Physician Cost Measures and Patient Relationship Codes (PCMP) Technical Expert Panel

September 7, 2023

Summary Report

October 2023

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1 INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC (referred to as "Acumen") to develop, maintain, and re-evaluate cost measures for use in the MIPS cost performance category through the *Physician Cost Measures and Patient Relationship Codes (PCMP)* contract (75FCMC18D0015/Task Order 75FCMC19F0004). Acumen also maintains the Medicare Spending Per Beneficiary (MSPB) Hospital measure used in the Hospital Value-Based Purchasing (VBP) program. The PCMP project continues a previous contract, *MACRA Episode Groups and Cost Measures* (2016 to 2019).

As part of this work, we convene a standing Technical Expert Panel (TEP) to provide input on overarching issues across all activities. This report summarizes the TEP meeting on September 7, 2023. Section 1 outlines the structure and composition of the panel. Section 2 summarizes each session's presentation, member discussion, and key findings. The discussion summaries presented do not represent consensus but consolidate related feedback. Finally, Section 3 outlines the next steps for this project.

1.1 Project Context

The Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) of 2015 established the Quality Payment Program (QPP), which rewards the delivery of high-quality patient care through Advanced Alternative Payment Models (Advanced APMs) or the Merit-based Incentive Payment System (MIPS). MIPS assesses eligible clinicians in four performance categories – quality, promoting interoperability, improvement activities, and cost. MACRA requires that cost measures implemented in MIPS include consideration of care episode groups and patient condition groups (referred to as "episode groups"). Acumen constructs clinically valid cost measures for MIPS using extensive engagement, including a TEP, measure-specific panels of clinician experts (Clinical Expert Workgroups), person and family engagement (PFE) representatives, and the general public via field testing and public comment periods.

1.2 Standing TEP

The PCMP TEP comprises 20 members with diverse perspectives and areas of expertise. The panel includes:

- Experts in health care, payment policy, payment models, and performance measurement;
- Clinicians across many specialties; and
- Patient advisors who share their perspectives from lived experiences.

Please see Appendix A for the complete list of TEP members or the TEP Composition List posted alongside this report. Table 1 below lists the TEP meetings and their discussion topics.

Table 1. PCMP TEP Meetings

Meeting Date	Location	Topics
February 5-6, 2020	Washington, DC *(with virtual option)*	• Chronic episode-based cost measure framework • Patient Relationship Categories (PRC) and Codes reporting limitations • Measure maintenance and re-evaluation • MSPB Hospital measure re-evaluation • Alignment of cost and quality • Measure prioritization and conceptualization for future development
July 20, 2021	Virtual	• Refining service assignment • Cost measurement gaps • Approach to cost measure calculation
August 29, 2022	Virtual	• Risk adjustment and social risk factors • Cost measurement gaps
August 30, 2022	Virtual	• Accounting for mortality in cost measures • Comprehensive re-evaluation
September 7, 2023	Virtual	• Total Per Capita Cost (TPCC) re-evaluation • Field testing report refinement

Most recently, the TEP met via webinar on September 7, 2023. On this day, 12 of the 20 members attended from 1:00 to 5:00 pm ET. In preparation for the meeting, Acumen provided TEP members with an agenda and presentation slides. The *PCMP TEP Charter* was also distributed to the members for review and was ratified by the 12 members who attended the meeting.

The TEP meeting began with an introductory session to provide an update about project activities since the previous TEP sessions in August 2022. The rest of the meeting consisted of two sessions focusing on different aspects of the project:

- Re-evaluating the Total Per Capita Cost (TPCC) measure.
- Exploring actionable refinement areas for the field testing reports.

A moderator from Acumen presented the discussion questions for the panel.

2 DISCUSSION SUMMARY

This section summarizes TEP member discussions and recommendations, and each subsection focuses on a meeting session. Subsections 2.1 and 2.2 summarizes the presentations, member discussions and key takeaways on the comprehensive re-evaluation of the TPCC measure and actionable refinement areas of the field testing reports, respectively.

2.1 Total Per Capita Cost (TPCC) Re-evaluation

During this session, Acumen provided an overview of the TPCC measure, including a brief history of the measure's development and construction methodology. Acumen also noted the feedback received on the TPCC measure during the recent public comment period and presented discussion questions on re-evaluating the measure. Section 2.1.1 summarizes Acumen's presentation, section 2.1.2 outlines the TEP members' discussion, and section 2.1.3 contains key takeaways.

2.1.1 Summary of Presentation

This session discussed the comprehensive re-evaluation of the TPCC measure, focusing on the service and specialty exclusions and the trigger methodology.

The TPCC measure was initially introduced to MIPS in performance year (PY) 2017 and was based on the version of TPCC used in the Physician Value-Based Payment Modifier (VM) Program. The measure was re-evaluated using input from the PCMP TEP in 2018 and introduced to MIPS in PY 2020 with several changes to the triggering, attribution, and cost assignment methodology. The TPCC measure seeks to evaluate the overall cost of care delivered to a beneficiary for care management outside the inpatient setting, including primary care, preventative care, chronic disease management, and other ongoing outpatient care management. This population-based cost measure operates in conjunction with the episode-based cost measures (EBCMs), allowing more clinicians to participate in MIPS, ensuring comprehensive coverage across specialties, and promoting effective care coordination throughout a patient's care pathway. Moreover, the TPCC measure is integrated into the MIPS Value Pathways (MVPs), a participation framework intended to align and connect measures and activities across performance categories.

Acumen comprehensively re-evaluates the TPCC measure every three years since its introduction in MIPS. This process involves initial information gathering (e.g., literature reviews, public comments, empirical analysis, clinical guideline reviews) and may identify potential substantive changes beyond the types of changes considered through annual maintenance. If substantive changes are identified as part of the comprehensive re-evaluation, measures will follow the appropriate pre-rulemaking and rulemaking processes before potential implementation in MIPS. For the upcoming re-evaluation of the measure, Acumen reviewed feedback from interested parties on the TPCC measure. Some stakeholders advocated for additional specialties and clinicians to be included within the measure's attribution. For instance, representatives of Physical Therapy and Occupational Therapy (PT/OT) providers supported their respective inclusions. Other commenters, such as those from Cardiology and Oncology specialties,

emphasized the need to avoid attributing the TPCC measure to specialized providers in their fields through specialty or service category exclusions. Lastly, commenters recommended refining the exclusion criteria to prevent attributing highly specialized TINs mainly comprised of physicians outside the scope of the TPCC measure but attributed due to the billing patterns of advanced care practitioners (i.e., nurse practitioners [NPs], physician assistants [PAs]). In general, comments showed some consensus on the importance of specialty exclusions for the TPCC measure, which serve as a safeguard against inappropriate attribution.

During the webinar, Acumen provided a brief overview of the steps used for constructing the TPCC measure as detailed in the Measure Information Form.[1] This section of the presentation focused on the first two steps of the measure construction methodology on identifying the candidate events and applying the service category and specialty exclusions, which are the focus of the upcoming re-evaluation. The TPCC measure uses candidate events to identify care relationships. These events include an initial outpatient evaluation and management (E/M) service followed by either a second E/M service or other primary care service. Requiring an initial outpatient E/M service excludes clinicians who provide outpatient care management but do not typically bill E/M codes (such as physical therapists, occupational therapists, clinical psychologists, and clinical social workers). The clinician group (i.e., Tax Identification Number [TIN]) billing the initial E/M primary care service and the individual clinician (i.e., TIN and National Provider Identifier [TIN-NPI]) responsible for the plurality of candidate events provided to a patient within that TIN are attributed. Furthermore, a beneficiary's costs are attributed to either a TIN or TIN-NPI only within a one-year window following the candidate event that initiated the attribution window.[1,2]

Service category and specialty exclusions play a critical role in refining attribution. Specialty exclusion criteria remove clinician cohorts using Health Care Finance Administration (HCFA) specialty codes to exclude specialties primarily providing specialized or procedural care. These excluded specialties include 58 specialties in categories such as surgical sub-specialties, non-physicians without chronic management responsibilities, internal medicine sub-specialties with extensive procedural sub-specialization, and pediatricians who do not typically practice adult medicine. The remaining specialties are further refined using the service category exclusion criteria which removes clinicians based on billing patterns rather than HCFA specialty codes. The service category exclusion criteria remove any clinician who meets a specified billing threshold for specialized services (i.e., global surgery, anesthesia, therapeutic radiation, and chemotherapy).

Acumen presented the following questions for discussion:

- *Should the current HCFA specialty exclusions be modified?*
- *Are there specialties in the measure that align with the intended scope of TPCC but may have sub-specialties that should be identified for exclusion?*

[1] The TPCC Measure Information Form, which details the measure methodology, is available for download from this zip file: https://www.cms.gov/files/zip/2023-cost-measure-information-forms.zip
[2] The TPCC Codes List, which details the codes used to construct the measure, is available for download from this zip file: https://www.cms.gov/files/zip/2023-cost-measure-codes-lists.zip

    - *If so, what service patterns could be used to uniquely identify these clinician cohorts?*
- *Should existing service category exclusions be modified?*
- *Which services indicate outpatient care management? Are there services representative of care management not currently included in the trigger methodology?*
- *Should the trigger methodology be expanded to include services provided by clinicians who do not typically bill E/M codes?*
    - *If so, what types of services could be used to introduce these clinicians to the measure?*

2.1.2 TEP Member Discussion

Overall, the TEP agreed to continue excluding certain HCFA specialties because this approach helps to prevent false positive attributions, contributing to the measure's validity. One member suggested removing neurology from the exclusion list, noting a significant cohort of patients whose neurologists take the lead in coordinating their care.

The TEP also raised concerns regarding the individual attribution of advanced care practitioners, like NPs and PAs, working in specialty practices. NPs and PAs typically bill for a mix of outpatient management and specialty services. Thus, the TPCC measure can be individually attributed to NPs and PAs and to the clinician groups to which they belong. One member noted that advanced care practitioners may also perform therapeutic radiation procedures, but the current HCFA specialty exclusion criteria would not exclude these clinicians. As such, the TEP suggested refining the clinician group (i.e., TIN) attribution criteria to prevent the inclusion of specialty practices through NPs and PAs. Acumen investigated the specialty code exclusions in 2019 and found that such occurrences were rare. However, Acumen plans to reassess the frequency of clinician group attribution through the billing patterns of NPs and PAs and refine the measure specifications to reduce the likelihood of attributing clinician groups that provide care outside the intended scope of TPCC.

One member expressed that chronic care management by physical therapy (PT) providers could be within the scope of this measure. PTs provide ongoing care to patients with chronic diseases such as neuromusculoskeletal conditions. Other members contested the appropriateness of attributing PTs even though they may provide chronic care management. The members stated PTs would likely be attributed patients with comorbidities and care needs outside the scope of the PTs' managing influence. Members noted that for the TPCC measure to include PTs, first the specialty would need to be removed from the HCFA exclusion list. Secondly, the list of trigger codes would need to be expanded as PTs do not typically bill the trigger outpatient E/M services.

The discussion extended to whether or not to attribute TPCC to emergency medicine clinicians, with mixed feedback. Some members advocated including emergency medicine clinicians in the TPCC measure, stating that emergency departments provide primary care for patients who lack other options. The TEP recognized that emergency care supplements primary care management and that the

care is episodic rather than longitudinal. Since TPCC assesses a year of costs, emergency medicine clinicians are unlikely to influence overall care costs following the emergency department visit. Acumen clarified that emergency medicine providers are excluded from attribution based on previous discussions on TPCC re-evaluation. Acumen also noted that the Emergency Medicine episode-based cost measure proposed for use in MIPS in the Calendar Year 2024 Physician Fee Schedule proposed rule is intended to assess the value of care provided by emergency medicine clinicians.

2.1.3 Key Takeaways

- The TEP supported the exclusion of certain HCFA specialties.
    - In the post-meeting survey, TEP members recommended removing neurology from the list of excluded specialties, thus including it in the measure. Members also recommend to continue excluding psychiatry, pediatric medicine, physical/occupational therapy, and licensed clinical social workers from the TPCC measure as they do not typically bill the trigger outpatient E/M codes.
- The TEP raised concerns about attribution of clinician groups due to the billing patterns of the NPs and PAs within specialty practices where all other clinicians would otherwise be excluded from TPCC attribution. The TEP advocated for refining attribution methodologies to prevent this occurrence.

2.2 Field Testing Report Refinement

This session focused on actionable refinement areas for the field testing reports. It also included a group user testing session where members of the panel reviewed the latest version of the field testing reports and provided feedback on ways they can be improved. Section 2.2.1 outlines Acumen's presentation, Section 2.2.2 summarizes the TEP members' discussion, and Section 2.2.3 contains key takeaways.

2.2.1 Summary of Presentation

Acumen began this session by first explaining the purpose of field testing. Field testing is a step in the measure development cycle where interested parties may learn about the draft version of the cost measures in development and provide feedback on their specifications. In this process, Acumen generates field test (FT) reports for all providers meeting the testing case minimum for a measure, which providers can then download from the Quality Payment Program website. Users sign in to access their reports; however, additional materials such as the draft measure specifications (i.e., draft measure methodology and draft measure codes list) are available publicly on the QPP Cost Measures Information page. After reviewing their FT reports and other materials, clinicians may provide feedback on the draft measure specifications and the FT materials, including the FT reports. Acumen prepares a report summarizing all input, which will then feature in discussion with each measure's Clinician Expert Workgroups ("workgroups") for a Post-Field Testing Refinement (PFTR) Webinar.

FT reports offer a snapshot of provider performance for a draft measure specified during field testing. FT reports are available for clinicians and clinician groups and are

purely informative, without any end use by CMS for payment adjustments. Field testing occurs for measures in development (i.e., not currently in use) and serves only to receive broader feedback on measure specifications during the development process. Further, mock FT reports are available on the QPP Cost Measure Information page for feedback from all interested parties (e.g., those who did not receive FT reports). FT reports comprise three components, described in Table 2 below.

Table 2. FT Report Components

Document	Description
FT Report (portable document format [PDF])	Measure-specific report with data and other information regarding performance (measure score), background on the measure, various breakdowns of performance, and glossary tables for metrics used in the report. Users will receive 1 FT report per measure.
Episode-Level File (comma-separated values [CSV])	File containing information and data on many variables and metrics for each episode attributed to the clinician or clinician group.
Data Dictionary (CSV)	File defining each variable or metric within the episode-level file.

Providers will receive a PDF FT report for each measure for which they met the testing case minimum, one episode-level CSV file with all of their episodes across all measures, and one data dictionary (also a CSV file).

Acumen gave a brief history of the evolution of FT reports over 5 Waves of development starting in 2017. Notable changes to the FT reports include:

- Transition from Excel to PDF and CSV format based on stakeholder feedback
- Additional background information and metric explanations within the reports
- More detailed metrics on costs and performance, such as spending by categories and updated peer/comparison groups

The purpose of this session was to solicit feedback from the panel on possible improvements to the FT reports, including enhancements for the following:

- Data elements (i.e., what is included and how the elements are ordered)
- New/improved information/explanations (e.g., of the cost measure, metrics, and how to interpret results)

Acumen walked through all sections of the FT reports, their data elements, metrics/variables, and textual accompaniments, soliciting feedback on each. These were pulled from the mock FT report. Acumen also gave an overview of the over 50 variables included in the episode-level CSV file, which are listed in categories in Table 3 below.

Table 3. Episode-Level File Variable Examples

Information Category	Metrics Included	
Episode	• Name of EBCM • Sub-group (if applicable) • Start and end date • Trigger codes	• Episode cost (observed + risk-adjusted) • Risk score • Patient relationship codes
Patient	• Health Insurance Claim (HIC) number • Sex • Date of birth	• Part D enrollment status • Number of Hierarchical Condition Categories (HCCs) in lookback window
Clinicians Providing Care	• Names of attributed clinicians and their specialties • Names of hospitals, skilled nursing facilities (SNFs), and home health agencies (HHAs) providing care 1st and 2nd during episode	• Non-attributed clinicians contributing the most episode costs
Specific Services	• Number of inpatient admissions during episode • Number of emergency department visits during episode	• Observed cost (and percent of overall episode cost) for each file type

Acumen conducted a group user testing session, where the TEP reviewed a mock FT report to gauge completeness, flow, and usefulness. Acumen presented the following discussion questions before the group user testing session on identifying potential refinements or enhancements for the FT reports:

- *What do you understand, and what do you not understand in the report?*
- *Which descriptions are difficult to understand, and how may they be improved?*
- *What is still missing in the report that would add great value?*
- *Are there different tables, metrics, or comparison groups that should be added?*
- *Which data elements are of greater value versus lower value to you? What adds less value and may be removed?*
- *What data elements ought to be moved up or down in the report (e.g., essential first-page items)?*
- *Which elements of these reports would be most valuable to patients if EBCMs are publicly reported?*
- *What other general considerations may improve this report?*

2.2.2 TEP Member Discussion

During the discussion, the TEP responded to the information, structure, and metrics currently included in the FT reports. One panelist asked if it would be possible to have an indicator on graphs or histograms to guide the reader to where their score is located within the visual. Acumen will investigate this possibility, though they noted that it may not be technically feasible with the mass production of FT reports in PDF format. A panelist also asked for clarification why the two histograms are distributed differently in the reports. Acumen noted that this explanation is available in the report's text, but that the report can expand on this information.

Panelists also raised the idea of flagging costs associated with low- or high-value services. One panelist suggested that this may only be possible with electronic health record (EHR) data, but they also noted that claims data may be used to identify these services. Acumen will investigate the possibility of creating claims-based metrics to provide additional context about clinician performance and using low- or high-value services within episodes.

One panelist also stressed that linking costs in the report to specific providers and episodes would be helpful. Acumen noted that the information in the episode-level CSV provides this. One panelist also asked if high and low costs are identifiable by US Medicare HIC number, and Acumen confirmed that this is available in the episode-level CSV. The TEP also noted that embedding additional information about risk adjustment methodology within the field testing documents would be helpful.

TEP discussion around the explanations offered in FT reports was positive, and the members indicated that there is an appropriate level of description. Further, questions about FT reports that panelists had were readily answerable using the descriptions in the FT reports. For instance, a panelist asked how providers can receive the episode-level CSV file with their reports. Acumen clarified that every provider receiving an FT report also receives an episode-level CSV within their zip file. A panelist also asked who receives reports, and Acumen clarified that all providers meeting the testing case minimum for the measures do, which is explained in the reports. Finally, a panelist asked about any end use by CMS of FT reports. Acumen clarified that field testing happens during development and is for informational purposes only, meaning providers can review their preview of performance on the draft version of the measure to understand the measure and assess potential improvement areas or strategies for the future. Acumen includes this on the first page of the report, and it notes that the information doesn't affect any scoring or payment adjustments in MIPS.

2.2.3 Key Takeaways

- The TEP supported the continued inclusion of the elements, metrics, and explanations that are currently in the FT reports.
- The TEP expressed support for additional visual features to aid the reader's interpretation of their score in charts (e.g., within the histograms).
- The TEP recommended researching additional information to distinguish high- and low-value services in episodes.
- In the post-TEP survey, TEP members suggested the following information be added to the FT Reports:

    - Further breakdowns of cost by Major Diagnostic Categories (MDCs), MS-DRG, skilled nursing facility (SNF) stays, medication categories, and imaging
    - Stratified measure scores based on whether patients are dually-enrolled in Medicare and Medicaid
    - Additional metrics on timing and frequency of adverse events.
- In the post-TEP survey, TEP members suggested the following information be added to the episode-level CSV file:
    - Regional data
    - Patient risk indicators, such as diabetes and obesity
    - Separate information for inpatient rehabilitations facilities and long-term care hospitals.
- In the post-TEP survey, most TEP members recommended using additional resources such as the United States Preventive Services Task Force (USPSTF) ratings, national care guidelines, and outlier data to identify low- or high-value services.

3 NEXT STEPS

The input provided by this TEP will help inform future measure development and measure maintenance activities. After the meetings, Acumen followed up with TEP members on their feedback and recommendations, gathering targeted input through a post-meeting survey. Based on the guidance received during the meetings and the survey responses, we will be taking the following next steps:

- **TPCC Re-evaluation:** We will confirm the HCFA specialty exclusion criteria, exploring the possibility of removing the neurology specialty. Furthermore, we plan to conduct further analysis on the frequency of attributions of clinician groups by the billing practices of nurse practitioners and physician assistants to inform potential refinements to the measure specifications to reduce the likelihood of misattributing clinician groups that provide care outside the intended scope of TPCC.
- **Field Testing Report Refinement:** We will make updates to the Field Test reports, such as adding clarifying language and adjusting which metrics to include. We will also explore the feasibility of creating claims-based metrics to provide additional information about clinician performance and using low- or high-value services within episodes.

4 APPENDIX A: TEP MEMBER COMPOSITION

The table below includes the full list of TEP members, their professional roles, and their affiliated professional organizations.

Table A1. PCMP TEP Composition

Name, Credentials	Professional Role	Organizational Affiliation, City, State
Anita Bemis-Dougherty, **PT, DPT, MAS**	Vice President, Clinical Practice, APTA	American Physical Therapy Association, Alexandria, VA
Akinluwa (Akin) Demehin, **MPH**	Senior Director of Quality and Patient Safety	American Hospital Association, Washington, DC
***Kurtis Hoppe**, **MD**	Physical Medicine and Rehabilitation Physician	American Academy of Physical Medicine and Rehabilitation, Rochester, MN
Caroll Koscheski, **MD, FACG**	Gastroenterologist	American College of Gastroenterology, Hickory, NC
***Alan Lazaroff**, **MD**	Geriatrician	American Geriatrics Society, Centennial, CO
***Shirley Levenson**, **PhD, FNP-BC, PMHNP-BC**	Psychiatric Mental Health Nurse Practitioner	American Academy of Nurse Practitioners, Caldwell, TX
Robert Leviton, **MD, MPH, FACEP, FAMIA**	Physician Advisor	American Medical Informatics Association, Mamaroneck, NY
Edison Machado, **MD, MBA**	Chief Strategy Officer and Senior Vice President, IPRO	American Health Quality Association, Lake Success, NY
***James Naessens**, **MPH, ScD**	Emeritus Professor of Health Services Research	Mayo Clinic, Rochester, MN
Shelly Nash, **DO, FACOOG**	Senior Vice President, Global Chief Medical Information Officer	Fresenius Medical Care, Altamonte Waltham, MA
***Diane Padden**, **PhD, CRNP, FAANP**	Nurse Practitioner, Vice President of Professional Practice and Partnerships, AANP	American Association of Nurse Practitioners, Austin, TX
***Parag Parekh**, **MD, MPA**	Ophthalmologist	American Society of Cataract and Refractive, Surgery Dubois, PA
David Seidenwurm, **MD, FACR**	Neuroradiologist, Network Medical Director, Quality and Safety Medical Director, Sutter Medical Group	American College of Radiology, Sacramento, CA
Mary Fran Tracy, **PhD, RN, APRN, CNS, FCNS, FAAN**	Associate Professor, Assistant Dean, and Director of Graduate Studies, University of Minnesota	National Association of Clinical Nurse Specialists, Minneapolis, MN
Janice Tufte	Patient Advisor	Society for Participatory Medicine, Seattle, WA
***Ugochukwu (Ugo) Uwaoma**, **MD, MBA, MPH, FACP**	CEO of Resolute Care	Trinity Health of New England, Hartford, CT
Danny van Leeuwen, **RN, MPH**	Patient Advisor	Health Hats, Arlington, MA
***Michael Wasserman**, **MD, CMD**	Geriatrician	California Association of Long Term Care Medicine, Newbury Park, CA
Gregory Wozniak, PhD	Vice President, Health Outcome Analytics, Health Outcomes Group	American Medical Association, Washington, DC
Adolph Yates, **Jr.**, **MD**	Academic Orthopedic Surgeon	American Association of Hip and Knee Surgeons, Pittsburgh, PA

*Denotes members unable to attend the meeting.

5 APPENDIX B: PCMP COST MEASURE PROJECT TEAM

The multidisciplinary Acumen measure development team includes individuals with knowledge and expertise in cost measure development, clinical practice, healthcare policy and financing, pay-for-performance and value-based purchasing, and quality improvement. The following 11 individuals from the project team attended the TEP:

- David Moore, Moderator
- Sri Nagavarapu, Senior Research Director
- Joyce Lam, Senior Research Manager
- Laurie Feinberg, Senior Clinical Researcher
- Heather Litvinoff, Senior Clinical Researcher
- Sam Bounds, Research Manager
- Binglie Luo, Research Manager
- Allie Newsome, Senior Policy Lead
- Ken Tran, Senior Policy Associate
- Elizabeth Peters, Policy Lead
- Kai Kargbo, Data & Policy Analyst
- Oscar Gonzalez, Senior Policy Lead
- Sam Wands, Data & Policy Analyst