Report on the Better Care Summit (12/5/2024)

Better Healthcare Policy Group

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Report on 12/5/2024 Better Care Summit

Introduction & Executive Summary

On December 5, 2024, the Better Healthcare Policy Group hosted the Better Care Summit at the Association of American Medical Colleges Learning Center in Washington, DC. The event aimed to advance the principles outlined in the 2023 Better Care Plan and promote discussions about its implementation. It built on an earlier meeting of nearly 40 stakeholders, including payers, employer coalitions, providers, patient safety advocates, and health quality professionals, who gathered to explore strategies for putting the plan into action. The Summit featured two keynote speakers, both of whom addressed primary care and three focused workgroups: accelerating movement to risk-adjusted prospective payment models; employer-led initiatives; and patient safety & health outcomes reporting. This report summarizes the key findings and recommendations.

Executive Summary

The Better Care Summit featured two keynote speakers and three expert panels. Both keynote speakers focused on primary care. Panel discussions reinforced the need for greater accountability, transparency, consumer-driven quality ratings, and stronger reporting mandates to create a higher-performing, patient-centered healthcare system. By aligning policy, technology, and market incentives, healthcare stakeholders can drive systemic improvements in care quality, affordability, and accessibility.

Joseph R. Betancourt, M.D., M.P.H. (**"**The Future of Primary Care") emphasized the urgent need to reform primary care in the U.S. to address systemic failures, including poor health outcomes, rising chronic conditions, and disparities in maternal and women's health. He highlighted chronic underinvestment, workforce shortages, and administrative inefficiencies as major challenges. To improve primary care, he advocated payment reform, increased accessibility, workforce development, patient-centered care, and greater national funding. He also underscored the role of technology, including AI and virtual care, in enhancing efficiency and reducing provider burnout.

Mark McClellan, MD, PhD ("Primary Care in the U.S. -The Promise and the Peril") emphasized the need for Medicare payment reforms to enhance value-based care, public trust, and cost-effectiveness. He highlighted election-driven healthcare dissatisfaction and the risks of new leadership. Key priorities include modernizing risk adjustment, improving data sharing, and integrating evidence-based practices. Medicare and Medicaid reforms should expand accountable care, refine risk models, and leverage AI and EHRs. Challenges include specialty care integration, outdated fee-for-service data, and ineffective voluntary CMMI pilots. Solutions focus on population-based payments, better data interoperability, and technology-driven improvements. He urged bipartisan collaboration to drive innovation, transparency, and sustainable healthcare reform.

Panel 1: Payment Reform & Value-Based Care

Panelists identified regulatory burdens, financial instability, provider organization resistance, operational inefficiencies, and consumer disconnect as major barriers to scaling value-based care (**VBC**) and ensuring quality and patient safety. Current fee-for-service arrangements prioritize volume over outcomes, leading to fragmented, reactive care rather than proactive, coordinated interventions that prevent complications and reduce harm. Additionally, rising labor costs and inadequate reimbursement models strain provider organizations, limiting their ability to invest in preventative care, care coordination, and safety initiatives. Many provider organizations remain hesitant to transition to risk-based models due to cost unpredictability and the lack of real-time data-sharing tools needed to track quality metrics and patient safety indicators. Patients also face barriers to engagement, such as complex access restrictions and prior authorization hurdles, which can delay necessary care and worsen health outcomes. Panelists recommended regulatory reforms to streamline administrative burdens, stronger financial incentives for

preventative care, and expanded use of risk-sharing models to reward quality outcomes rather than service volume. Investing in real-time analytics, AI-driven safety monitoring, and data-sharing platforms was seen as essential for improving care coordination, reducing medical errors, and identifying high-risk patients earlier. Enhancing patient engagement through clearer incentives, simplified access, and education on VBC benefits was also prioritized. Ultimately, panelists stressed that without systemic reforms to financial models, regulatory frameworks, and data infrastructure, VBC cannot achieve its core goals of improving quality, enhancing patient safety, and reducing preventable harm.

Panel 2: Employer-Led Strategies for High-Quality Care

Panelists emphasized that employers face both rising healthcare costs and significant quality challenges, which impact workforce health, productivity, and retention. Market consolidation and opaque pricing force employers to pay substantially higher rates than government payers, while avoidable hospitalizations, low-value care, and fragmented primary care drive absenteeism and turnover. Yet employers often lack the technical resources, regulatory support, and consumer engagement tools needed to implement high-value, cost-effective care models. To address these issues, panelists highlighted the effectiveness of tiering and steering strategies to guide employees toward high-performing provider organizations through structured network designs and benefit incentives. Additionally, they proposed policy reforms to curb monopolistic practices, promote tax incentives for value-based care, and enforce transparency in provider organization performance. Expanding direct primary care models, integrating quality ratings into provider organization selection tools, and aligning executive incentives with quality outcomes were key strategies discussed. Real-time data tracking, AI-driven safety monitoring, and EHR integration were identified as crucial for ensuring that quality improvements are measurable and actionable. Educating employees about the benefits of value-based care and narrow networks was also seen as essential for reducing resistance and improving engagement in higher-quality, lower-cost healthcare options.

Panel 3: Patient Safety and Healthcare Quality Improvement

Panelists emphasized the urgent need for greater transparency, technology, and accountability to address significant (3x) variations in hospital outcomes. Public reporting of patient safety incidents, readmission rates, and patient-reported outcomes have improved care quality. But public reporting of hospital safety data remains fragmented due to inconsistent reporting requirements, lack of standardized metrics, limited transparency, and reliance on retrospective analysis rather than real-time tracking. To drive change, experts called for mandatory performance reporting, aligning executive compensation with safety metrics, and leveraging AI-driven monitoring to detect preventable harm. Epic Systems and Leapfrog Group announced a pilot project using EHR data for real-time hospital safety reporting to enhance transparency and accountability. Panelists also urged hospitals to adopt AI-powered patient feedback tools integrated into portals and mobile apps, allowing consumers to immediately rate their healthcare encounters. Displaying a “Last 90 Days Quality Score” could provide real-time performance trends, improving provider organization accountability. Cleveland Clinic’s real-time satisfaction tracking demonstrates how these tools can enhance care responsiveness.

These were a**reas of substantial agreement** among the Better Care Summit participants

- The need for primary care reform and investment
- Scaling value-based care with infrastructure, leadership, and risk-reducing.
- Technology as an enabler to improve care delivery and quality using AI and EHR data systems.
- Greater consumer engagement and educating consumers to overcome trust barriers.
- Focus on outcomes & transparency by aligning incentives with outcomes and public reporting.
- Need for policy reform to drive innovation and fairness.
- Workforce & training support, tackling burnout and closing workforce training gaps.

Joseph Betancourt, MD, MPH: The Future of Primary Care

Dr. Joseph Betancourt, President of the Commonwealth Fund, shared his insights on the future of primary care, emphasizing its potential to transform the U.S. healthcare system. Reflecting on the Commonwealth Fund's mission since 1918, he highlighted systemic failures despite high spending, including poor life expectancy, rising chronic conditions, and stark disparities, particularly in maternal and women's health. Dr. Betancourt called for leveraging public frustration to advocate for affordability, access, and incremental progress, supported by innovative payment models and team-based, coordinated care.

Challenges in Primary Care

A significant challenge lies in chronic underinvestment, as only 5% of U.S. healthcare spending goes to primary care, compared to 14–15% in peer nations. Underfunding limits preventive care and access. Workforce shortages exacerbate the issue, with declines in primary care physicians, an aging workforce, and fewer medical graduates pursuing the field. Systemic barriers, such as administrative burdens, inefficiencies in electronic health records, and the lingering effects of COVID-19, have demoralized providers. Access issues, including long wait times in rural and underserved areas, and a growing number of individuals without a regular doctor, highlight the urgency of reform.

Key Recommendations

Dr. Betancourt advocated several reforms

- Shift from fee-for-service to hybrid payment models with prospective payments.
- Improved Accessibility to ensure universal access, particularly in underserved areas.
- Workforce training for healthcare provider organizations in community-based settings.
- Patient-Centered redesign of care delivery to optimize the experience for patients and care teams.
- Greater national funding and policy reform to prioritize primary care.

The Role of Technology

Technology holds promise in revitalizing primary care. Artificial intelligence (AI) and tools like virtual care, home monitoring, and wearables can streamline workflows, reduce administrative burdens, and improve efficiency. AI could assist with tasks such as summarizing patient records and providing decision support, freeing clinicians for patient care. Additionally, team-based care models will expand, incorporating roles like nurse practitioners, health coaches, and community health workers to address evolving patient needs.

Overcoming Barriers

The success of primary care depends on addressing funding challenges and physician burnout. Payment models, such as those in Medicare Advantage, have shown how resources can be effectively directed to primary care, though broader adoption and integration are needed. Burnout solutions must go beyond superficial fixes by restructuring governance, workflows, and payment models to better support provider organizations.

Conclusion

Dr. Betancourt concluded by emphasizing the need for sustainable financing, the democratization of technology, and the creation of team-based systems that adapt to patient needs. With focused innovation and policy support, primary care can become the cornerstone of a healthier, more equitable healthcare system.

PANEL 1: RISK-ADJUSTED PROSPECTIVE PAYMENT MODELS

Panel 1 focused on the challenges in implementing value-based care (VBC) models, particularly through primary care, payment reform, and fostering collaboration among stakeholders. The panel included: Peggy O'Kane (NCQA); Jerry Penso (AMGA); Susan Denzer (APG): Rob Mechanic (Institute for Accountable Care): and Erin Smith (Elevance Health): Leader in payer-provider organization partnerships and risk-based care initiatives. The discussion explored systemic barriers to advancing VBC models and presented actionable strategies to overcome these challenges while improving outcomes and reducing costs.

MAJOR OBSTACLES

Regulatory Burdens

Regulatory complexities rooted in fee-for-service models continue to hinder the transition to value-based care (VBC). Panelists noted that many current regulations, designed for outdated payment systems, impose significant administrative burdens on provider organizations without delivering proportional value. The inefficiencies of compliance frameworks like merit-based payment systems were highlighted as barriers that complicate provider organizations' efforts to focus on patient-centered care. Reforming these structures was identified as critical to enabling smoother adoption of VBC.

Financial Pressures

Rising costs and inadequate reimbursement models create significant financial strain, particularly for provider organizations attempting to transition to risk-based care. Panelists emphasized that increasing labor costs and declining profitability for some provider organizations make adopting capitation models or taking on financial risk highly challenging. Additionally, underfunded primary care remains at the center of these challenges, as it struggles to maintain sustainability while supporting the broader goals of VBC. Ensuring financial viability for all participants in the healthcare ecosystem is essential to overcoming these barriers.

Provider organization Resistance and Risk Aversion

Many provider organizations remain hesitant to adopt value-based care due to their financial reliance on fee-for-service models and the unpredictability of healthcare costs. Panelists explained that specialists, in particular, face disincentives to move away from traditional models, as they often benefit financially from maintaining the status quo. Furthermore, the inherent uncertainties associated with risk-based care deter many organizations from fully committing to new systems. Reducing this resistance requires addressing these financial dependencies and creating more predictable cost structures.

Operational Challenges

Operational inefficiencies, leadership gaps, and inadequate tools pose significant challenges to implementing value-based care. Panelists highlighted the critical need for better data-sharing infrastructure and real-time decision-support tools to assist provider organizations in managing population health and financial risk effectively. Strong leadership and a culture of collaboration were also emphasized as pivotal in overcoming systemic inefficiencies. Without these foundational elements, scaling VBC initiatives remains a daunting task for healthcare organizations.

Consumer Disconnect

Value-based care models often fail to align with consumer priorities, leading to limited engagement and adoption. Panelists noted that misaligned incentives, such as bureaucratic processes and complex access protocols, often frustrate patients. Challenges like prior authorization and limited network flexibility further exacerbate these disconnects, reducing the appeal of VBC systems. To achieve better alignment,

value-based care must address consumer concerns related to affordability, streamlined access, and simplicity.

Panel 1 Recommendations

Streamline Regulations

Simplifying regulatory frameworks is essential to reducing administrative burdens and allowing provider organizations to focus on high-quality care. Panelists stressed the importance of reforming outdated compliance models to remove inefficiencies and support the shift to value-based care. Eliminating unnecessary complexities in reporting and payment systems can empower provider organizations to redirect resources toward patient-centered initiatives, ultimately improving outcomes.

Enhance Financial Sustainability

Stable and predictable financial models are necessary to enable provider organizations to transition to value-based care successfully. Panelists advocated for creating reliable risk-sharing arrangements that mitigate financial uncertainty and encourage broader adoption of risk-based models. Additionally, increasing funding for primary care and providing targeted incentives are essential to ensuring its central role in the value-based care ecosystem. Financial sustainability is a cornerstone for long-term success.

Foster Collaboration and Leadership

Strong leadership and cross-sector collaboration are critical for scaling value-based care and achieving better population health outcomes. Panelists emphasized the need for coalitions that bring together stakeholders to share best practices and foster innovation. Leadership must drive both cultural and operational shifts, building the trust and momentum needed to implement transformative healthcare models. Collaboration across organizations is necessary to overcome barriers and create sustainable improvements.

Improve Consumer Engagement

Aligning incentives with consumer needs and simplifying access to care can significantly enhance the effectiveness of value-based care. Panelists highlighted the importance of addressing bureaucratic hurdles, such as prior authorization, to reduce consumer frustrations. Educating patients about the benefits of value-based care and tailoring systems to prioritize affordability and streamlined access are crucial for building trust and driving engagement in these models.

Leverage Technology and Infrastructure

Investing in advanced technology and infrastructure can significantly enhance the implementation of value-based care initiatives. Panelists pointed to the importance of real-time analytics, data-sharing platforms, and decision-support tools to enable provider organizations to make informed decisions and manage population health more effectively. With the right technological support, healthcare organizations can overcome operational inefficiencies and deliver higher-quality care that meets the goals of value-based systems.

Panel 1 Takeaway

Panel 1 underscored the critical need for systemic reforms to advance risk-adjusted prospective payment models. By addressing regulatory inefficiencies, ensuring financial sustainability, fostering collaboration, and aligning consumer needs with VBC incentives, stakeholders can overcome barriers and create a more equitable, efficient healthcare system.

Mark McClellan, MD, PhD:
"Primary Care in the U.S. -The Promise and the Peril"

Mark McClellan discussed challenges and opportunities in Medicare payment systems and risk adjustment models. He is currently the Director of the Margolis Center for Health Policy at Duke University. His work has focused extensively on health services research, particularly in areas like quality of care, payment reform, drug and device innovation, and advancing value-based care. Key points included:

Acknowledgment of Progress and Challenges

Value-based care, accountable care, and other reforms have made progress, but they lack broad public resonance. Urgency exists to enhance communication and measurable outcomes to gain public trust.

Election and Leadership Implications

The recent election has emphasized healthcare dissatisfaction and the need for simpler, cost-effective care. New leaders, including RFK Jr. as HHS Secretary and Dr. Oz at CMS, bring mixed agendas, blending public health goals with potential risks, such as concerns over vaccine policies.

Policy Foundations and Priorities

Support for risk-adjusted prospective payment models, enhanced data sharing, and better patient safety reporting remains central. Efforts should focus on integrating evidence-based practices into the healthcare system while avoiding non-evidence-based approaches.

Opportunities in Medicare and Medicaid

Further transition to accountable care in Medicare, including enhancing the Shared Savings Program and regional direct contracting efforts. Addressing concerns about data infrastructure and risk adjustment methodologies, particularly in Medicare Advantage, which still relies heavily on outdated fee-for-service data.

Challenges and Innovations

CMMI (Centers for Medicare & Medicaid Innovation) pilots struggle with savings in voluntary models, emphasizing the need for broader mandatory efforts. Integration of specialty care into team-based models remains a priority for reducing hospitalizations and improving outcomes. Advances in electronic health records and AI offer potential for more accurate data, but current systems lag in utilizing these technologies for payment reforms.

Risk Adjustment Concerns

Current models exclude asymptomatic conditions (e.g., hypertension, CKD, obesity) that, if managed early, could prevent costly complications. Reliance on outdated and uncoordinated fee-for-service (FFS) data undermines payment accuracy and care outcomes.

Proposed Solutions

Modernize risk adjustment to incorporate accurate and representative data. Use electronic health records (EHRs) and advanced tech for identifying key risk factors and improving patient outcomes. Emphasize early intervention for undiagnosed chronic conditions, like CKD, to reduce long-term costs.

Role of Technology and Data

Support advancements like TEFCA for interoperability and data sharing. Leverage AI and automated quality measurement to ease provider organization burden and improve care delivery. Accurate data and incentives are essential to ensure technology improves outcomes and reduces costs.

Specialty Care Challenges

Specialty care often lacks integration with primary care in value-based models. Reforms should promote collaboration between primary and specialty care to manage chronic conditions better. Shift specialty care payments towards population-based models (e.g., PMPM) rather than volume-driven incentives.

Future Steps

Expand learning networks and registries to optimize care delivery and facilitate rapid improvement. Develop flexible payment reforms that allow for iterative adjustments based on real-world data and outcomes.

Evolving Models

ACO REACH and direct contracting could evolve with a focus on accountability and evidence-based care. Consider structural reforms in Medicare fee schedules to promote prevention and coordination, while addressing risk adjustment and quality measures holistically.

Call to Action

Urgent need for bipartisan collaboration to align healthcare reforms with evidence-based approaches. Attention to innovation, transparency, and community-based efforts can help achieve sustainable healthcare improvements.

Mark emphasized the urgency of aligning payment models with modern technology and care practices, fostering better outcomes for beneficiaries, and making healthcare systems more effective and sustainable.

Panel 2: Employer-led Initiatives

Panel 2 explored challenges and opportunities in improving healthcare quality, reducing costs, and fostering systemic change through employer-led initiatives. Panelists included: Bob Galvin (Blackstone Advisors); Won Andersen (Purchaser Business Group on Health); Barak Richman (George Washington University); Lee Lewis (Health Transformation Alliance) ; Fatema Salam (JP Morgan Chase) Representing Morgan Health; and Richard Scheffler (University of California, Berkeley). his discussion explored systemic barriers, consumer behaviors, and employer responsibilities in driving healthcare innovation while offering actionable strategies to address these challenges.

Summary

The panel emphasized the pivotal role of employers in advancing value-based healthcare models to improve quality, reduce costs, and address systemic inefficiencies. Panelists highlighted key obstacles, including market consolidation, consumer resistance to narrow networks, legal and fiduciary pressures, technical knowledge gaps, and insufficient regulatory enforcement. Despite these challenges, the discussion showcased promising solutions and actionable strategies for transformation.

To overcome these barriers, panelists recommended policy reforms to address monopolistic practices and inefficient tax policies, as well as expanded adoption of direct primary care and value-based models. Consumer education was deemed essential to dispel misconceptions about narrow networks, while HR departments and employers must be equipped with technical resources to navigate complex healthcare systems effectively. Collaboration across stakeholders and the use of advanced technologies like AI and EHR integration were underscored as vital to scaling best practices and driving systemic change.

Unique Economic Pressures faced by Employers

The panel discussion acknowledged the **unique economic pressures faced by employers** in the healthcare system. Here's how these points were addressed

Employers Pay Higher Prices than Government Payers

Won Andersen and Bob Galvin discussed how employers often pay significantly more for healthcare services compared to government payers like Medicare. This cost disparity is attributed to market dynamics, including provider organization consolidation and opaque pricing structures, which limit employers' negotiating power.

Impact of Employee Absenteeism and Turnover

Fatema Salam and Lee Lewis noted that employers not only bear the direct costs of healthcare but also face indirect economic impacts due to employee absenteeism and turnover. Poor healthcare quality or access can result in higher absenteeism rates, reduced productivity, and challenges in retaining talent. These factors were highlighted as significant drivers for employers to invest in value-based care models and preventative health initiatives, which can reduce long-term costs and improve workforce stability.

Incentives for Employers to Manage Costs

Employers have a vested interest in promoting employee health to mitigate these indirect costs. This includes initiatives like advanced primary care, biometric screenings, and tiered networks that steer employees toward high-value provider organizations. These strategies aim to reduce absenteeism and turnover by improving health outcomes.

Economic Tensions in Employer-Sponsored Insurance

Barak Richman highlighted that employers are often caught in a difficult position—paying higher healthcare costs due to inefficiencies in the system while also being legally obligated to offer cost-effective plans. These economic circumstances create a strong incentive for employers to push for systemic reforms, such as tax policy changes and antitrust enforcement, to alleviate the financial burden.

Obstacles to Advancing Value-Based Healthcare Models

Market Challenges

Market consolidation, inefficiencies in employer-sponsored insurance, and lack of competition hinder the scalability of value-based models. Panelists highlighted how limited focus on healthcare by businesses, hospital mergers, and monopolistic market conditions increase costs and reduce quality without improving outcomes.

Consumer Behavior

Employees' resistance to narrow networks and misconceptions about value-based care create significant barriers to adoption. Panelists emphasized the need to address widespread employee misconceptions about narrow networks and suggested piloting programs to help employees understand the benefits of value-based care.

Fiduciary and Legal Pressures

Employers face legal risks and fiduciary obligations that complicate healthcare plan management. Panelists stressed the challenges of managing healthcare plans prudently while balancing fiduciary responsibilities with cost complexities, including potential legal challenges when steering employees to specific provider organizations.

Technical and Knowledge Gaps

Employers and HR departments lack the tools and expertise to implement value-based care effectively. Panelists highlighted the importance of equipping HR teams with analytical tools, training, and external expertise to manage value-based initiatives effectively.

Policy and Regulatory Barriers

Ineffective antitrust enforcement, monopolistic practices, and outdated tax policies prevent meaningful progress. Panelists noted how monopolistic behaviors and inadequate oversight stifle competition and innovation, limiting the success of cost-containment initiatives.

Panel 2 Recommendations for Overcoming Challenges

Policy and Market Reforms

Reforms are needed to reduce inefficiencies, increase competition, and eliminate systemic barriers such as market consolidation and outdated tax policies. Panelists advocated for stronger antitrust enforcement, tax reforms, and revisiting employer-sponsored insurance structures to incentivize cost-efficient models.

Promote Direct Contracting and Value-Based Models

Employer-driven initiatives such as direct primary care and narrow networks can improve care quality and reduce costs but require innovative frameworks and partnerships to scale. Panelists recommended expanding direct primary care and integrating it into traditional insurance frameworks to improve accessibility and care quality.

Consumer Engagement and Education

Educating employees on the benefits of value-based care and narrow networks can overcome resistance and drive behavioral change toward cost-efficient options. Panelists proposed piloting programs and comprehensive campaigns to dispel misconceptions and showcase the long-term advantages of these models.

Equip HR and Employers with Tools

Employers and HR departments need advanced tools and resources to navigate complex healthcare systems and implement value-based care initiatives effectively. Panelists stressed the importance of providing technical resources, external expertise, and leadership training to bridge knowledge gaps and support HR teams.

Foster Collaboration

Multi-stakeholder collaboration among employers, provider organizations, and policymakers can scale best practices and drive systemic healthcare improvements. Panelists emphasized building coalitions and employer-provider organization partnerships to create direct contracts that reduce costs and improve quality.

Leverage Technology

Leveraging technology like AI and electronic health records (EHRs) can improve real-time data tracking, enhance safety monitoring, and reduce inefficiencies. Panelists discussed the potential of advanced analytics, AI, and data tools to streamline healthcare payments, enhance safety monitoring, and identify low-value care for targeted interventions.

Key Takeaway

Systemic healthcare transformation requires a coordinated effort among employers, policymakers, provider organizations, and technology partners. By addressing these obstacles and implementing the

recommended strategies, stakeholders can pave the way for a more equitable, efficient, and value-driven healthcare system.

PANEL 3: PATIENT SAFETY & HEALTHCARE QUALITY OUTCOMES

Panel 3 explored strategies for improving healthcare safety and quality by leveraging data, fostering transparency, and enhancing collaboration. Moderated by John Toussaint, the panel featured prominent voices in healthcare innovation, including: Leah Binder (Leapfrog Group); Barbara Fain (Betsy Lehman Center); Elizabeth Drye (National Quality Forum); and Brandon Stockton (Epic Systems Corporation) This discussion addressed systemic challenges in safety reporting, stakeholder accountability, and the use of technology to drive meaningful improvements, while highlighting actionable strategies for transformation.

Dr. Toussaint began by highlighting the alarming 300% variation in mortality rates across U.S. hospitals, emphasizing the urgent need to close the quality gap. Panelists emphasized the importance of data-driven solutions and collective accountability to improve patient safety and healthcare outcomes. Despite obstacles such as fragmented data collection, provider organization overconfidence, and public disengagement, panelists highlighted innovative strategies for addressing these challenges. These included advancing transparency, aligning incentives, and leveraging technology to create safer, more efficient systems.

PANEL 3 RECOMMENDATIONS FOR DRIVING PATIENT SAFETY

Data Collection and Transparency

Panelists emphasized the importance of improving data collection practices and public reporting systems to enhance accountability and incentivize safety improvements. One panelist advocated standardizing serious reportable events and aligning quality measures to create consistent benchmarks, reduce provider organization burden, and enable actionable improvements. Another panelist stressed the need to make safety data public, empowering consumer choice and accountability, and noted successes in reducing infection rates through transparency and benchmarking. A panelist supported integrating monthly safety data reporting through electronic health records (EHRs), enabling real-time tracking and systemic safety enhancements.

Public Awareness and Advocacy

Panelists discussed the importance of engaging the public and amplifying awareness around healthcare safety issues to drive advocacy and systemic change. One panelist highlighted the need to reframe healthcare safety narratives to resonate with consumers, citing successful examples from public health campaigns. Another panelist advocated leveraging employer and media campaigns to sustain pressure on healthcare organizations to prioritize safety and transparency.

Hospital Accountability and Incentives

Aligning incentives and holding leadership accountable were identified as critical strategies for improving safety outcomes. One panelist discussed tying safety metrics to executive compensation to foster organizational accountability, noting measurable improvements in infection control driven by transparency initiatives. Simplifying reporting processes and aligning safety incentives with measurable goals were also highlighted as methods to encourage compliance among provider organizations.

Systemic and Structural Improvements

Panelists addressed the need for cultural and structural changes within healthcare systems to prioritize safety. Benchmarking for peer comparisons was identified as a powerful tool to identify performance gaps

and drive improvements. Examples were shared of healthcare facilities improving safety performance through transparency and competition after receiving unfavorable assessments.

Leveraging Technology

The role of technology in transforming safety practices was discussed, with an emphasis on thoughtful deployment. Panelists noted the potential for AI tools to detect preventable harm while cautioning against issues like alert fatigue among clinicians. Effective integration of such tools can enhance safety monitoring and reduce errors. Collaborative efforts focusing on integrating claims data, EHRs, and patient-reported outcomes were proposed to create a more comprehensive approach to safety and diagnostic excellence.

Alignment Across Stakeholders

Panelists identified collaboration among public, private, and governmental stakeholders as essential for systemic change. Multi-stakeholder partnerships were discussed as a way to enhance safety integration across care settings. Alternative payment models, such as value-based care, were proposed to reduce hospital admissions and align incentives with safety goals.

Epic/Leapfrog Pilot Project

A previously unannounced collaboration involving **Epic Systems** and **Leapfrog Group** highlights efforts to improve healthcare safety and data reporting by using and EHR (rather than claims) database. The panelists discussed a proposal for monthly safety data collection using Epic's EHR platform. This initiative aims to make hospital safety data more frequent and actionable, addressing the challenges of outdated or infrequent reporting. The collaboration focuses on creating real-time performance metrics, initially targeting high-priority safety issues such as mortality rates from hospital acquire infections, with plans to expand into other domains. This partnership underscores the importance of integrating EHR capabilities to enhance transparency and drive systemic improvements in hospital safety. And it signifies a step toward aligning advanced health IT solutions with public safety reporting goals.

Cross-panel Agreement & Differences

All panels acknowledged systemic barriers such as market consolidation, regulatory complexities, and misaligned incentives that hinder the progress of value-based care (VBC) and quality improvement. Cross-sector collaboration was a recurring theme, with panels emphasizing the need for stakeholder alignment between payers, provider organizations, employers, and policymakers. Joint initiatives, such as direct contracting and multi-stakeholder coalitions, were highlighted as essential for scaling best practices and overcoming entrenched challenges.

1. Unified Vision for Scaling Value-Based Care

There was alignment on the necessity of scaling value-based care initiatives through robust infrastructure, leadership, and financial models that de-risk adoption for provider organizations while improving affordability for consumers.

2. Technology as an Enabler

Panels consistently recognized the role of technology, particularly AI, electronic health records (EHRs), and advanced analytics, in streamlining care delivery, improving data sharing, and enhancing real-time decision-making. The use of integrated data systems and AI tools was proposed to address both safety gaps (Panel 3) and operational inefficiencies (Panel 1).

3. Need for Greater Consumer Engagement

Consumer behavior and resistance to narrow networks or unfamiliar care models were identified as significant barriers across panels. All agreed on the need for consumer education campaigns to dispel misconceptions about VBC and narrow networks and to build trust in the system.

4. Focus on Outcomes & Transparency

Panels emphasized aligning incentives with measurable outcomes, particularly patient safety metrics (Panel 3) and financial sustainability (Panels 1 and 2). Transparency in reporting, including public accountability measures and real-time safety data, was seen as critical for driving improvement and trust.

5. Need for Policy Reform

Strong agreement existed on the need for regulatory and policy reforms to simplify compliance, encourage innovation, and dismantle monopolistic behaviors in healthcare markets. Proposed reforms included tax incentives for efficient care models, antitrust enforcement, and updated payment systems tailored to VBC.

6. Workforce &Training Support

All panels touched on the importance of addressing workforce challenges, such as burnout and training gaps, particularly in primary care (Panel 1) and HR teams managing employer-sponsored insurance (Panel 2).

SOME DIFFERENCES

While there was substantial alignment on many overarching themes, some points of disagreement emerged among the panels regarding priorities, approaches, and feasibility

1. Role of Employers in Healthcare Innovation

Panel 2 highlighted employers as key drivers of innovation in value-based models, advocating for expanded adoption of employer-led initiatives like direct primary care and tiered networks. Other panels were more cautious about the scalability of employer-driven solutions, citing limited technical expertise in HR departments and the challenges of aligning diverse employer goals with broader healthcare reforms.

2. Balancing Consumer Incentives & Network Flexibility

Panel 2 advocated for narrow networks and direct contracting as cost-effective solutions, despite acknowledging consumer resistance. Panel 1 stressed the need for greater flexibility to accommodate patient preferences and suggested that overly restrictive networks might alienate consumers and reduce trust in VBC.

3. Integration of Specialty Care into Value-Based Models

Panel 1 called for stronger incentives to integrate specialty care into primary care-led VBC models to reduce costs and improve outcomes. One keynote speaker and Panel 3 noted the unique challenges of specialty care integration, such as existing misalignments in payment structures and cultural differences among specialties, which make immediate integration challenging.

4. Role of Payment Models in Risk Sharing

Panel 1 leaned toward hybrid or prospective payment models to incentivize provider organizations to take on financial risk and align with VBC goals. Some perspectives in the keynote and Panel 2 questioned the readiness of the healthcare system for large-scale risk-sharing arrangements, citing potential financial instability for smaller provider organizations and employers.

5. Degree of Transparency in Safety Reporting

Panel 3 strongly supported full public transparency in safety metrics, arguing it drives accountability and consumer engagement. Some participants raised concerns about unintended consequences, such as discouraging hospitals from reporting errors due to fear of reputational damage, suggesting a phased or anonymized approach to safety data disclosure.

6. Approach to Regulatory Reform

Panel 1 focused heavily on simplifying existing regulations to reduce administrative burdens on provider organizations, particularly those transitioning to value-based care (VBC). They saw regulatory reform as essential for operational efficiency. Panel 3, however, advocated for strengthening certain safety-related compliance mechanisms, such as mandatory public reporting and accountability metrics, which could potentially increase administrative complexity.

DISCUSSION

The Differences section highlights critical areas of contention among stakeholders, but the potential for resolution could be enhanced by exploring the broader implications of these disagreements.

Differing Views on Transparency and Stakeholder Collaboration

Panel 3 advocates for full public transparency in safety metrics to drive accountability, while others caution against unintended consequences, such as reduced error reporting due to reputational concerns. Full transparency could foster trust among patients and stakeholders by demonstrating a commitment to safety and accountability. However, it may also discourage hospitals from candidly reporting errors if they fear reputational damage or financial penalties, potentially undermining the quality of data. A phased approach to transparency or anonymized reporting might mitigate resistance and ensure hospitals feel safe to participate fully. These divergent approaches could delay consensus on transparency policies, stalling broader efforts to align safety practices across the healthcare ecosystem.

Role of Employers in Healthcare Innovation

Panel 2 champions employers as primary drivers of value-based care (VBC) through innovations like direct contracting, while other panels are cautious about scalability due to limited expertise and alignment issues. Employer-led initiatives could lead to faster adoption of innovative models, leveraging employers' economic influence to reshape the market. However, inconsistent adoption across employers may create fragmented progress, with uneven quality improvements and cost savings. A lack of consensus on this role may prevent a unified strategy for integrating employer-driven models into broader healthcare reforms, potentially limiting their scalability and systemic impact.

Balancing Consumer Incentives and Network Flexibility

Panel 2 favors narrow networks for their cost-efficiency, while Panel 1 stresses the need for flexibility to maintain consumer trust and adoption. Narrow networks could reduce costs and incentivize high-quality care provider organizations, but their success depends on consumer buy-in. Resistance from consumers who perceive limited choice as a disadvantage may hinder adoption, requiring extensive education campaigns to align perceptions with benefits. Misalignment on this issue could lead to inconsistent implementation of VBC models, with some stakeholders adopting restrictive networks and others prioritizing flexibility, potentially reducing the overall effectiveness of reforms.

Integration of Specialty Care into VBC Models

Panel 1 advocates for incentives to integrate specialty care with primary care in VBC models, while others highlight cultural and structural barriers to immediate integration. Successful integration could improve outcomes for chronic and complex conditions by ensuring cohesive care delivery. However,

cultural resistance and financial misalignments may slow progress, with specialists reluctant to participate in value-based models that disrupt traditional payment structures. Differing perspectives on this integration could delay efforts to create holistic care models, perpetuating fragmented care and limiting the potential cost and quality improvements achievable through VBC.

Approach to Regulatory Reform

Panel 1 stresses simplifying regulations to reduce administrative burdens, while Panel 3 calls for strengthening safety-related compliance measures. Simplified regulations could accelerate VBC adoption by reducing operational complexity for provider organizations. However, loosening oversight might compromise patient safety improvements, particularly in hospitals with historically lower safety performance. This tension could create competing priorities for policymakers, forcing a trade-off between short-term operational efficiency and long-term safety gains, complicating the design of a unified regulatory framework.

Better Care Summit Presenters & Panelists

Dr. Joseph Betancourt, Keynote Speaker

Dr. Joseph Betancourt is the president of the Commonwealth Fund. One of the nation's preeminent leaders in health care policy, equity, quality, and community health, Betancourt formerly served as the senior vice president for Equity and Community Health at Massachusetts General Hospital (MGH), and as founding director of the Disparities Solutions Center. Additionally, Dr. Betancourt was a member of one of the first classes in the Commonwealth Fund–Harvard University Fellowship in Minority Health Policy, where he earned an M.P.H. from the Harvard T.H. Chan School of Public Health. He has devoted his career to improving the quality and value of health care for diverse populations.

Mark McCellan, Keynote Speaker

Mark McClellan, PhD. is Director and Robert J. Margolis, M.D., Professor of Business, Medicine and Policy at the Duke-Margolis Institute for Health Policy at Duke University. He is a physician-economist who focuses on quality and value in health care including payment reform, real-world evidence and more effective drug and device innovation. At the center of the nation's efforts to combat the COVID-19 pandemic, the author of COVID-19 response roadmap, and co-author of a comprehensive set health policy strategies for COVID vaccines, testing, and treatments, Dr. McClellan and his Duke-Margolis colleagues are now focused on health policy strategies and solutions to advance the resilience and interconnectedness of 21st Century public health and health care . Mark is a former administrator of the Centers for Medicare & Medicaid Services and former commissioner of the U.S. Food and Drug Administration where he developed and implemented major reforms in health policy. Dr. McClellan is an independent board member on the boards of Johnson & Johnson, Cigna, Alignment Healthcare, and PrognomiQ; co-chairs the Guiding Committee for the Health Care Payment Learning and Action Network; and serves as an advisor for Arsenal Capital Group, Blackstone Life Sciences.

Panel 1: Risk-Adjusted Prospective Payment Models

Peggy O'Kane

Margaret E. O'Kane is the founder and president of the National Committee for Quality Assurance (NCQA). She is a member of the National Academy of Medicine and has received the Picker Institute Individual Award for Excellence in the Advancement of Patient-Centered Care, as well as the Gail L. Warden Leadership Excellence Award from the National Center for Healthcare Leadership. Modern Healthcare magazine has named O'Kane one of the "100 Most Influential People in Healthcare" 12 times and one of the "Top 25 Women in Healthcare" 3 times. She is a board member of the Milbank Memorial Fund and on the Board of Healthwise, a nonprofit organization that helps people make better health decisions. O'Kane holds a master's degree in health administration and planning from Johns Hopkins University, where she received the Distinguished Alumnus Award.

Jerry Penso

Jerry Penso, M.D., M.B.A., is president and chief executive officer at AMGA, a trade association that represents medical groups and other organized systems of care, including some of the nation's largest, most influential integrated healthcare delivery systems. Dr. Penso previously served as chief medical and quality officer for AMGA and president of AMGA Foundation. Under his leadership, the impact of AMGA's quality programs grew to improve care for 26 million patients. Prior to joining AMGA, Dr. Penso served as medical director, continuum of care for Sharp Rees-Stealy Medical Group (SRSMG), the largest integrated healthcare delivery system in San Diego. Dr. Penso received his Master's in Business Administration from San Diego State University, his Doctor of Medicine degree from the University of Southern California, Los Angeles, and a Bachelor of Science degree in chemistry from the University of California, Berkeley.

Susan Denzer

Susan Dentzer is one of the nation's most thoughtful health care policy analysts; a frequent speaker and commentator; and an author of studies and commentaries in Modern Healthcare, the New England Journal of Medicine Catalyst, the American Journal of Public Health, the Healthcare Financial Management journal, and other prominent publications. She is the President and Chief Executive Officer of America's Physician Groups, the nonprofit organization representing more than 360 large physician groups focused on patient-centered, coordinated, and integrated health care that is accountable for both costs and quality. She is an elected member of the National Academy of Medicine and the Council on Foreign Relations and is a fellow of the National Academy of Social Insurance and the Hastings Center. Dentzer graduated from Dartmouth and also holds a master's degree in health care delivery science from the institution. She is the former editor-in-chief of the health policy journal Health Affairs and former on-air health correspondent for the PBS NewsHour.

Rob Mechanic

Robert E. Mechanic, M.B.A., is Executive Director of the Institute for Accountable Care, a non-profit research institute dedicated to studying health care payment policy and the impact of innovative care delivery models. He is also Senior Fellow at the Heller School of Social Policy and Management at Brandeis University where his research focuses on health care payment systems and federal health policy. Mr. Mechanic was previously Senior Vice President with the Massachusetts Hospital Association and Vice President with the Lewin Group, a Washington D.C.-based health care consulting firm. His work has been published in The New England Journal of Medicine, JAMA, and Health Affairs. From 2011 – 2022 Mr. Mechanic was a trustee of Atrius Health, an 800-physician multispecialty group practice in Eastern Massachusetts. He earned his MBA in finance from The Wharton School.

Erin Smith

Erin Smith is the Staff Vice President of Payment Innovation at Elevance Health, where she leads the development of payment innovation programs for all lines of business. Erin has worked in value-based care design and implementation for a number of years. She previously managed risk contract negotiations and payer relationships at Aledade. Erin also played key roles in policy and federal government affairs at naviHealth and continued to expand her expertise in government affairs at Cardinal Health following its acquisition of naviHealth. At Avalere, Erin provided strategic insights on value-based care and Medicare policy. Prior to Avalere, Erin led CMS Innovation Center's specialty payment models, including the Bundled Payments for Care Improvement (BPCI) and the Oncology Care Model (OCM).

Panel 2: Employer-led Initiatives

Lee Lewis

Lee Lewis serves as Chief Strategy Officer for the Health Transformation Alliance. He leads efforts across over 50 jumbo employers and five million employees to save lives and save billions of dollars through improved health delivery, outcomes and experience.

Fatema Salam

Fatema joined Morgan Heath from the Center for Medicare and Medicaid Innovation (CMMI) where she served as the model and policy lead for the Vermont All-Payer Accountable Care Organization (ACO) model, a CMMI initiative to facilitate aligned, multi-payer ACO programs, scaled across the state. Prior to that, she was part of the Aligning Forces for Quality initiative and advised community-wide, multi-stakeholder leadership teams funded by the Robert Wood Johnson Foundation on accelerating achievement of quality of care and outcome goals at the regional level. Earlier on, she was Senior Program Director at the National Quality Forum where she led national committees on evidence-based health care performance measures, practices and tools for quality improvement and public reporting.

Bob Galvin

Robert Galvin, MD, is CEO of The Right Doctor which connects people with serious illnesses to expert physicians and centers of excellence. He is also a Senior Advisor at Blackstone, where he was an Operating Partner and CEO of Equity Healthcare. Dr Galvin is one of the founders of value-based purchasing and has started three non-profits supporting quality measurement and payment reform: the Leapfrog Group (co-founder), Prometheus, and Catalyst for Payment Reform (CPR). His policy work has been published in the New England Journal of Medicine, the Harvard Business Review and Health Affairs. He is a member of the National Academy of Medicine and Professor Adjunct of Medicine and Health Policy at Yale.

Won Andersen

Won is COO at Purchaser Business Group on Health. She leads PBGH's CAA strategic initiative and PBGH's Advisory Services focused on data and fiduciary excellence. Won has 35 years of consulting experience developing human capital, health and benefits strategies for with large jumbo public and private employers.

Barak Richman

Barak Richman is the Alexander Hamilton Professor of Business Law at The George Washington University Law School, and a Senior Scholar at the Clinical Excellence Research Center at the Stanford University School of Medicine. He recently completed 20 years on the faculty of Duke University, where he was the Katharine T. Bartlett Professor of Law at Duke University, Professor of Business at the Fuqua School of Business, and a Founding Faculty of the Margolis Institute for Health Policy. He is temporarily serving as a Special Counsel for Competition Policy in the Office of the General Counsel in the U.S. Department of Health and Human Services.

Panel 3: Patient Safety & Healthcare Quality Outcomes

Elizabeth Drye

Elizabeth Drye, MD, SM, is the National Quality Forum's (NQF's) Chief Scientific Officer and Vice President, Quality Measurement, at The Joint Commission. She works collaboratively to facilitate alignment on and further the use of low-burden, high-impact quality measures to drive meaningful improvement. Previously, at Yale Center for Outcomes Research and Evaluation she directed the development of many outcome measures in national use and advised CMS on its transformation to digital quality measures. Before becoming a physician and focusing on quality measurement, she worked in senior governmental public health policy positions in Washington, DC, including Chief of Staff of the White House Domestic Policy Council and Health Legislative Assistant to U.S. Senator Joe Lieberman.

Leah Binder

Leah Binder, MA, MGA, is President & CEO of The Leapfrog Group, a national nonprofit representing employers and other purchasers of health care calling for improved safety and quality in hospitals. Leapfrog publishes free ratings of hospitals and ambulatory surgery centers and grades hospitals on how safe they are for their patients. She has served on numerous national boards and councils, including the National Quality Forum, Women of Impact, CMMI's Accountable Care Action Collaborative, and the National Alliance of Healthcare Purchaser Coalitions. Prior to her position at The Leapfrog Group, Leah spent eight years as vice president at Franklin Community Health Network, an award-winning rural hospital network in Farmington, Maine. Prior to that she served as senior policy advisor at the New York City Mayor's Office. She started her career at the National League for Nursing, where she handled policy and communications for more than 6 years.

Barbara Fain

Barbara Fain, JD, MPP, serves as Executive Director of the Betsy Lehman Center for Patient Safety, a Massachusetts state agency named after the Boston Globe health care reporter whose death from an overdose of chemotherapy ignited the patient safety movement 30 years ago. The Center is leading an effort to implement the state's new Roadmap to Health Care Safety, developed by a broad consortium of Massachusetts provider organizations, patients, payers, and policymakers dedicated to overcoming the barriers to better safety outcomes, including the lack of actionable data. Barbara received her BA from Brown University, JD from UC Berkeley, and MPP from the Harvard Kennedy School.

Brandon Staunton

Brandon is a software developer at Epic Systems. In his role as Product Lead, Brandon oversees the development of their Bugsy Infection Control product, Inpatient quality reporting, and Acute Care predictive models for conditions like Sepsis and Deterioration. His work focuses on the use of software to drive more equitable delivery of healthcare and to bring quality improvement breakthroughs from bench to bedside. In his free time, Brandon is an avid cyclist and loves to spend time with his two pit bull puppies.

BETTER HEALTHCARE POLICY GROUP

The Better Healthcare Policy Group consists of these senior healthcare executives, researchers and economists who share a common interest in adapting Medicare Advantage to meet the needs of Americans under age 65.

George C. Halvorson – Chair, Institute for InterGroup Understanding; Former CEO, Kaiser-Permanente Health Plans and five other health care delivery and financing organizations; former chair, The International Federation of Health Plans and The Partners for Quality Care.

Jon M. Kingsdale, PhD. – Board Chair – Atrius Health Equity Foundation, Associate Professor at Boston University and Adjunct Professor at Brown; organized and led the Massachusetts Health Connector, the model for health insurance exchanges under Affordable Care Act (ACA).

Richard M. Scheffler, PhD. – Distinguished Prof. of Health Economics & Public Policy, UC-Berkeley, Founding Director of the Nicholas C. Petris Center on Health Care Markets and Consumer Welfare. He is an elected member of American Academy for the Advancement of Sciences .

Allyson Y Schwartz – former President & CEO of the Better Medicare Alliance and member of the U.S. House of Representatives from Pennsylvania.

Stephen M. Shortell, PhD. – MBA, MPH – Distinguished Prof. of Health Policy & Management Emeritus, UC-Berkeley, elected member of the National Academy of Medicine; past editor of Health Services Research; past president of the Association for Health Services Research

John Toussaint, MD – Executive Chairman, Catalysis Inc.; founding chair of the Wisconsin Collaborative for Healthcare Quality & the Wisconsin Health Information Organization.

Peter A. Wadsworth – Managing Partner, Amory Associates; former healthcare investment banker & health insurance executive specializing in managed care.

Gail Wilensky, PhD. (in memoriam) –former Administrator of the Medicare & Medicaid and chair of the Medicare Payment Advisory Commission; currently trustee, of the United Mine Workers of America's Combined Benefits Fund; numerous non-profit and corporate boards. *It is with deep regret that we learned of the passing of our esteemed colleague on July 11.*

Lucy Xenophon, MD, MPH - Chief Transformation Officer, emeritus, from Mount Sinai Morningside in New York City. She holds a medical degree from the New York University School of Medicine and a Master's Degree in Health Management and Policy from Columbia University