actually is a dashboard. And it says we're at a total of two million patients. This is an old slide. We're actually aggregating data nightly from five million patients. We've

done this for GI and urology. We divided this into our disease states. And everything you see on this page is a filter.

If you can go to the next slide please. I'm going to use IBD[33] as the poster child for the next level of information here. These are more granular filters for inflammatory bowel disease. And it allows us to actually start to slice and dice our patient populations to get granular information down to the individual physician, the individual office, the individual patient population. So this is really key to what powers our program.

Next slide please. Importantly this is what we were particularly interested in, right? These are metrics that were pulled from our care pathways to look at this disease state. We have others for other disease states. And we measure performance of our patients and our physicians based on these metrics across five million patients.

We therefore, in inflammatory bowel disease, first time ever we were able to actually set a national baseline of how good our physicians

33 Inflammatory bowel disease

are at getting our patients to be adherent with their care plans. Which we know correlates to better outcomes and lower overall costs for the system. So this is key.

Next slide please. The results of this is, in the 121 offices that we measured with this dashboard, the six that you see in the boxes here were the pilot programs. And we were able to dramatically improve their patients' adherence scores with a focused effort over six months in six locations.

And that actually has now been expanded, this was just in April, we've now expanded this to 24 locations. We're adding at least four locations every month. So it's a pretty rapid rollout of this program.

Next slide please. What you see, importantly, is that in that six months in that six locations, we identified over 900 patients that had fallen out of adherence with their care plans. And on the right, what you see is that we were able to capture just under half of those with this concerted effort. And that yielded additional labs, additional office visits, additional procedures in some situations.

And very importantly, over on the left side of that, changes in medications. Particularly the biologics. As you note, some of these biologics were extraordinarily expensive and needed to be used very carefully and very appropriately. This helped us to identify those patients who either were not responding and needed to be switched or who would have been benefitted from a biologic and were not on one. So this is really key to population management.

Next slide please. So really when you design a program, I would say that you have to have better information, and you have to put together models that start with the patient but focus on the practice, because the practice is the one that is the entity that is going to be delivering that care.

If you've got better information, then you can make sure that everyone in this ecosystem wins with that information. But again, keep in mind that this system has to work in two worlds. It has to work in your risk-based world, and it has to work in a fee-for-service world because that's where our patients are going to live, in both of those worlds. This model actually enables

that. So I'll stop there and say thanks.

DR. LIN: Thank you, Paul. Finally, we are glad to welcome Ms. Kaitlyn Pauly, who is the Chief Integration Officer for the American College of Lifestyle Medicine. Kaitlyn, please go ahead.

MS. PAULY: Thank you. Great presentation so far. I'm Kaitlyn Pauly. I serve as the Chief Integration Officer for the American College of Lifestyle Medicine. And today I've been asked to present on payment innovation and benefit design for patient empowerment.

Next slide. We're all likely too familiar with the unsustainable epidemic of chronic diseases in American. We know that 90 percent of health care costs are tied to chronic diseases, and that 80 percent of these diseases are driven by lifestyle factors.

Next slide. Our health care system should be designed to address root causes of disease instead of only managing symptoms. The reality is that lifestyle-related chronic conditions are not properly addressed in medical and health professional education. And because of our fragmented one-to-one episodic short visit approaches to care delivery, there is often not

enough time or resources to properly address lifestyle in clinical care settings. The focus remains on disease and symptom management instead of root cause treatment.

This is reinforced by lack of sustainable payment and reward systems to address lifestyle-related root causes. There are even misalignments that unintentionally penalize health restoration, disease remission, and medication de-escalation.

Next slide. This is part of why the American College of Lifestyle Medicine was founded in 2004. To educate and equip clinicians on how to treat root causes of chronic disease and to advocate for changes in the current health care ecosystem to support clinicians, to deliver, and patients to receive lifestyle interventions.

Lifestyle medicine is a medical specialty that treats root causes with therapeutic lifestyle interventions allowing clinicians to restore patients' health and reignite their joined practice. Sick care manages symptoms while root cause care restores health.

Next slide. And for those who haven't heard of lifestyle medicine, it is a medical specialty that uses therapeutic lifestyle

interventions as a primary modality to treat, potentially reverse, and prevent chronic diseases, such as cardiovascular disease, obesity, and type 2 diabetes.

Next slide. The lifestyle medicine six pillar framework includes optimal nutrition, physical activity, stress management, restorative sleep, avoidance of risky substances, and connectedness. Imagine a world where clinical care teams can support and guide their patients towards structure, evidence-based lifestyle interventions either as a first treatment option or as an adjunct treatment for medications or surgical procedures to truly address the root causes of disease and optimize health outcomes.

Not only is lifestyle medicine a way of bringing full informed consent of all treatment options into health care, it also empowers patients to engage in their own health journeys.

Next slide. The lifestyle medicine framework and care delivery approach is evidence-based. Clinical practice guidelines for most chronic diseases lists lifestyle change as a first treatment recommendation and as an effective adjunct for most pharmaceutical and surgical

interventions.

Next slide. And disease now shows -- our research now shows that the same lifestyle factors that cause chronic conditions can also be used intensively to put diseases into remission, de-escalate and even discontinue medications. Our nearly 15,000 members are achieving these types of outcomes daily, and they need support to sustainably scale their success.

Next slide. So the vision is for benefit design that enables patients' awareness, empowerment, and control of health where trained clinical care teams can lead and support care delivery that reinforces lifestyle changes to prevent, treat, and remit chronic conditions.

Next slide. Our ideas for benefit design that might help in this cultural shift toward patient empowerment include expanding coverage for therapeutic and intensive therapeutic lifestyle interventions delivered by trained clinical care teams. Eliminated or limited cost sharing for high-value lifestyle services that address root cause prevention treatment and remission of product conditions. Coverage for evidence-based lifestyle intervention beyond clinic walls where

people live and work. Coverage for engagement with all qualified team members who deliver evidence-based lifestyle intervention. And I think we already heard today that many of the services that clinicians offer, like dieticians offer, are not available for coverage right now.

Coverage for tools that allow for asynchronous follow-up to support health behavior change and engagement. And then coverage for services that address barriers to applying lifestyle change, like nutritious food access and supervised exercise therapy. And then of course removal of one-time beneficiary roles for lifestyle interventions that currently do exist.

Next slide. For this we also need aligned payment incentives and quality measures that reward evidence-based root cause treatment, along with removal of penalties and barriers for providers that are using these approaches.

So two quick examples of penalties include when clinicians can support health restoration of their patients through lifestyle only intervention, they may get dinged on some medication adherence quality measures. And with risk scoring and value-based arrangements, when a

clinician can support a patient into disease remission, their risk score goes down, and the payment for the clinician also goes down. The payment should really support and reward clinicians for offering evidence-based lifestyle interventions that engage and empower their patients to take control of their own health.

Next slide. So similar to benefit design, some ideas for payment innovation that could help support this patient empowerment include compensating fairly for those therapeutic and intensive therapeutic lifestyle interventions that are delivered by trained clinicians offering hybrid payment models to cover multi-modal interprofessional care team delivery of lifestyle interventions. Offering proper payment and clarity for delivery of group visits, also known as shared medical appointments, that can scale the treatment options.

Expand the digital and asynchronous tool care coverage which really helps people understand how they can control their own health behaviors. Expanded options to address upstream drivers of health. Offering incentives and rewards, not penalties, for disease remission, health

restoration, medication de-escalation, and patient engagement.

And use metrics like lifestyle improvement, patient activation, quality of life. Health improvement, health outcomes, disease remission, medication reduction, measure progress, incent and reward clinicians for delivering these amazing interventions and outcomes.

The great news is that we're now seeing requests for information about payment that supports lifestyle interventions like nutrition, social support and physical activity, and quality measures for nutrition and well-being.

Next slide. If you feel that evidence-based structure lifestyle intervention should be available to patients and that clinicians should be able to sustainably deliver lifestyle interventions, there are a few things could help.

Supporting physician-led interprofessional pilot programs to test hybrid payment models that align with lifestyle behavior change guidelines. Removing structural and systemic barriers that address the payment and quality measure of misalignments that I mentioned

today. Collaborating with stakeholders across the health care ecosystem to co-design benefits that empower patients and reward clinicians.

And while today's time was really spent on health care's role and patient empowerment, health care alone cannot tackle America's chronic disease crisis. I'm sure that you can all agree that stakeholders across America should take ownership in moving our population toward making healthier choices easier for all Americans.

Thank you for your time and attention today. I'll look forward to taking questions.

DR. LIN: Thank you, Kaitlyn. And thank you to all our experts for those great presentations.

Now we will open the discussion to our Committee members. At this time, PTAC members please flip your name tent up or for our virtual Committee members, please raise your hand in Zoom if you have questions for our guests.

In the interest of ensuring balance across different perspectives and questions, we encourage experts to keep each response to a few minutes.

I'm going to go ahead and start with

Krishna.

MR. RAMACHANDRAN: Thanks, Walter. Thanks, team, great job presenting. Yes, I loved hearing your perspectives.

Curious on you all know sort of value for the Medicare Trust Fund. Beneficiaries is a topic that's very important broadly as a nation.

I'm curious if you can share your perspectives on just return on investments so many of, any of the sort of levers you were all speaking about.

Just are you seeing early outcome improvements whether it's financial, non-financial, that would be helpful for us to learn more about?

DR. BERGGREEN: I'll go first. So, the question is are we delivering value? And the answer is, you can deliver value in any payment model that you come up with.

I think the more relevant goal for the physician practice is to deliver a better outcome for the patient, to change some of the dynamics that lead to poor outcomes. In some situations, that's something that we can prevent, and in some it's not.

But the fact that there's gaps in care, that patients are falling through the cracks, that things are simply not getting done because of the limitations of the systems in which we are operating, doesn't seem to be something that we should tolerate.

And so, what I've designed is a way to recapture that and deliver that value in the form of better outcomes in whatever type of payment model you're engaged in.

I'd be interested to hear other, others' opinions on that.

DR. JOHNSTON: Yes, I guess, for us, we participate in as many of those programs as we can, the ones that are trying to simulate innovation, and to focus on value.

And I agree with Paul that it starts with actually doing a good job. Knowing that you're doing a good job. But the reality is those programs have been disappointing for a couple of reasons. I think one actually relates to what Kaitlyn was talking about.

They are annual programs, right? So the rewards are all based on annual performance. A lot of lifestyle interventions actually don't accrue

in the year in which they are provided.

And so, that's a fundamental flaw of those programs. Why invest, if I'm taking the risk, I own all the costs, why invest in something that's not going to pay off in that year? Particularly with all the transfer between plans that occurs.

This isn't unique to Medicare, this is true also in commercial as well. But it is a fundamental problem.

For Paul's profession, it's partially been solved by saying something like a colonoscopy is outside that; we want that done. And it becomes a quality metric.

Colonoscopy is an example of another thing that if you're an insurer just focused on that given year, you'd rather that happen next year, or the year before, not the year that you insured that patient.

So there are kind of workarounds for some aspects, but they've been unsuccessful. But I think even more important, success in that, in those programs, whether it's Medicare Advantage or whether it's ACO REACH, or really all of the programs, are more based on risk coding than they

are on actually achieving better outcomes for patients and reduced spend. Particularly reduced spend for waste. So I think the, and how do you get around that problem, that is a extremely low problem, but that's partly what's driven us to say we have to be our own insurer. Because if we're not, then we're just subjugated to someone else's rules. And then, we have to spend more energy and risk coding than actually taking better care of people.

And if we don't, which is the way we started, it was like we're not going to do that. That doesn't help the member, and it doesn't help society for us to focus on risk coding.

The problem with that is everybody else is working on risk coding. And so, then the benchmark dramatically impacts us.

And so, then we have to achieve 10 percent, 20 percent delta in performance just to get to the risk coding advantages that others who have focused on that have been able to achieve.

So those are I think, some of the, I love the attempts. It's the right direction. It's given us an opportunity to do some great innovation. But I think we really do have to think about how the

program can mature, and do what we'd like it to do.

DR. LIN: Thank you for those responses. I'm going to go to Chinni next.

CO-CHAIR PULLURU: Thank you. My question is regarding design improvements. I'd love to direct it to Robby, Kaitlyn, and then Dr. Johnston and Berggreen, as well.

So what design improvements are important to make for supplemental benefits to drive real value to the system? And think also through the lens of waivers that can be put on the current environment.

MR. KNIGHT: I appreciate the question, Chinni. As I think about how we got here for supplemental benefits, it's been a pretty interesting ride in general, over the last several years.

2019, the average benefit value for supplemental benefits was about $155 per member, per year.

Last year, it was roughly $1,500 per member, per beneficiary, per year if you exclude a few benefits there. In addition to having a 10x increase in the value over five years, utilization

has also doubled.

So what that math equates to is roughly a 20x increase in overall cost for health plans that are having to choose between funding cancer care, and funding over-the-counter vitamins.

And so, the real question here is what kind of model needs to exist, and let's just be honest about what exists today, and what really should exist.

As I think about today, these benefits come out of medical loss ratio spend to claims dollars. But today what's happening is health plans are using these dollars or these benefits to really drive more membership acquisition.

So I would say is it cost acquisition for marketing for them? It's not intended primarily to be an overall value driver for them to really be a tool in their toolkit, to drive tangible, real ROI[34] when it comes to cost of care improvements.

And to be fair, I say that as a benefits administrator in this space. I think the question becomes on value and what you can do to drive real outcomes and tangible ROI.

34 Return on investment

I think you have to create a model where the provider is actually the center of that, right? And today that's not the case. Today you have benefit plan design that is done on the front side, and it's just, in many cases these at-risk providers are actually eating some of the cost of it.

So as I think about things with some of the things that we're doing here in general, when it comes to overall engagement for beneficiaries, we're seeing a remarkable amount of engagement on a per member, per month basis.

And so, think about the general health in general. Engagement is typically about 4 to 5 percent once per year. We're seeing over 70 percent monthly active users. That is consumer rate of engagement.

And so, my perspective here is why don't you take that, identify what other challenges exist in that member's life, and then really drive overall cost of care improvement.

And my position here is that you do that by putting the vision in the center. By creating some parameters in place that says if you have these conditions or these sort of overall

challenges, here's the things that physicians or pharmacists can prescribe in terms of interventions to really drive ROI and value.

We've always talked about that. We're doing the national plan, national pilot with a large payer and again, we're seeing almost 60 percent of those people that we require to get A1Cs to be a stage, yes, a stage gate if you will to get additional benefits.

And it's happening, right? So again, my asking of the group is if these are truly MLR[35] dollars, if they're truly claims spend that's going into it, I think we need to refocus the industry and the market around what truly is value.

And what other players that are, because there's some that are getting this outsized value at any retail or as others.

And saying how can we help them to support us for this challenge. Because as Chris Klomp mentioned, who is the head of Medicare -- we have roughly, and my numbers might be a little off here, but member benefits contributes roughly about $2.2 billion in savings.

35 Medical Loss Ratio

That sounds great until you realize it's only roughly about $1.7 trillion of spent.

So if any one of us really owned that business, we'd say this math isn't working. So we really need to redesign what actually does work to really drive ROI and true value here, so, thank you.

MS. PAULY: And in terms of benefits design or design in general, I think a lot about the care delivery. And I think we've established today that you cannot have a value-based care without high-value, or value-based payment without high-value care.

And thinking about how do we re-design the care that we're offering to patients. And I think patients are really in a place where they want to have high value, engaged care with their clinical care teams.

We see this for our clinicians in our network. They are excited about the ability to have a lifestyle medicine provider who focused on the upstream drivers of care and their lifestyle, and empowerment.

I'll pass the time to someone else. I don't think I quite answered that question.

DR. JOHNSTON: Yes, and just to pick it up, I think Robby's response is right, right on. I think the yes, those supplemental benefits or additional benefits are really used as a marketing tool.

But, even more, they're to market to the, to a, the right kind of person. And so, like even the ones I was showing in the commercial marketplace for Everly, they're really to attract healthy people into the plan, and then of course they'll get coded up so that they can, they look sicker than they are, which then contributes to our belief that there is cost savings.

But that's really what they're used for. I think it should be, and just as you said, Robby, I think we, there is evidence base for a lot of interventions that are in that space, including all the ones that Kaitlyn was talking about.

Those are the kinds of things that should actually be supported and wrapped into it where the benefit really is a healthier person, not a freebie.

And so, yes, I'd love to see that evolution to support things that are really aligned with in the evidence base.

I would also say one of the major challenges we have is member engagement. And again, I love that, Robby, you get that member engagement is so critical.

It's hard to get members to do what is in their best interest. And so, too, if we can start to think about those benefits as enhancing member engagement, that is an awesome goal that everyone would benefit from.

DR. BERGGREEN: Yes, all great points. I'll just add this from a practice standpoint, right? Because the practice is the ones who are actually caring for the patients, and responsible for the outcomes.

If you don't have a system in your practice that enables you to globally care for those populations of patients and affect their outcomes at scale, then you really have no ability to change the dynamic, right? So to deliver a better value at scale.

And I will tell you something else that when you think about this, remember that whatever plan that we're having designed for us, maybe in Medicare, maybe it's a commercial insurer, we can't segment the care we deliver to our patients

based on a plan design.

We're going to deliver the best quality care that we can to every patient in our practice.

So whatever we come up with has to be in the best interest of our entire practice, not a segment of patients. And so, that's more challenging because we really have to keep our eye on the big ball here, rather than a small segment of that ball. And when we're building these programs into practice, they're very difficult to build. They're very expensive to build, and they're very expensive to maintain.

So there's got to be some benefit to the practice as well. And quite honestly, a risk-based model in specialty care, the adoption around the country has been pretty underwhelming.

And then, in my specialty, it's been non-existent. Even though we can do it and we're ready for it, they're just not there. So we're proceeding in both worlds, right? Fee-for-service, and ready for risk.

DR. LIN: Thank you for those responses. Larry?

DR. KOSINSKI: Again, a great session. Thank you to all the speakers. You guys have all

reaffirmed for us the reason this Committee exists is that we're supposed to be focusing on what the provider space needs in building value-based care solutions.

And I'm struck with the comment that Paul has said a couple of times here today. Focus on the practice. And it really we need to focus on the business model of the practice. And that our move to value-based care is sensitive to that.

And Clay touched on a couple topics that prompted me to think of questions that I'd like to use to just emphasize the situation.

The first one has to do with risk. And, obviously, Clay, you've been in the same situation I've been in over the last few years where you generate savings.

You're very proud of your savings, and those savings get denigrated when there's a risk adjustment put on by the plan. And it is costly to have our providers code in the necessary way for us to generate the risk assessments. And there is no extra reimbursement to a practice to focus on this coding.

So, I think my first question, and I have another one to follow, but my first question is

what have the four of you done in your practices to promote more accurate coding so that you're ready for risk-based contracts? And that you don't lose your shared savings from poor coding?

DR. JOHNSTON: Yes, so we've had to do this extensively. And again, just in the beginning, we I wouldn't say ignored it. We knew it was an issue but we chose to focus on the improving outcomes, and lowering costs. Reducing waste in care.

And it was only when we realized what we were, what a hardship that was creating for ourselves, that we recognized that we needed to actually shift direction.

So, what we do now, and now it's like it's really hard to catch up right, because you, it's over multiple years.

For example, for ACO REACH and their prior year, it takes years to catch up. And ACO REACH only allows you a small 3 percent increase in a RAF[36] score in a given year. There are lots of issues like that.

So, we use, first of all educating people about the importance of the coding and why we have

36 Risk adjustment factor

to care about it.

That's frustrating too, because it's again it's like wait, we told you you could be the kind of doctor with integrity that we said.

We don't believe in over-coding, we just believe in coding to the level that's appropriate. And that's the other key thing.

And then, IT systems that flag prior year, HCC[37] codes that could be re-used in a given year as an example. Or that create opportunities based on a review of what's in the record.

And so we use that, those feed up recommendations at the time of visit. And then, those are responded to.

So those are examples of things that we've put in place.

DR. BERGGREEN: I'll go next, and hey, Larry, good to see you.

DR. KOSINSKI: Nice to see you.

DR. BERGGREEN: So let me just give you a perspective from a private practice standpoint. Of course, we have a very robust compliance department.

We have people that do nothing but

37 Hierarchical Condition Category

validate coding, and make sure that we're very compliant.

And that's a big deal for us, but not because we're in risk-based models. Simply because we want to be compliant and code correctly.

In private practice, then you deal with commercial insurers. And as many on this panel know, in the last few weeks the Cigna and Aetna policies are automatically down coding level 4 and 5 visits.

That's what private practice is dealing with right now. So our heads are spinning because of the pressures that we're facing from all sides of the ecosystem right now.

And, while we have an entire department to make sure that we're coding correctly, our priority is, is making sure that we're being paid appropriately in a fee-for-service model.

So, whatever is formulated from a risk-based plan, correct coding is not really a problem for us.

The problem is that we have a mixed constituency of payers. And we're having to deal with threats from that.

Just my take.

DR. KOSINSKI: Others?

MS. PAULY: Hi, I don't own a practice; represent clinicians who own practices across the country.

And the biggest thing we hear about the risk scoring that becomes a challenge for people who really focus on delivering better health outcomes, is that they get paid less once they do that.

And there's no incentive for having a healthier patient population in a risk-based model with the current coding the way it is, so.

DR. KOSINSKI: So it's not only, not only cumbersome to code correctly, it can interfere with your payment.

MS. PAULY: Correct, yes.

DR. KOSINSKI: I don't want to -- Robby, did you have a comment? No?

MR. KNIGHT: No, no comment.

DR. KOSINSKI: Okay. So, my second question has to do and that was another thing Clay brought up. And that is the copay issue.

And we heard in a previous session today that it makes no sense that when you want people with preventative, proactive care to be paying

copays because an $8 copay can kill the utilization of those.

And I think Paul mentioned chronic care management, and Clay, you mentioned it as well.

And so, what strides have you made with your payers to get, to minimize that copay issue for the patients when you're proactively billing for a service to provide chronic care management?

DR. JOHNSTON: Yes, so that's a great question. We've worked hard on this as well. And again, this is one part of our rationale for having our own insurance, right?

I mean the way we treat copays is just like hit people on the head. Quit spending in health care. We're going to take some money out of your pocket whenever you do. And that's obviously dumb.

You want to use the copay to encourage the right behaviors. And sometimes you, you're getting too little of a behavior, and so to encourage it, you might even want the copay to be negative, right, to actually subsidize somebody doing something that's in their best interest.

We can do that obviously with our own insurance. The other insurers have been really

inflexible in terms of how they thought about it.

So for ACO REACH, we have petitioned to get copays removed for certain activities that we provide, and they'll do that.

So they'll let us say okay no copay for CCM. We don't need to collect for that, and so we can bring people into it.

For the MA[38] plans, they haven't been, they haven't accepted that from us. I think that in all of those plans, it's a shared risk arrangement right?

So they, if there are savings associated with the care that we're delivering, they're pocketing half of it on average in those plans.

And they're paying 100 percent of what we bill. And so, I think they still see it as a potential grab.

That, I think, is extremely short-sighted. We know those kinds of programs work, and they really should be fully supported in those plans.

A good example is something that actually could be a shift. It could be that MA plans are required to provide CCM coverage without copay.

38 Medicare Advantage

That would be an awesome thing that would drive the right behavior and response from practices as well.

DR. BERGGREEN: Yes, Clay, I agree with you. The chronic care management program and has actually been very beneficial, and it's been a good idea.

What we saw, and the cost is modest, right? The copay for those patients can be as little as $8 a month. And they don't necessarily get that cost every month.

But during the public health emergency, copays were able to be waived. And we did, and we had remarkable enrollment in our clinic and management program.

And as soon as the public health emergency was over, enrollment plummeted. And it's built back up, but it's been years to build that back up.

So that seems like a sort of, almost a no-brainer is that why would we be charging such a nominal fee for a service that provides so much value when it's such low-cost service?

The other very frustrating thing is that some of the commercial payers still don't cover

chronic care management services. And CIGNA is one of them nationally. The Blues give us nothing but trouble about chronic care management services.

And so, that seems to be counter-productive. They're trying to deliver quality and a longitudinal care to their patient populations.

They have a very low-cost, high-effective service that does that. And yet, they're putting out payment barriers and that one I don't get.

MR. KNIGHT: One of the things that the way we think about it is probably a little different, is we develop chronic care management, I think a lot in terms of the pharmacist is sort of the most optimal side of care if you will.

If you have bundled payments or other kinds of different interesting payment models that could exist, my view is you guys are actually interested in reinvesting in other places. And so, certainly not a fan of the copays for all the reasons that you folks here all talked about.

I think where our approach to date has been to work with health plans and say like, here's an overall pool of dollars that we need to be able to manage for you, right?

And if you have individual HEDIS[39] measures, let's talk about that, right? So individual HEDIS measure is C06, medication review, medication reconciliation.

The average cost for CMS today is about $124. In retail pharmacy, it's literally half that.

And so, my view is here is if you want to really drive the value and outcomes here, shift it to the side of care that's most efficient, so then you can then reinvest in driving real outcomes here.

Now the challenge with that is you need to be able to provide better information and data back to the PCP that you have in place there.

But I guess my comment here more globally is there's got to, again it's $2.2 billion in savings on $1.7 trillion spend.

There's got to be ways to rate that savings and then reinvest because what we're doing today isn't working. And from a cost profile, there's sort of a different model here.

And my perspective again, given our work with over 50,000 pharmacy locations in the U.S.,

39 Healthcare Effectiveness Data and Information Set

is that you should optimize a side of care to then generate those dollars that you can then reinvest.

MS. PAULY: And while chronic care management is a great model that a lot of our clinicians are using, many of them are also delivering intensive and therapeutic lifestyle change programs in shared medical appointments, or group medical visits.

And the copay has been a barrier for our clinicians, especially for the patients who can't afford to pay multiple copays over the course of weeks or months, if there's a series of visits that's focusing on their chronic disease.

So that has been definitely the experience, and it causes attrition over time. So patients may just be engaged in the first few visits, and then over time if they have multiple copays, decide they can't afford it anymore, so.

DR. KOSINSKI: Thank you all. But it looks like maybe we have a waiver, a waiver option here, to, to fight for. Thanks.

DR. LIN: Are there any other questions from my fellow PTAC Committee members? Chinni.

CO-CHAIR PULLURU: This is maybe a little bit more specific for building on Krishna's

question earlier today.

When you look at the various lifestyle changes that we've seen, and the various sort of supplemental benefits, what would you point at that has the largest ROI in terms of pure just spend management?

So I'll throw it out there.

MR. KNIGHT: I'll take that one here first. Definitely food. Food and transportation are the number one barrier we have for beneficiaries and members being able to get to these appointments to whether it's dieticians that we provide support for, or A1C performance interventions, is absolutely transportation.

And that's the first one in terms of overall ROI and outcome certainly food. That the literature is pretty substantial and out there in terms of the impact that SNAP[40] has had on overall driving cost of care and preventive maintenance.

It's great that you want to drive care and outcomes, but the reality is in order to first do something that's important for a patient, you have to first serve their first order of needs and the most important to the patient.

40 Supplemental Nutrition Assistance Program

And if you can't get to the doctor, you can't get to their grocery store, you can't even eat, and you're having choose between cutting bills in half and making, eating for that week, that's a very foundational problem to solve for.

And so, I think what we've seen is food has the best interventions. What I'll also say as part of that challenge though, is that there's a complete lack of coordination between CMS and Department of Agriculture that I think is changing now.

Around whether it's EBT[41] dollars, or WIC[42], SNAP, TANF[43], all those dollars there, and then other supplemental benefits, that you need to have to provide a more holistic coordination of care there to really drive value.

But from what we've seen in general here, our certainly ROI is much more pronounced in things like transportation, and food benefits.

MS. PAULY: I would agree with Robby in terms of the food and nutrition as seeing the most substantial cost benefit.

41 Electronic Benefits Transfer
42 Special Supplemental Nutrition Program for Women, Infants, and Children
43 Temporary Assistance for Needy Families

And with intensive therapy to lifestyle change, nutrition is absolutely the number one way that patients can achieve disease remission and improve mental health outcomes.

And if a disease goes into remission, the cost for care goes down longitudinally.

So, but also wraparound care is necessary like if we think about medical tailored meals and produce prescription programs, those can be really great acute interventions to offer patients.

But if they don't have the ability to maintain nutritious dietary patterns following the intervention, they may wind right back in the same place.

So education, education, nutrition education, culinary education, and then healthy food access are all really important for achieving those long-term outcomes for food intervention.

DR. JOHNSTON: Nothing really to add. I agree completely, it's nutrition and the transportation issue is really important for some, as well.

DR. BERGGREEN: Yes, I'm going to just take maybe just a little bit more global of the view. I think it's compliance with a treatment

plan. And identifying the barriers to that, right?

And Robby was saying sometimes it's transportation. Sometimes it's dollars. And sometimes life gets in the way.

So a system to, for the practice to help to take some responsibility for helping the patient to be compliant with the plans that the physician has outlined, seems to me to be sort of part of the solution.

DR. LIN: Thanks for those responses. I wanted to circle around to a comment that Paul made earlier, that the practice takes care of the patient, and the practice is responsible for outcomes.

This session is largely around empowering and enhancing patients in their own care journey.

And I'm wondering if any of you have thought much about making the patient in part responsible for their outcomes.

If so, in what way and secondly, what kind of performance measures have you thought about in terms of effectively measuring patient empowerment and patient engagement?

DR. JOHNSTON: Yes, so I'll just tell you

how we've been thinking about this. Because this is, I think that's a great question and it's like yes, the patient is responsible for how healthy they are.

And ignoring that ignores their critical role to anything working.

For us though of course, their outcomes are determined by their actions, by our actions, and by chance.

Nothing that I'm doing today will help me prevent inflammatory bowel disease that we know of. Paul could probably tell me that's not quite right, the amount of fiber that kind of thing.

But whether I get that or not is largely chance. And so, we don't want to penalize somebody for having bad luck.

So for us, it is how do we engage our members, again we try not to call them patients because they don't want to be patients, how do we engage our members in taking the right steps in their care?

And then for us, the tool that we use is the copay. So we, because now there's an expectation that you're having to pay for your health care. So that effectively is creating a

subsidization for them to do the right thing.

Then of course, it's back on us in clearly defining what those right things are, right? So that we can create a structure in which those benefits can accrue to someone if they do the right thing.

In that structure too, there is a right thing for a clinician. And that's different from a RVU[44] system, right?

And so, we're at the same time creating that incentive structure for clinicians and that's also a new challenge, replacing the RVU with did you do the right thing in order to achieve a better health outcome, or reduce waste for this member?

And so we're kind of building those systems in parallel.

Being the payvider allows us to do that, right, because if we weren't the provider, we wouldn't have control of clinicians and clinician behavior, and all those things.

And if we weren't the payer, we wouldn't have control of the benefits. So that's like one of the real nice things about being in the position that we're in.

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44 Relative Value Unit

MR. KNIGHT: Hello?

DR. BERGGREEN: I'm sorry, go ahead, Robby.

MR. KNIGHT: So one of the things I think you, one of the things that Paul mentioned that I really like is thinking about really focusing on the treatment plan here.

And I think about putting the patient, the member, at the center of their own care. Part of the opportunity here for us in general here, is to realign what kind of benefits or challenges, realign benefits and solutions for the individual patient.

And so today for example --

(Audio interference.)

MR. KNIGHT: -- and they get quite a lot of dollars for that benefit increasingly less, but still quite a lot of dollars.

Back in my prior life, what I saw when I was at Walmart was members that would only have an OTC benefit.

They would go buy something and then just sell it on eBay because they have these dollars, they had a finite amount of fixed income dollars they were trying to spend, and they're trying to

make ends meet.

Because the reality is they only need so much in vitamins. And so to Paul's point, I think part of the really interesting value here in terms of thinking about a more holistic view of keeping members in the center, right, is making those benefits or those kinds of programs dependent on what the individual member and that provider actually think is the best treatment of action for that member's overall care, right?

So, true personalized benefits based on individual need. That's where I had hoped things were going with Vivant, but instead it was used as a marketing vehicle to drive marketing costs versus actual ROI.

I think the real value here to having the patient being in the center and in a lot of these sort of, and in these interventions they need support with is to actually be able to have them help with that provider to determine what's the best course of action.

What they actually need to improve their overall health outcomes. And that be centered based on the treatment plan that they set alongside that physician, so thank you.

DR. BERGGREEN: Yes, the challenge that we have in identifying what leads to a good outcome versus a bad outcome, is that for many of our diseases, and I'll use inflammatory bowel disease as a poster child.

But we don't have those metrics. We have published guidelines that say this is what you should do in this situation.

But measuring that across populations of patients or nationally, is something that hasn't been done.

We actually as part of the dashboard that I showed you, what we were able to do with that was actually take those metrics that we identified from care pathways that were published, and set a national baseline for care in that disease state.

It can be done for any disease state. And so when you set that national baseline, then at least you have something to measure against.

And until you have that, it's really hard to either reward or penalize people for behavior because you don't know what you're measuring against.

And so, that effort, I know it's underway in other specialties and certainly in my specialty

it is.

But that's a soft target in a lot of situations. And not all practices have the sophistication that we've been able to build.

So I'll just tell you that the goal posts are, can be fuzzy. Hard to measure against.

MS. PAULY: Yes, and Paul, just to build on the measure piece. A lot of the things that may influence a disease are happening outside of the clinic walls. And are happening with patients' behaviors. And currently we're not really capturing that information in health care.

We are making a big effort to capture more lifestyle really to factors through lifestyle assessment, but if you're not, if you don't know what a patient's doing outside of the clinic walls, how can you even address what's causing worsening chronic condition?

So I think including other measurements, and this could include both patient self-reported measure and also the measurements that are being taken from the amazing digital technologies that are out there, the wearables, and feeding that in and using it to make better decisions and support patient education about how their health, or how

their behaviors are influencing their health outcomes.

DR. LIN: Any other questions?

(No audible response.)

DR. LIN: So maybe I'll just pick up on what Kaitlyn just said about wearables and digital health tools.

Are any of you using innovative approaches to incentivize patients to use digital health tools in value-based payment models?

DR. JOHNSTON: We are using them, and we are subsidizing the cost for them when we can. When it's in our best interest to do so. But beyond that, we're not.

So, and then those are the sort of typical tools that you see. In particular, we have a strong focus on blood pressure so those remote cuffs that, so we subsidize that for our members and risk clients.

DR. BERGGREEN: Yes, we also, we deal with a lot of fatty liver and obesity management in GI, and leads to a significant chronic liver disease.

And we have a remote patient monitoring with digital scales. And we actually provide those

to patients for free.

If they'll simply get on those at least twice a month, although better if they can do it at least 16 readings a month, eventually we recoup the cost of the scale.

But that's the only real wearable digital device that's applicable in GI right now.

MS. PAULY: And from our members, I've heard them using both the cuffs, as well as the scales and RPM[45]. But also the CGM[46] to monitor blood glucose levels throughout the month.

I think those have been really effective for some of our patients that are tracking diabetes-related disease.

MR. KNIGHT: We haven't to date. At some point, we probably will. I think for us, our view is that there is enough low-hanging fruit in other areas to find extra dollars or value to provide to members to, that are quick wins if you will and higher value.

So we're focusing on those first, but at some point likely, we will get into the space.

DR. LIN: Excellent, thank you.

45 Remote patient monitoring
46 Continuous glucose monitoring

Committee members, if you have any other questions for our session participants, please flip your name tent up. Or virtual Committee members, please raise your hand on Zoom.

If not, I'd like to thank all four of our experts for joining us today. You helped us cover a lot of ground in a short amount of time during this session. And you're welcome to stay and listen to as much of the meeting as you can.

But at this time, we have a break until 1:05 p.m. Eastern Time. Please join us then for the public comment period and Committee discussion.

Thank you all again.

(Chorus of thank you.)

(Whereupon, the above-entitled matter went off the record at 12:02 p.m. and resumed at 1:05 p.m.)

*** Public Comment Period**

CO-CHAIR PULLURU: Welcome back. At this time, we'll have our public comment period.

Is there anyone here with us today who would like to give us a three-minute public comment?

(Pause.)

(No audible response.)

CO-CHAIR PULLURU: At present, we had one person who signed up for a public comment. Mr. Brian Scarpelli, who is the Executive Director of Connected Health Initiative.

We'll await to see if Brian is on.

(Pause.)

CO-CHAIR PULLURU: Not hearing from Brian, and hearing none in this public space, this is the end of the public comment period.

*** Committee Discussion**

Now the Committee will discuss everything we learned yesterday and today. Based on this public meeting, PTAC will submit a report to the Secretary of HHS with our comments and recommendations on using data and health information technology to transparently empower consumers and support providers.

Committee members, please refer to the potential topics for deliberation document on the table in front of you during this discussion.

If you have a comment, please flip your name tent up or for your virtual Committee members, please raise your hand in Zoom.

Who would like to start? Lee.

CO-CHAIR MILLS: Thank you, Chinni. So, Larry Kosinski sent in some written comments since he was unable to attend this portion of the meeting. So his thoughts are as follows.

One, he says he was very impressed with Mendel Erlenwein's presentation. Loved his concept of care coordination management as being the Middle Earth, the important middle part in the process.

Build the brain to amplify the heart is a powerful statement around making AI more human.

In our world of value-based care, it would be great for AI to build the neural pathways, to build anticipatory care management, and make it more automated and less labor intensive.

There is still an issue with communication from care coordinators, care managers to providers. We certainly know that to be true.

There is an opportunity to leverage ambient recording to generate AI solutions around care management, and he thought that was a powerful opportunity.

In the second session, Larry's comments were focus on the business model of the practice,

and creating value-based care solutions.

We've heard this over and over again over the last several years.

Risk coding is a problem. The practices are not doing good enough job coding for risk, and we clearly heard that they are uncertain what the value in it is for them.

Proactive care solutions need to be first dollar and not incur a copay. This could be a waiver option for us to suggest around the CCM and TCM codes.

Those were Larry's comments.

CO-CHAIR PULLURU: Any other Committee members want to comment on the last two days? Go ahead, Jay.

DR. FELDSTEIN: It was very interesting about the AI applications that may be possible in health care, especially in physician reimbursement models.

And I think it's something that our Committee should seriously consider recommending to the Secretary, that we really kind of opened it up to non-traditional providers per se, to bring us AI models. And I think it's worth exploring.

CO-CHAIR PULLURU: Thank you, Jay. Krishna?

MR. RAMACHANDRAN: Yes, something when Larry mentioned it too. It was nice to, the copay thing was a good interesting just to see some of these like simple barriers that come in the way of broader value-based care; broader patient empowerment engagement.

So I think certainly an opportunity for us to spend some time just surfacing up those sort of like smaller barriers that we can recommend to be revisited.

Either in the context of a waiver, or just otherwise like design, benefit design sort of improvements as well. So I thought that was a good sort of takeaway for us.

Two was Jay's point in the AI stuff, too. I think that's a feels like there's worth experimenting in the context of incentivizing, and making sure there is experimentation being done in the AI space.

So, setting aside some incentives to further, whether it's AI care coordination, or some way of like creating more, more capacity for the health care system because I know that's a

sort of broader provider shortage is an issue anyways for us.

And so, a way for us to responsibly test AI by incentivizing, I think this might be worth, worth sort of making that recommendation, too, so.

CO-CHAIR PULLURU: Lindsay?

DR. BOTSFORD: Yes, thanks, Chinni. Plus three, I guess the issue of removing cost sharing barriers, or co-insurance barriers, for care coordination are things I think we've heard this in multiple meetings.

It continues to get shared again in the context of new tools, and data, and AI. So not a surprise but again, I agree with Krishna. Maybe there's some low-hanging fruit in terms of more explicit recommendations for waivers, for existing programs to just remove that barrier.

I think two things that were unanswered but raised in the conversation here, is just the amount of potential new data and tools that are about to be introduced into the space, and wanting to be paid for.

And a real lack of metrics and success measures. So identifying a gap as we think about potential payment, we're going to need to think

about how we measure success without just introducing more process measures to further glut the reporting, and burden of documentation.

I think we also heard a little bit yesterday around just as we need to be thoughtful that payment can keep up with the volume of things that are about to hit primary care doctors in particular. But physicians of all specialties.

And just really need to be thinking as while moving a total cost of care payment models might be the goal.

If we don't come up with interim things, we're going to drown our primary care workforce in the amount of data and things to come.

So, I think really getting more people on the team involved in care coordination with all this increased data, AI maybe is one part of that team.

And I think the final piece would be as we ask for patients and providers to be more comfortable with engaging in alternative data sources, I think we have to be thinking about what are the guardrails to ensure that data isn't used to deny payment.

So, I think with the potential, I don't

know that we have heard really so the sufficient guardrails to ensure that people who are surfacing and looking at this amount of data, don't also have that used against them to say something wasn't done, or a metric was not made.

CO-CHAIR PULLURU: Walter?

DR. LIN: I was quite struck by how different the content of Day 2 today was, compared to Day 1.

I felt like Day 1 was much more about empowering consumers; and today, we spoke about data and health information technology more to support providers. And so I thought that was a good mix.

I see a lot of potential in using better, using data better to support providers. The whole AI panel discussion was fascinating, and I think shows how rapidly that technology is changing the very practice of medicine.

And also, I was impressed with organizations like Harbor Health, who is using data to help patients make the right choices, especially with kind of steering them to higher quality, more efficient providers through the use of lower, or no copays as an example.

So, there's a lot of promise there in terms of using data and health information technology to support providers.

In terms of empowering consumers, I came in, as I said yesterday as a skeptic, and I leave as a skeptic.

I think empowering patients, activating them without making them accountable in some way, shape, or form in their own health care, might be good but not sufficient to make this a worthwhile effort in total cost of care models.

And a large part of that is because we don't have much evidence that empowering patients especially in the Medicare population, especially in the seriously ill that drive a large part of Medicare spending, that this really affects outcomes.

And so, I think there is a lot of room to develop more studies, create the evidence base that supports patient empowerment, and the engagement really matters to improving outcomes, both quality and cost outcomes.

And I think there is a lot of opportunity for CMMI to maybe embed some of these ideas, these technologies, into payment models to test them and

see if they actually work to achieve the desired outcomes.

CO-CHAIR PULLURU: Thank you. Josh, did you want to weigh in?

DR. LIAO: Yes, I really appreciate the last two days. Has my gears turning on a number of things I think in integrating a little bit of what I mentioned yesterday with some things we heard today.

I think some high-level takeaways, I think first, I think innovation is welcome and good but really should be purpose-driven.

I think data and technology and what we can do really should ideally serve the public good, and that interest.

And while I think there are many stakeholders, value for taxpayers, beneficiaries really in public programs should I think, take precedence over enriching private interest. So, I think that should be front and center.

The second, I think trade-offs as I mentioned before, I think are real and have to be navigated and not ignored.

And so, personalization has to be balanced with system, speed balanced with safety,

novelty and equity. And I think we should just be explicit in our choices around that.

I really like the start the last two days about thinking about real scalable solutions. I heard a lot of we should. I think it's a great place to begin.

I'd love as other Committee members have noted, to kind of get to kind of what are we doing now, and what are we learning. And so, I look forward to more of that in the future.

I would just caution us to be a little bit hyper aware and evidence-based. I think lots of, I, among anybody, am excited about the potential of prediction MLAI[47], et cetera.

But I think it's fair to say at the aggregate level, many use case benefits are stated, perhaps overstated.

Monitoring is relatively limited, and the unintended consequences of any technology are real. I think we need to remember that.

Finally, couple things quickly, I think just addressing the economics of change. The silos that some of our SMEs[48] talked about are not just

47 Machine learning and artificial intelligence
48 Subject matter experts

technical. They reflect business models and structures.

And so, I think breaking them down has consequences. Some are obvious; some are less so, and I think we need to acknowledge and manage those.

And then, I was reflecting on the charge of us as a Committee thinking about physician-focused payment models.

And I think one of the things that I'm reflecting on is not everything in every program needs direct payment. And this reflects other people's comments about how are we going to pay for all this, and how would we do it?

Reflects comments about how maybe there's not any perfect way of changing, exchanging money across hands.

But if you think about Medicare as an example, most of the things covered under Medicare are covered under bundled services.

Whether that's the inpatient perspective payment system, the outpatient system, et cetera.

We don't parcel out every single thing into a code, or a discrete service, or coverage determination.

And I think that's probably for the better, so as I reflect on some of the comments from today, it makes me wonder kind of where are the places we should kind of artfully not do anything related to payment for some of these things?

If the business cases and the economics are as real as some of our SMEs are suggesting, there shouldn't be necessarily that motivation to do that.

So I would just be cautious because otherwise, I think we could run into this risk of kind of doing more to do more, and part of us finding balance is to do less strategically, and to do more in other places. So, thanks.

CO-CHAIR PULLURU: Thank you, Josh. Lee, did you have any comments?

CO-CHAIR MILLS: Appreciate all those comments and agree. I was struck at times today that regarding AI and advanced data systems, we were hearing essentially the plea to use, it made me go back to my systems theory training about the whole point is to make it easier to do the right thing, and harder to do the wrong thing. And make it so there's enough safety built in the system

that you almost can't do the wrong thing, right, without breaking glass.

And so, it's I'm going to be the third person to mention it, but I was struck by we've been talking for ever since the codes were created, about the barrier to patients and doctors to do the right thing of the copays.

And the CCM, the TCM, and the collaborative psychiatric care management codes.

So again, I think that's a perfect opportunity for CMS in its waiver power or model design to remove those barriers to getting higher value care.

I heard a strain today that hasn't been picked up quite yet about focusing in on some of the supplemental benefits in Medicaid and MA, and emphasizing the benefits that are proven increased value in health outcomes, and systematically reduce those or take off the table, those that are mainly about marketing.

I know in MA, it's a private company's money to spend as they choose, but it's still within program design parameters.

And for Medicaid where you're very directly spending taxpayer money, even though it's

a supplemental value add benefit, it should be for something that actually adds value. Not just adds marketing or splash.

So certainly we heard food benefits, transportation benefits. Hearing aid benefits are key and actually are almost never included in Medicaid programs. So I would focus in on those for sure.

And then on AI, really jazzed and encouraged by the conversation. Love to hear about stories of innovation.

I was struck multiple times that the AI innovation world is racing ahead far, far faster than our regulatory compliance and legal framework can keep up with. And that perhaps the most conservative force known to man is the compliance attorney team in any modern health system.

And so, I think that's a good opportunity for again, through its regulatory powers and/or waivers, and/or model design for CMS to offer some perhaps through MSSP, but just to offer some safe harbors for use of the AI tools that are clearly driving value, and lowering costs, and take it a step further to say if it's clearly increasing value and quality of care, why do we not rush to

essentially make that the expectation as opposed to that's the innovators?

Let's try to tip from the early adoption innovators as quickly as we can, to mainstream adoption. And that there might be a role for a model to overtly incentivize the use of these. And then that would allow some A to B testing from those who have adopted, those who have not, and prove its value even better.

So, that's what I had.

CO-CHAIR PULLURU: Thank you. And I have just a couple of things to add to the entire Committee's input.

I think the power of AI is to be seen in health care. Health care is one of those places where I think it holds the most promise, particularly because it has computational power to tie in datasets.

And I think one of the things that came in in the conversations was the ability for personalization, whether it was yesterday or today through the care management platforms.

That level of personalization that allows us to deliver sort of that human loop care, is where I believe there's the greatest promise.

The other thing that hasn't been mentioned that I was struck by, was the identity management that came in.

And how the ability to actually have appropriate identity management allows for patient consent, and allows for it to be seamless through multiple environments.

And that's something that can be done today. So we don't have to wait for that. We don't have to worry about, or we do have to worry about compliance, but we don't have to, there isn't a proof point. We know that works because it's been done in so many other situations.

So I think that's one thing that we should stress.

I want to double-click on what Lindsay said about the inadvertent use of this computational power, and the ability to tie various datasets together.

While they're powerful in personalization, we do have to make sure that there are guardrails built into the system to not inadvertently create more disparity in benefits. Or create more disparity in outcomes.

As well as be used as a power to deny

payment for things that meritoriously deserve payment.

I think my favorite line was the incentives to use for the use of ethical and Meaningful Use in AI, is maybe a potential that can increase adoption in a rational way.

So with that. Josh, I believe you have another comment?

DR. LIAO: Yes, sorry if we have time for, if the Co-Chairs will permit time for Committee discussion.

CO-CHAIR PULLURU: Yes, yes, we do.

DR. LIAO: Okay. I think I was reflecting on actually just these last few comments.

And I think again it's important, I think Lee yesterday made a really important comment about stagnant reimbursement for physicians, and how payments to physicians and group practices obviously can drive innovation.

And yet, this comment about the copay for something like CCM or other things highlights the point that increasing payment increases the burden to patients as well.

And so we're not getting away from, and by in turn, taxpayers and beneficiaries. So we're

not getting away from that in any of these kind of conversations.

The other thing I really take, Chinni, your point really well, and I'm struck with kind of this idea that one of the driving motivations for groups like ours and others, is that we believe there's waste and redundancy in the system.

And so, you would imagine in an ideal world like that they would help us identify those, right?

That we should stop paying for certain things. But then we also want to start paying for other things.

And so, I think I would just encourage us as a Committee to kind of think about that, reflect on what our partners at CMMI and other places are doing when they're judged, the things like cost savings to stable quality, or stable costs and increased quality.

We urgently need data around these things, but as you try to solve the one problem, I think we could potentially create issues with the other.

And I think this copay discussion is a great example. And I think data to determine

coverage is, determinations is another.

I don't know those are purely good or bad things. They're both.

CO-CHAIR PULLURU: Thank you, Josh. Anybody else have any additional comments?

(No audible response.)

CO-CHAIR PULLURU: So barring none, I'd like to thank all of our Committee members for sharing your very valuable comments across this two-day meeting, and your time in spending the day here, the two days here.

Before closing, I'd also like to check with the ASPE staff to see if there are any clarifying questions for us.

Marsha, Steve, do you have any questions or comments?

DR. CLARKE: I don't, thank you so much. It was a very good conference. Thank you.

DR. SHEINGOLD: Yes, I think it was a great meeting, and I think as support staff, we have the responsibility now to take all this information and fit it in the framework that Krishna presented yesterday morning in order to make a good report to the Secretary.

*** Closing Remarks**

CO-CHAIR PULLURU: Thank you. And prior to closing, I'd like to mention a Committee member who was unable to be here today. But this is his last formal meeting.

Jim Walton, who has served on PTAC with us. We will miss him, and we wish him well in his endeavors.

And Jim's been an incredibly valuable voice on this Committee, speaking for many parts of the health care system that are often overlooked and marginalized. So thank you to Jim.

I want to thank everyone for participating today. Our session experts, my PTAC colleagues, and those listening in.

We explored many different topics using data and health information technology to transparently empower consumers and support providers.

Special thanks to my colleagues on PTAC. There was a lot of information packed into these two days, and I appreciate your active participation and thoughtful comments.

The Committee will work to issue report to the Secretary with our recommendations from this public meeting.

And with that, one final thank you to the Committee and session experts for joining us to make this a memorable and informative PTAC public meeting.

*** Adjourn**

This meeting is adjourned.

(Whereupon, the above-entitled matter went off the record at 1:30 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: Public Meeting

Before: PTAC

Date: 09-09-25

Place: Washington, DC

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