CMS Innovation Center Listening Session – Strengthening Equitable Access to Advanced Primary Care
April 26, 2022

>>Dr. Sarah Folger, CMS: Good afternoon, everyone. Thank you so much for joining. I'm watching the numbers climb but to be responsible with the time that we have allowed today, I wanted to get started.

And first off just want to welcome everyone to the CMS Innovation Center listening session we have planned for today. Specifically we will be talking about strengthening equitable access to advanced primary care.

My name is Sarah Folger and I have the privilege of serving as the moderator for today's discussion. I serve as the acting group director for the patient care models group at the Innovation Center.

Before we get started, I did want to tackle a couple of administrative items. First, wanted to let everyone know that this session will be recorded. Second that closed captioning is available for this event by clicking the closed caption CC button at the bottom of the screen. Third, I want to point out that we have a Q-and-A function available to us during this meeting and I encourage all of you to use it. Due to the size of the event, we may not be able to respond to everyone's question but we'll be monitoring it closely and capturing any follow ups there. Lastly, I would ask if there's any press on the call to please submit questions through the CMS Media Inquiries Portal. That link is being shared now in the chat.

So, again I want to thank everyone for joining us today. I am now pleased to formally introduce Dr. Liz Fowler, Deputy Administrator for CMS and Director of the Innovation Center.

Liz, the floor is yours and next slide please.

>>Dr. Liz Fowler, CMS: Thanks so much Sarah and good afternoon everyone. We're really grateful for you taking time to engage with us on what the CMS Innovation Center or CMS is doing to strengthen equitable access to advanced primary care. Special thanks to all of our panelists who are joining us today.

For those not familiar with what we do, CMMI was created in 2010 as part of the Affordable Care Act, with the goal of transforming Medicare and Medicaid into a more value-based healthcare system.

In October, we released a strategy refresh that detailed our vision for attaining a health system that achieves equitable outcomes through high quality, affordable, person-centered care. This strategy is closely aligned with CMS Administrator Brooks-LaSure’s strategy and goals for the agency. And key elements of our strategy link back to the agency's broader agenda to make sure we collaborate with partners across the industry to achieve a larger vision for our beneficiaries and enrollees.

Advancing health equity is, in particular, a shared goal across both the CMS Innovation Center and CMS at large. As part of our effort to improve quality we're committed to embedding equity into all aspects of our models. And increasing our focus on underserved populations, strengthening equitable access to primary care is one component of this work, and will remain an area of focus for the Innovation Center.

Over the past few months we've been seeking feedback from stakeholders on critical issues like engaging safety net providers, incorporating beneficiary perspectives into our models and our health equity strategy. Today's roundtable focuses on equitable access to primary care and part of our effort to operationalize our commitment to enhance stakeholder engagement and transparency. We've learned a lot from the primary care models, the Innovation Center has led to date. We'll get into more details later but suffice it to say that our Comprehensive Primary Care models and Primary Care First have and continue to take primary care providers along the path of value-based care.

As we alluded to in our White Paper, there are learnings we can apply towards a new primary care model. And it's our intention that any new model we develop leverage tactics to drive more people into accountable care relationships, center health equity, address affordability, provide the right tools and supports, and partner with payers across the health system.

But achieving our vision for advanced primary care adoption requires partnership with patient advocates and beneficiaries, with community based organizations, with other payers, including states, and of course the provider community. We want feedback from all of you on how we can achieve meaningful transformation of our health system, especially as it relates to the integral role primary care plays. We sincerely appreciate your time and thoughts, so that we can all be working together to shape a health system that best serves our communities.

Now turning to today's agenda, next slide please.

Today will start with an overview of the Innovation Center's vision for advanced primary care and the role equity will play in our strategy before looking ahead to the future will then facilitate a roundtable to hear from experts on the ground and conduct Q-and-A and then from there.

I think I'll turn it over to Purva Rawal to get us started. She's our Chief Strategy Officer and she's going to start out by taking about the foundational role of advanced primary care in our strategy.

>>Dr. Purva Rawal, CMS: Thank you Liz. I want to say good afternoon to you all, and thank you again for joining.

As Liz described, a little over a year ago, the Innovation Center took stock of lessons learned. In the first decade of the Innovation Centers work over 50 models were launched, including several advanced primary care models. Liz mentioned a few of them, the Comprehensive Primary Care model and Comprehensive Primary Care Plus model, and now the Primary Care First, PCF, model.

And we looked back to help us chart the course forward for the next decade, with a renewed vision to help build the health system that achieves equitable outcomes to high quality, affordable, person-centered care as you see here. And equitable access, with high quality primary care, is critical to making this vision a reality for more of our beneficiaries. And, as many of you may have seen, five objectives guide the implementation of the Innovation Center's new vision. I'll talk more about each of these briefly.

Next slide please.

The first objective is to drive accountable care. The goal laid out is bold: For every Medicare beneficiary and the vast majority of Medicaid beneficiaries to be in an accountable care relationship by 2030. This means that we need to focus on models that can facilitate accountable care relationships between patients and providers, such as advanced primary care in which patients' needs are met through the delivery of integrated and coordinated care.

Our second strategic objective is one that was also spoken about, and that our Chief Medical Officer Dora will speak more in detail about momentarily. The second strategic objective is to advance health equity. We believe that promoting equity and addressing health disparities are critical to improving health care quality. We've detailed a number of areas that we're exploring to embed equity throughout the lifecycle of our models, all the way from development to implementation and evaluation. And these areas include ways we must increase participation amongst safety net providers in our models, including in future advanced primary care efforts and collecting demographic data to measure our progress, as well as reducing population level inequities.

The third strategic objective, you see here, is focused on supporting care innovations that enabled the delivery of person-centered, integrated care in the case of advanced primary care. This includes screening for social needs and the delivery of integrated behavioral health services. Innovations that will continue to support efforts to ensure that model participants also have access to actionable practice specific data so that primary care providers have the data they need, for instance, to manage patients care and to make appropriate referrals. We're also going to continue to look at payment flexibilities and mechanisms that support the delivery of care management. And screening for social needs as well. Last, we also understand the importance of peer-to-peer learning collaborative that allow model participants to share best practices.

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Our fourth strategic objective focuses on ways our models can advance affordability by addressing healthcare prices and reducing duplicative or unnecessary care. Exploring how our models can address the source of waste that drive up direct and indirect patient costs and innovations that models can promote the affordability of high value care. This means you must consider both the direct and indirect costs patients face from navigating the complex health system. For instance, access to high quality primary care can help reduce unnecessary care, you can also help support referrals to high quality specialty care.

And our fifth and final objective is focused on how we will partner to achieve the system transformation that's our goal. The vision and objectives we've laid out are ambitious, and we will need to collaborate with patients and beneficiaries, providers, health plans, employers and states, among others.

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I hope it is clear to everyone here today that testing innovations to increase equitable access to high quality primary care is critical to achieving our vision and objectives. So today we hope to begin gathering a range of insights on the major challenges facing primary care in America today and how the Innovation Center can play a role testing innovations that advance equity, that create opportunities for more primary care providers to engage in value based care and then promote the delivery of care that's more coordinated across primary and specialty care that's more integrated and holistic.

The opportunity to hear from our panelists here today, from participants and others as we go along on this journey is critical to help inform future model designs. So I'm very excited about the discussion today and want to thank everyone, all of our panelists, again for their participation, and all of you out there listening today.

With that I'm going to turn it over to our Chief Medicare Officer and health equity lead Dr. Dora Hughes.

>>Dr. Dora Hughes, CMS: Thank you for the introduction and background on the CMMI strategy refresh.

The CMS Innovation Center recognizes the foundational role of primary care and healthcare system transformation, as evidenced by its historical focus and investment on testing primary care models. As we move forward, we will look to broaden the footprint of CMMI'S primary care models in an equitable manner. In order to scale our impact more widely, we believe our investments in primary care will be a driver in achieving better outcomes for beneficiaries and promoting high quality, affordable person-centered care.

To understand today's audience's perspective on the greatest challenges facing primary care providers, and partners as well, we would appreciate you answering the poll question on your screen.

In your efforts to deliver advanced primary care, I'm reading the poll question, what are the top two challenges that you and the providers you represent face? We know that may be hard to select only two, but we are trying to see what rises to the absolute top and so, if you could choose between: Patients' comprehensive medical and social needs; Continuous strain from Covid-19; Disparities and accessing care; Behavioral health needs of patients; Workforce concerns (e.g., shortages, turn-over burn-out); Obtaining and maintaining certified Health IT; Uncertainty future reimbursement; or Other.

If you choose "other" we are hoping that you will put into the Q-and-A box to capture some of your thoughts and other answers that we did not contemplate that should have been part of the poll. So, let's see if we could, if you're able to enter in your answer and please let us know when the findings from this poll are ready to be shared.

There we have it, the top two as I look: workforce concerns tops the list and the second is the comprehensiveness of the medical and social needs that need to be addressed. But certainly I'll also note that disparities and certainty of future reimbursement and behavioral health needs rise to the top as well.

Thank you for that and, again, if you have additional thoughts we'd love, if you could elaborate upon them in the chat, particularly for those of you that selected other is your answer.

Then in terms of moving to the next slide and focusing on today.

As many of you know, in 2021 the National Academy of Sciences Engineering and Medicine, or NASEM, published a report focused on implementing high quality primary care, with a focus on transformation and the report identifies five key objectives for implementation, as detailed on this slide. The first objective is paying primary care providers to care for people rather than delivering services. This involves a transition to a hybrid payment model that features both fee-for-service and capitated

payments. The second objective is ensuring high quality primary care is available to all patients in every community. The third objective is training primary care providers in the areas where people live and work. The fourth objective is designing it so that it serves multiple stakeholders, including patients, families, and inter-professional care teams. The final objective is leveraging these objectives to ensure high quality primary care is implemented throughout the United States.

We can move to the next slide please.

There is historical recognition that primary care is a driver for health equity and the reduction of disparities. The NASEM report highlights the need to go beyond equal access to high quality, whole person care and to consider a series of additional efforts, which include first focusing on improving health outcomes, specifically for disadvantaged populations and reducing disparities in clinical care. Efforts to reduce disparities include identifying and mitigating social needs for individuals and addressing social the terms of help at the community level. And second, leveraging care teams that reflect the communities they serve and promoting a system that supports care teams and building relationships with individuals, families and the broader community.

So with that I will turn it now back over to our moderator, Sarah Folger, and please move to the next slide. Thank you so much.

>>Dr. Sarah Folger, CMS: Great, thank you so much to all of you for the introductory remarks. Just two more slides before we turn to our esteemed panel to respond to some questions on our behalf.

Recapping here some of what you've already heard my colleague share around the long standing commitment that the Innovation Center has made to advancing primary care, we've taken a number of steps, through various models. All of which share the goals that you can see, on the left hand side of the screen here, of strengthening and primary care through payment reform and care transformation activities supporting clinicians and providing comprehensive whole person care. Improving access and outcomes for patients, beginning with the CPC or Comprehensive Primary Care model, the innovation has consistently built on lessons learned to improve with each new primary care model, as well as to broaden participation.

Most recently, the Primary Care First model was launched in 2021 with nearly 3,000 practices covering 26 regions. This model includes payment options for practices ready to accept increased financial risk in exchange for flexibility and potential rewards based on performance, including support for practices serving high needs populations.

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As we look to the future of primary care and other CMMI models, we reviewed lessons learned from the Innovation Center's first decade, as part of our strategic refresh mentioned earlier, in remarks. These lessons learned will serve as a foundation for how we design models to test new innovations and meet emerging challenges in primary care. For today's discussion I'd like to highlight four of those lessons learned.

First, participants in primary care models to date have been able to transform how they deliver care to patients driving whole person care through our models. However, participation among independent

practices, has been limited. Second, increasing recruitment and participation of providers that deliver care to underserved communities is critical to ensuring that models are representative of the beneficiary population and our promotion efforts around equitable access. Third, to date CMMI models have not yet generated savings, meaning the impacts on total cost of care will likely take longer to materialize. Finally, multi-payer alignment within models has shown mixed success but continuing to reduce burden and increase the sustainability of primary care practices participating in value-based care will be critical to future success.

With this background in mind, we'd like to transition to our discussion portion of the session, next slide please.

We think it's critical that we reach out to experts in the field who can inform our work. This roundtable is one of many equity and primary care focused events in the pipeline over the next several months that will ensure we are hearing from as many leading individuals and organizations in this space as possible.

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We are pleased to welcome several leaders from patient advocacy groups, provider groups, foundations and research experts all to take part in today's panel discussion on advanced in primary care in the Innovation Center models. Joining us today are: Shawn Martin, Executive Vice President and Chief Executive Officer of the Academy of Family Physicians. Dr. Lisa Watkins, Director of the multi-state collaborative through the Milbank Memorial Fund. Dr. Gary Bevill, Family Medicine Specialist for SAMA healthcare. Dr. Leon Dougal, and I'm sorry I corrected Leon's title on the slide, but he's coming to us as a Family Medicine Physician from Ohio State University. Sarah Combs, Director for the Health System Transformation from National Partnership for Women and Families. Dr. Rebecca Etz. representing us as a physician as well for today's panel, and Rebecca forgive me, I will read your title when we get to that slide. And then, Aparna Higgins, Senior Policy Fellow from Duke Margolis Policy Center.

This group brings a diverse set of experience and expertise across primary care covering topics such as multi-payer alignment, equity, high value primary care, specialty collaboration, beneficiary perspectives and general primary care practice. During this panel, the group will focus on the five questions listed on this slide.

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Our first question we're going to actually get responses from two of our panelists. So, Shawn Martin from the Academy of Family Physicians and Dr. Lisa Watkins from the Milbank Memorial Fund are going to respond to our first question.

What are the current challenges facing primary care in the United States? What role should the CMS Innovation Center specifically play in testing innovations to address those challenges?

Shawn, I'd like to invite you to provide the initial remarks. Thanks so much.

>>Shawn Martin, Academy of Family Physicians: Thank you so much for the invitation to be here today, and certainly for the leadership of the entire CMMI team for prioritizing this conversation.

I think it has been and continues to be very important for the health of individuals in the country and I'm honored to be here with Lisa, and we may say a lot of the same things, but will say it with great enthusiasm and create some alignment behind them. I'm going to speak to the challenges of primary care and recommendations on what CMMI can do so.

I think the first challenge for me is really the misalignment between expectations of primary care and how we resource primary care. In this country, there is broad agreement that primary care is a common good. It improves individual and population health that reduces costs, and it certainly helps individuals achieve their desired level of health and health maintenance. As compared to other disciplines of medicine, or certainly other independent interventions, we continue to under resources in terms of financial support. The amount of overall money we invest in the primary care function, but we also tend to make it very complicated to provide comprehensive, longitudinal, omnichannel primary care in this country. We create a regulatory framework that makes that almost impossible for many to achieve true comprehensive longitudinal delivery models, both in the public and private sectors.

The second thing is that we tend to create a regulatory structure that makes the financing structure less valuable. So in instances where we've increased the financial resources available to primary care physicians or primary care practices, it has come with a regulatory obligation that essentially negates in real time or needed effort, the value of those additional financial resources that are providing to the practice themselves. So many positions, many practices, will make a determination that the effort required to achieve additional financial resources isn't worth it, and the complexity of this comes into play.

My next issue, which is the lack of alignment across payers. For my members, for the average family physician, they engage with 10 or more payers, including Medicare and Medicaid. So this lack of alignment creates 10 or more regulatory structures that are associated with their financing structures and that regulatory burden alone is an obstacle. But it's also a de-motivator for innovation and for many practices around the country.

Then my third is that I personally feel that we evaluate primary care all wrong. We tend to want to evaluate primary care on a disease-based, individual quality metric improvement approach. What we really need to be thinking about are longitudinal and population-based evaluations. How is the practice doing? With respect to populations of patients attributed to the individual practice and are they really accomplishing better health, which is producing lower costs, by lower utilization and key drivers of spend in a country and at the top of that list is emergency department use, and of course hospitalizations and readmissions. We need to recalibrate, if you will, what we measure and in the process of doing so will create a different conversation around the value of primary care.

So, for recommendations are first obviously invest more money in the primary care function. I think this gets misconstrued into more money for salaries for primary care physicians or clinicians. But that's not necessarily what I'm saying, although my members would love that. I just think there needs to be more money in the primary care function, overall. There also needs to be an investment and trust, and I spoke about this regulatory framework. You can't provide additional dollars and then add a complete another layer of regulatory process to that you're going to have to infuse finances without increasing the regulatory obligation of the practices.

The second thing is really taking away any requirements or measurements that aren't really meaningful. We need to measure what's meaningful. We need to really evaluate the function of primary care in a more holistic and population-based way and move away from the individual metrics associated with individual diseases, and particularly those that are incremental in nature.

The third thing is focused on improvement. I still think it's really important the end goal here is to provide better care to individuals and populations. We need to be working with primary care practices and clinicians to improve the overall care they're providing. Part of this is really becoming agnostic to modality, letting them do what they need to do to provide better care and not being as concerned as we have been from a historical nature on the modality of care, whether it be telehealth or digital health or in-person or a phone call. Empowering the practices to do what's best for their individual patients, and of course the population.

Then, finally, the last recommendation I would have is just a variety of models. Each individual primary care practice or primary care physician or clinician is responsible for and responsive to a community and the types of approaches they're going to take are going to be different, based upon the populations they serve, the communities they serve. I think any approach that is one size fits all is going to continue to face headwinds because at the end of the day, the practices, want to take care of the people in front of them, and they want a model and financing model that is supportive of them doing so.

So I will pause there and turn to Lisa.

>>Dr. Lisa Watkins, Milbank Memorial Fund: Thank you Shawn, and I could just sort of say "what he said" and we could move on to the next set of questions, but I have a few things to add.

First of all, I do say that I agree with everything that Shawn has mentioned, I think these are all incredibly important pieces and I just want to add a couple of challenges to more clearly articulate them.

I think we do have, and everyone knows, we have a workforce crisis, not only ahead of us, but actually that we're dealing with right now, and that was certainly brought to a further light in the current environment around the public health emergency and the pandemic of the Coronavirus. That being said, there needs to be a strong effort to truly use integration of teams and to have that be the resource that creates a patient-centered care for primary care. And, that is going to take some ingenuity and willingness to perhaps step away from a traditional roles that many of us have played over the years. I see that is very important, and I think that also tied into the workforce issue specifically for primary care physicians is the pay issues in terms of that people walking out of medical school now graduating are looking at hundreds of thousands of dollars in debt. And the likelihood that they can pay that back comfortably in the practice of primary care versus a subspecialty is dim, so we will need to address that as well.

I think, just to emphasize, one other piece that I think is a huge challenge for practices, especially those that are independent or smaller or rural or inner city without direct access to a larger system or resources around integration of data and communications, especially with specialist with hospitals with social services, etc. That is certainly on the road to being addressed but it's been a long road. Thus far it's you know, over a decade since we've started working on some of this work. I think that this is something that has to be moved forward in a very aggressive way that will also help standardize some of the issues around equity and access to care that is sadly just truly unfair, as we know, as we have all observed.

The specific roles for the Innovation Center I have several in mind, I agree with Shawn that there needs to be a menu of options for practices to be able to choose from in terms of programs that the Innovation Center is putting forth. And there's no question that when CMS stands up and says "we're doing this program please join us", it's a thought leader, it brings credibility to any program and it really does attract a larger swath of practices and payers, and I think that that has to be expanded.

We're delighted to see Primary Care First follow on the heels of the Comprehensive Primary Care programs, but there needs to be more opportunities and a different level, so the practices that are not necessarily as sophisticated as those that are in primary care, first in terms of what they have access to around data and comfort level with taking risk, we need to widen the tent.

Another piece for the Innovation Center to consider is letting the models be tested for a longer than the five years or four years or six years that we've seen over the last decade or decade and a half. Everyone knows it takes at least a year to ramp up to get started to get comfortable. We're talking about behavior change on the part of patients and their families and clinicians, their allied health professionals, and our data systems that doesn't happen in a year. There's not going to be a return on investment in them a relatively short time line that all of these programs have been subject to.

So with that, I will finish and thanks, once again, very much for this opportunity and to be able to share our opinions.

>>Dr. Sarah Folger, CMS: Huge thanks to both of you for those very powerful remarks for sure. I'm going to keep us moving but turn for our physician perspective from Dr. Gary Bevill and Gary I'll pose the question for you, if you want to come off mute and turn your video on.

The end of the CMS Innovation Center has had a 10 year history of testing primary care transformation models from your perspective, what are the most important lessons learned to infuse to inform, excuse me, our future advanced primary care work?

>>Dr. Gary Bevill, SAMA Health Care: Hey thanks for having me on.

A brief background, I'm in South Arkansas town of about 18,000. We're rural, we're two hours from the any nearest tertiary center. And I've been in practice for 40 years now. In 1998 a couple of local solo practices, like me, we formed our clinic and that was some learning and different times. But then, when we got the opportunity to be in CPC classic we did a complete paradigm that I think ties in exactly with what the panelists have already said. We totally changed the layout in our clinic and we created teams. We color coordinated the teams and we have a physician, nurse practitioner or PA supported by three LPNs. And then we have two other nurses, one is a care coordinator and one care manager. And we did that across the spectrum. We had already been assigning our patients to the teams, I mean to individual doctors, but then we kept it with the teams.

Over our experience and then later on when we went to CPC Plus, we also joined an ACO that's primary care driven only. That ramped up taking some risk, with the benefit of the shared savings. So our statistics, everything did very well all of our metrics. We have like a 90% of continuity of the patient staying on the team either seeing me or that a nurse practitioner or PA working on my team. The

patients loved it, they were lot of times they just asked for, like my team is orange, so they would just ask for team orange.

We were able to, with the CPC funds, go from four doctors and two nurse practitioners to currently today we have seven physicians and eight APNs are PAs. We have totally empowered our staff, the staff are very happy. Like what has been brought up by the other panelists, the team approach is definitely the way to go, our nurses and even our X-Ray support because we kind of have everything we have in house, CT, MRI so that we can keep the patient in one spot, and they feel empowered they feel like they have made a difference in our patients' lives from that standpoint.

For us, one roadblock and it may just be unique to being in south Arkansas and we're in an underserved area. When Primary Care First came along, just without getting into a lot of the nitty gritty, but it looked like we were going to lose the CPC upfront payments, having to wait almost 18 months for the bonus. After doing the first year and everything, we had the potential to lose as much as $700,000. So we opted out, which for us was a step backwards. Then because of Covid on top of that, we just felt like we had no choice to because, at the end of the day, we're an independent small practice that we have to be able to pay the light bill and stay in business.

So my final sort of comment to see what I think CMS, and again I'm grateful for the opportunity to speak to this forum is, we think that the team of approach of continuity of care, the access like we're open, seven days a week, empowering the staff. We have shared all of our bonuses, with the staff. Like the other panelists have mentioned, we rolled virtually all the CPC money not into the MDs salaries but directly into all this support staff and it takes a lot of money to generate to cover the staff and those costs. So our thing would be if there's any way to move back to a program where you could invest at the CPC levels. That we think that our model has worked, and we think that that would make it easier for practices. I certainly agree, after having been in practice, as long as I have, starting out as a solo practitioner and fee-for-service to having the being on the quality end and hybrid models that what works in South Arkansas might not work in the inner city New York City. So having a variety of partners available.

Our experience has been that I think if you look at our clinics data over 10 years we have shown substantial savings in that just because of all these quality metrics that we put into place with our team approach. So anything that CMS could do along those lines to have more options to practices and looking at things more longitudinal certainly agree with that, because that's basically what our experience has shown. And one last thing, in talking about manpower, and just the whole primary care and trying to get med students to go into primary care, our doctors and nurse practitioners and PAs in our like I said, our staff have personal satisfaction and stress levels have been a lot lower since we made this change, where we started in CPC. So I think that again I feel less stress now days at least under the CPC part and I did when I was solo.

Again thanks everybody for asking me to take part.

>>Dr. Sarah Folger, CMS: Gary if I could just invite you to stay on for just one, second, I have a follow-up question for you, but I just thank you so much for following Shawn and Lisa in their remarks. I think it's so helpful to us to hear the practice experience.

I just wanted to draw thread between Shawn and Lisa and you Gary. Shawn flagged and you know, a needed investment in the primary care function, and I think, I don't want to put words in his mouth, but I can imagine partially what he was talking about are those infrastructure investments around team-based care on the growing set of expectations that are landing at the footsteps of our primary care physicians and their teams. I just wanted to see if you could share any thoughts on how your practice handles competing demands either across non-aligned payers, or you know, juggling the experience with Covid and your value-based care transition. If there's other arrangements in your community and how you go about prioritizing where you're finding yourself up against can mean competing demands in your practice.

>>Dr. Gary Bevill, SAMA Health Care: Real quickly, before we started CPC, we had six providers and about 23 staff members accounting our lab and X-ray. Right before CPC ended we're up to 15 providers and 76 employees. So the human resource investment has been huge and one of the challenges with Covid and dropping out, or back to fee-for-service, has been we have made the commitment to our staff that even as the partners' and owners' positions expand we have not laid off or cut positions and we are still trying to focus on our on the quality.

One little Arkansas quirky thing, at one point we were having to measure, for one group of payers, how many A1Cs are greater than nine for Medicaid in Arkansas, another one don't have any less than seven. So kind of like what Shawn and Lisa were saying about anything to reduce that burden would be helpful. It would be nice if the there was a better alignment from the standpoint of the different payers.

One other thing, to me: is there was a way to look at more longitudinal outcomes, because some of this does take a bit of fear involved.

Hope that answered your question.

>>Dr. Sarah Folger, CMS: It does thank you so much for the surprise question response. So I would say a great big thank you to Lisa and Gary for weighing in on question one in our full set.

I'm going to move us along and our next question where we're also going to have to respondents. So, welcome to Dr. Leon McDougle, Professor of Family Medicine at Ohio State University College of Medicine, and Sarah Coombs, Director for Health System Transformation at the National Partnership for Women and Families. And the question I would love for both of you to respond to; advancing equity is a core goal for the CMS Innovation Center.

What is needed to increase the reach of advanced primary care to underserved populations? For example, recruitment of safety net providers, learning supports and tools, financial incentives.

I'm looking forward to hearing your responses and Leon I would invite you to start us off.

>>Dr. Leon McDougle, Ohio State University College of Medicine: Thank you so much, Dr. Fogler. I have a list. I have five minutes and I'm going to go through this.

I would start by incentivizing three year family medicine primary care tracks by CMS supporting the GME slots for that training after completion of medical school. Also recommend funding additional GME residency positions to support training of primary care residents and fellows who agreed to a service

obligation in health professional shortage areas or medically underserved areas after completion of training. Priority should be given to funding more primary care, and I would say, family medicine GME positions for hospitals within a rural and urban health professional shortage areas and medically underserved areas. Priority should be given to funding more primary care GME positions for hospitals affiliated with medical schools with a higher social mission score. So, ranked number one, two, and three are Morehouse School of Medicine, the Harris School of Medicine, and Howard University have the highest social mission scores for medical schools.

Moving right along, increase continued support of purser programs, such as the Health Careers Opportunity Program and Center of Excellence grants and scholarships for disadvantaged students. And to ensure sustainability and diversity of healthcare workforce this outreach should be expanded to increase partnership with historically black colleges and universities, tribal colleges and universities and institutions, such as Hispanic serving institutions and those serving Asian American and Native American Pacific islander serving institutions.

And I'll come to an end here by encouraging CMS to clarify wording so state Medicaid plans know they can reimburse Community Health Workers to address social determinants of health. This would be a director's letter from CMS not a policy change. And end on these two things: explore ways to remove employment requirement barriers for use of Community Health Workers. Some Community Health Workers may face the same employment challenge that peer support workers in the addiction behavioral world face. Having a criminal record may prevent them from being considered as employees. And encourage CMS to identify and implement mechanisms for involvement of Community Health Workers, in existing or future value-based payment models consider incentivizing use via additional payment or ability to obtain for payments through incorporation of Community Health Workers.

I have a lot more, but what I've stated is about all I have time for.

>>Dr. Sarah Folger, CMS: Fantastic. Thank you so much, Sir. Will likely have some follow up questions for you shortly, but before we do I'll ask Sarah to respond to the same question.

>>Sarah Coombs, National Partnership for Women and Families: Thank you, good afternoon. I'm Sarah Coombs the Director for Health System Transformation, National Partnership. The National Partnership for Women and Families is a nonprofit nonpartisan policy advocacy organization based in DC. Among our core areas of focus is promoting health system transformation efforts that foster equity for patients and consumers.

So, for too long payment and delivery system reform efforts have not been designed with equity explicitly in mind, so I just want to applaud CMS for its increase efforts and focus to advancing health equity as a core goal for the department. And, as we all know by now, Covid-19 shed light on the many systemic inequities of our health system. It also provided a deeper understanding of why advanced primary care is needed and should be widely adopted. The elements of advanced primary care, such as coordinated multi-disciplinary team-based care that can be offered remotely, care that integrates behavioral mental health care, and care that focuses on the individual needs of each patient were really instrumental in providing continuity of care amid the destruction of the pandemic.

And while we also know that primary care can play a vital role in supporting efforts to advance equity, but payment and delivery system reform in primary care could widen inequities if not designed in a way

to feasibly include safety net and trusted culturally congruent community providers which underserved communities currently, depend on, as mentioned in the lessons learned that Sarah mentioned earlier. For women, particularly low income women and women of color, safety net providers are important sources of reproductive and sexual health care and primary care.

So, I'll offer a few recommendations in order for advanced primary care to reach rural communities and communities that are structurally disadvantaged by systemic racism and other social drivers.

First, we can all agree that financial incentives are critically important to support high quality of care, but for safety net providers that have been systemically underfunded and are operating under financially precarious conditions, financial incentives only serve as a band aid for safety net providers. New payment models require high financial, technological and personnel needs, such as Ben Money mentioned. Safety net providers are often in a disadvantage position to find those new investments in care delivery therefore first CMMI needs to ensure a level playing field and in the development and implementation of payment reform models by providing significant upfront investments to safety net providers to account for why disparities and resources that these providers have at their disposal.

Second, in addition to upfront investment, safety net providers should be able to participate in models that place a greater emphasis on improving patient outcomes and reducing health inequities and less on reducing total cost of care and should have a more robust risk adjustment methodologies to account for the diverse patients' needs and experiences.

Third, to support safety net providers in their transition to advanced primary care, CMMI should invest in technical assistance, shared learning collaborative and data infrastructure, such as the recent announcement to support on new data driven efforts for HRSA's Health Center Program.

And finally I would be remiss if I did not say that redesigning models of care and that address inequities and access and outcomes must put individuals and communities most affected by inequities and safety net providers at the center of care redesign. Health equity will never be achieved if providers and communities of color and other underserved communities are left behind. Thank you.

>>Dr. Sarah Folger, CMS: Thank you, both, and I would ask you to stay on camera just another minute because we have some time. While we have all of this expertise, you can rest assure we're going to try and tap into it. And thank you for the very, I would say, tactical suggestions that you both provided on future items that we might consider in our design.

Certainly we've been talking about how we can reach areas that are underserved and potentially areas that have not come along with us yet on the value based care journey and what we would need to do to aid in our recruitment efforts. I'm just wondering if either of you could weigh in on how you think we might have the most success recruiting independent small practices, safety net providers that have not yet embarked on the value based care journey to come along with us. Any ideas for recruitment strategies would be greatly appreciated.

>>Dr. Leon McDougle, Ohio State University College of Medicine: Well, in regard to recruitment for provider family positions, especially from groups who have been historically excluded from medicine, I think one will need to take a longer-term perspective and view on this. As Covid-19 pandemic revealed that there is a much needed growth in diversity of the physician workforce. And that would include, as I

stated with my additional comments, more of a continued partnership with CMS and supporting programming and especially GME funding to support GME programs in producing family physicians.

>>Sarah Coombs, National Partnership for Women and Families: And I would also add that, I think it's important to meet these safety net providers, where they are to really under have a critical understanding of what the challenges and opportunities that payment reform presents for them. Listening to, listening and understanding, what their needs and priorities are in order for them to join and in order for them to participate in advanced primary care.

>>Dr. Sarah Folger, CMS: Great thank you both so much for your remarks and I will move us along as the as the task master moderator for today's session.

So, I think next we are going to turn to Dr. Etz, who I butchered her title when we started, I promise not to do it this time around. She is a professor at VCU School of Medicine and also Co-Director of the Larry Green Center. So I welcome Dr. Rebecca Etz, and would love Rebecca, if you could respond to this question.

CMS is evaluating how to help all practices move from fee-for-service to value based payment. If provided with needed financial and other supports, how and when can smaller independent practices begin assuming initial financial accountability for quality performance?

>>Dr. Rebecca Etz, The Larry A. Green Center: Thanks. It's all in the “IF” statement, right? So I’m grateful for the focus on primary care today and for CMMI the problems you try to solve predate you by decades, so I appreciate your leaned-in approach. I think “reset” is the right answer here. Our usual approach to building on precedent is not our friend.

I can answer your question quickly and then I’ll take the rest of my time to explain. You can make the move now, no need to wait. By way of explanation, practices are not new to financial accountability, or the appropriate stewardship of population health. So, I have three points and two recommendations for you.

The first: Clinical measures and measures of performance are not the same thing. Switching to meaningful measures aligned with value-based care, would be a relief. Practices have measures right now. As you've heard, they have way too many of them and they're ill-fitting for primary care. They are at best producing waste and detracting from quality.

So, consider that 70 to 80% of primary care happens before or without any diagnosis and yet many measures, most of them are diagnosis driven. Consider that using clinical guidelines as targets is how our national focus on blood pressure as a quality measure both reduced hospital admissions for hypertension by 30% and increased hospitalizations for hypotension by 30% over the same time period.

Guidelines are meant to inform differential diagnosis and professional decision making. We need as many clinical measures, as we can possibly get to inform our professional actions, but that's not the same as performance measures, upon which value and payment should rely. Accountability is an assessment of the extent to which actions of a clinician or practice are aligned, with shared being the good word here, shared expectations and professional norms. Clinicians of any size practice are used to being held accountable, with every patient interaction and visit.

So that's, the first thing: Measure what matters for those who want to know. Does my doctor know me as a person? Is my doctor worthy of my trust? Do they know my health goals and help me to achieve them? These things are meaningful to me. Do I see a member of the Green team at least 75% of the time? Less meaningful.

Second, it's not just the measure, but the environment in which it's used that also matters and the current environment is hostile to primary care. It creates measures as targets which turns primary care into something like a survivor-like game show. Hit the target by any means necessary. Rather than incurring professional behaviors, the suggested move is a move towards supporting the stewardship of population health that the American people deserve. It's also moved to reestablish national awareness of the professionalism that's inherent in primary care practice. We're not trying to incentivize the most effective production of widgets here. We are interested in an environment that leads to carefully considered expert decisions and one that enables a single integrated narrative the health for every member of our population. It's that simple. So, first use measures that matter and second, measures only matter if they're used the right way.

And number three: Shift primary care away from models based on cost and towards a model based on investment and health care. The question is less about "are practices ready" and it's really more about have we discovered the political will to act. Really hope you have. US primary care isn't in danger folks, it's crumbling. The report from the National Academies uses those very words and they are endorsed by the 36,000 surveys that our center, The Larry Green Center, collected during the pandemic. We have no national data set for primary care. We only know primary care by proxy estimates and surrogates and assumptions based on things we do collect.

During the pandemic, our team surveyed frontline primary care weekly and then monthly for two years. Now the trends are consistent. Our average survey has about 1000 respondents and our latest findings are this: Over 60% of clinicians have personal knowledge of someone who quit or retired early during the pandemic. Close to 30% have personal knowledge of practices that closed during the pandemic fewer than a third can call themselves financially stable right now. And one in four plan to quit primary care within the next three years. This is the platform on which we rely, the only bad move here to be to just keep going as we are. The real question is, do we possess the collective will to act and change it?

If you go to New Primary Care Paradigm you will see a wonderful statement. A rare singular voice, that included Shawn Martin, who presented earlier, made jointly by all of the primary care physician disciplines. Predictable structured payments are the only way to allow practices to invest in long term solutions. The building of health information exchange, of low cost, high value relationships with local community and public health organizations, all that needs to be supported, and it is not in a fee-for-service environment.

The question I've been asked suggests that shifting away from fee-for-service to value-based care is an attention to quality as a new thing for small practices. That, they are not. In fact, one of the biggest problems facing practices today is the many distractions of what we might call a fee-for-documentation environment. That has been wasting great amounts of time and energy on measures that have little connection to primary care function and accountability. It steals away from time that they have to spend on quality care that's valued by everyone.

This audience is a little bit of insider baseball right, so you know these things, but it's worth remembering primary care is something of a social contract. Primary care agrees to be there for us, put our interests above their own, and for that we support them as a common good. Health care is the fourth largest industry in the US. We're pretty big and primary care is its largest platform they turned from a primarily in-person to primarily virtual based care at the start of this pandemic because of professionalism as a motivation pump fee-for-service. They receive no capital infusion they have no funding mechanism, no support for the training of the staff or their patients and they put the collective need of the population's health ahead of their own. It's time for us to live up to our side of the bargain.

You can increase that accountability by two things. Two recommendations that I would make. The first is reduce the number of poor measures used. We've already talked about that, but there's a real clear action step here, you can take. The Core Quality Measures Collaborative is a multi-stakeholder group that offers guidance on how to do that. It involves AHIP, the American Health Insurance Plans in all. CMS, in one move, you could use what they recommend as a core set and you could reduce the reporting burden of practices by more than 50%. That is policy gold.

Next, you can fund the Primary Care Extension Service. Many people don't know, but it was created as a federal mandate and the ACA, just like CMMI, but it was never funded. I would suggest that you take ownership of it, that you support it. It's actually been started through private investment and through grants support. There is an infrastructure there waiting to be nurtured that can help practices with the supports necessary for any adjustments you would have to make.

So, measure what matters, used in the right way, with an eye towards long term investment, practices can start that today, thank you.

>>Dr. Sarah Folger, CMS: Thank you so much Rebecca. Such helpful statements, and I'm struck by a lot of the comments that we've had thus far, as well as all of our panelists, on the need for longitudinal model design and the need for us to have kind of patients in the production of outcomes.

To your point Rebecca, around longstanding experience actually in these arrangements, and perhaps some erroneous construction of the question we provided to you today, but kind of wondering what if you can chime in on any ways, you would think we could really get at tight measurement around longitudinal population based outcomes.

>>Dr. Rebecca Etz, The Larry A. Green Center: Sure, so I have to admit, I have a bias here, because my team actually created a measure. It's the person-centered primary care measure it's now endorsed by CMS and NQF. It really is a measure that is not about clinical outcomes and it is not about process. It is about the function of primary care. It's about access, coordination, comprehensiveness, and continuity. It speaks to the kind of accountability that we want to support based on shared expectations between the patient population and the clinician population and professional norms that they are delivering care within professional guidance. It is possible to create measures that do that.

Measures that single out different disease bodies are necessarily treating one group as different from all others, which is exactly what we don't want in an equity based environment we never want to single out one group and treat them differently from all others. To measure correctly, is to connect that measurement to the purpose and function of primary care and to allow for questions of clinical guidance and professional decision making to fall within the venue of professional boards and societies.

The last thing that I would say about that is the clinical measures are absolutely necessary. We actually do want to know what's good care for diabetic patients or patients with type two diabetes. We actually do want to know if we are dealing with a population as a whole in a systematic way, whether there are gaps in care. All those things are necessary, but somewhere along the way we got so good at measuring things like blood pressure, we forgot that the purpose was not to know if Dr. Martin is the best measure of blood pressure, ever the purpose was to prevent MIs. So we want to make sure that we are providing an environment that allows clinicians to do that without treating them like they are working at BestBuy and we have to, you know, pay them based on a compensation package that has to do with how many sales they've made.

>>Dr. Sarah Folger, CMS: Thank you so much.

All right, I think it is time for me to move us along again and we have a new poll. So, I would ask our facilitators to flash that and I will go ahead and read this out loud for our audience.

What are the top two barriers to improving coordination between primary and specialty care? Looks like we can select up to two: Data sharing legal requirements; HIEs interoperability issues; Competition rather than partnership as a care team; Staff shortage for care coordination; Reduced access to specialist; Other.

So, if you could just take a moment before we move on and that would be great.

Okay, and you should be able to see the results up on your screen. It looks like 54% answered staff shortage for care coordination, 46% responded health information exchanges and interoperability issues as being the top two.

Thank you for your feedback on that. It tees us up nicely for where we're going to head next in the conversation today. And I am going to turn to Aparna Higgins, who is joining us. She is a Senior Policy Fellow at the Duke Margolis Center for Health Policy.

We've asked Aparna to weigh in on this question: What are the most significant barriers to improving coordination between primary and specialty care and what strategies can the CMS Innovation Center consider to facilitate care for beneficiaries?

>>Aparna Higgins, Duke Margolis Center for Health Policy: Well, Sarah, thank you so much and first of all I would like to you know, thank you and the leadership of CMMI for hosting this very important session and for the opportunity to participate and contribute to the discussion and this question about coordination between primary and specialty care. I think, is really key and important aspect to address in achieving CMS is goal of better quality better outcomes for Medicare beneficiaries and lower costs and also improvements in you know health equity.

In fact, I would say that there is a need to go beyond care coordination to really drive towards better clinical integration and broad scale adoption of team-based care models, which I think several you know my fellow panelists have also emphasized today in the context of health equity. And this has come up in the remarks of other panelists, thinking beyond the traditional medical model of how to coordinate care between primary and specialty care now extending it to community organizations. For example, if, as we

look to primary care physicians to address or help address some of the social risk factors that vulnerable populations face and kind of put this in perspective in terms of why this is so critical I wanted to share sort of two data points.

One is, and this has again been alluded to before, but put some numbers to it in terms of the share of spending that goes towards primary care estimates. So just that it's about you know 5% of total medical and prescription spending in the Medicare population. You know Shawn and others talked about resourcing primary care earlier and then, in you know, added to that there are studies that show between for Medicare beneficiaries, the care is actually shifted more towards specialist care. If you look at care in the outpatient setting and we're all aware that, on average, Medicare beneficiary see up to five physicians in a given year, but the proportion of beneficiaries who are seeing five or more physicians is actually increased over that same you know time period from something like 17% to 30%. So you can see the real need for addressing this issue of coordinating care between primary care and specialty care.

And I'd say there are a few barriers that I wanted to highlight, some of which are obviously has been brought up with the polling here.

The first is obviously the issue around interoperability and the lack of ability to share information in a seamless manner across different types of providers. In fact, it's kind of appalling if you see some recent research that showed that 70% of healthcare providers to rely on a fax machine to share results which, even in the 21st century seems mind boggling. So I think, while interoperability rules that seek to prevent information blocking help there's also challenges around getting the right kind of information out of the EHR to be able to coordinate care better. I think that's been found to be a challenge, as well as, how does that information gets transferred effectively and is the information that's transferred between primary care, specialty care actually, complete, provides the right type of information for clinicians in the point of care so that's sort of one sort of major bucket.

I think the second, I would say, and I think this is again being alluded to by some of the other panelists, in terms of enabling primary care physicians to be able to refer to high value specialist obviously primary care physicians must have a referral network and specialists that they might trust that they might go to. But I think there's a lack of systematic visibility into their referral patterns. And while providers who are participating in a PM receive data and information and reports, they may not always have the right kind of information to identify high value specialists and know enough about the quality of their specialty referral network.

I think the third thing I would highlight is there's also research to show that there's lack of clarity in terms of the roles of primary care versus specialist and caring for patients. So, for example, what's the role of the specialists? Are they merely serving as consultant in terms of helping with diagnosis of the condition or disease, or are they actually serving in a care management role? And if they're serving in a care management role, than what is the function of primary care versus what's the function of the specialist? Sometimes those things don't always get ironed out and can cause miscommunication and confusion.

I wanted to sort of highlight one other thing, and I think it actually ties back to APMs. I think, historically, and this has just been part of our learning process, we've focused on sort of parallel model design and implementation. So, on the one track we have models for primary care and the ACOs which is more population health focused now. On the other hand, we have these bundle payments or episode models

that you know are focused on specialist. I don't think that any of this has been intentional, but I think it's just been part of our learning process we haven't really sort of thought about carefully and intentionally about how to design and implement these models in a way that fosters greater coordination clinical integration.

So, I want to turn next to a few strategies that I think CMMI can pursue to address some of these challenges. Some of them fall in the in the bucket of what Purva talked about earlier in terms of supporting innovation. This is, again, through resources, technical assistance, learning collaborative and so forth. I would say the first would be, helping build a better data and information infrastructure that one enables more seamless sharing of information, real time, either through use of HIT or other mechanisms in order to provide better care for patients.

The second sort of part of that information infrastructure, I would say is generating reports and being able to help inform the referral practices of primary care physicians. And in addition to sharing information, I think, actually, maybe providing some technical assistance in terms of thinking more systematically about the referral process itself. There are many sort of points in that referral process where potentially failures could occur. So actually coming up with a framework and way of systematically thinking about how that referral process, would work or could work between primary care and specialist think would be incredibly helpful. And including that could be things like providing sample collaborative care arrangements that could be put in place between primary care specialist that clearly outline their roles and what function, they would serve in terms of managing patient populations.

I think extending beyond primary traditional medical specialties and also focusing on community resources increasingly, as we seek to address health disparities addressing social risk factors is going to be critical. And referring, the ability for primary care physician or their care coordinator, to be able to refer their patient populations to community resources will be important in addressing those social risk factors. So I think that's another area where CMMI can play a critical role in both learning from examples and existing data. For example, in North Carolina they have a system set up called NC360 that allows and enables this kind of referral to community organizations to address some of the social determinants of health. So how can we take the learnings from some state based efforts and actually scale them up more nationally and give primary cares the resources and the information they might need to refer to community resources.

And then, lastly, I think I would focus on this: How do we get to sort of the next generation of APM model design and implementation that is more intentional in terms of thinking about integrating you know the population based models and then the specialty models.

And a few sort of specific suggestions I would have in terms of model design and implementation would be: One, as others have alluded to, evolving the performance measures that are used in these models that are more siloed and maybe you narrowly focused on particular conditions to more person-centered outcomes measurement, including patient reported outcomes. That will require a better coordination between primary care and specialist.

Other approaches could be assessing and tying incentives for ACOs, for example, not just on their performance on total cost of care and overall population health quality, but also maybe on their performance on select episodes, especially episodes that are you know high cost, high prevalence. So really trying to drive the next generation of better quality and savings.

I think, focusing on sort of creating a shared accountability platform would also be important in terms of helping minimize the confusion of who owns the patient and who owns the savings so some clarity and simplicity around some of the technical aspects of model design.

And then, lastly, I would say that really thinking about moving to the next generation, especially models. So from a procedure focus much more to a condition focus model where the emphasis is more on upstream management of conditions could also help foster a better primary and specialty care coordination. There are some good examples in the field. One I would point out, is team-based care models that are currently in place for managing degenerative joint disease.

And then I will emphasize the multi-payer alignment too. As somebody who's worked on this issue for a long time, I would be remiss if I didn't bring that up. And I would agree with all of the other panelists on the importance of multi-payer alignment.

>>Dr. Sarah Folger, CMS: Thank you so much Aparna.

I have feverishly tried to take some notes and identify some themes throughout our time today and just given that we're still a little safe on time, I just wanted to summarize some of the key themes that I heard move throughout the session today. And just another huge thank you to all of our various steamed panelists for sharing their remarks on our quite targeted questions.

A couple of themes that jumped out at me.

Primary care general agreement: Primary care, I'll use Rebecca's phrasing, is a common good in need of better resourcing.

Resounding support for the importance of team-based care we heard about traditional participation of nurse practitioners and physician assistants from Gary and I think Leon raised some thoughts around CHW's being included in that team-based care approach and certainly as a partner.

Just closed out the question and response session chiming in on the role of specialists in delivering whole person care, I also heard mention and needing to think through the element of team-based care and the primary care infrastructure and the potential for shared accountability to meet medical and social needs staying on the social needs piece certainly thinking thoughtfully about social risk factors and also indicators moving more upstream in the process,

Both on the workforce challenges that are before us, which was also a thread that moves throughout the session but also supporting infrastructure, data infrastructure, Technical Assistance infrastructure for those that have not yet started to embark on the value based care journey.

Certainly, in the spirit of reducing burden but also becoming kind of more meaningful and purposeful, deliberate in our work, the importance of meaningful measurement of population-based outcomes person-centered outcomes. Potentially thinking differently about our evaluations and I think Shawn mentioned that as well, and also in the spirit of kind of burden reduction just the resounding importance of multi-payer alignment being a critical feature of our future footprint, as it has been in the past of our primary care models.

I would just ask, as I conclude the themes, not to put anyone on the spot, but I wanted to give you an opportunity, if there was anything else you wanted to highlight semantically throughout our session today.

>>Dr. Purva Rawal, CMS: Thank you, Sarah. I know I was getting a responses, we had some really great advice.

I think the other thing I would add, we talked a little bit about this, is just workforce challenges were just another theme and about the way that value based care and support on your comments in particular really helpful there.

Comments around really thinking about special team coordination to primary and specialty care, especially when we think about how to make curiously was possible from the industry perspective so those are extremely helpful.

>>Dr. Sarah Folger, CMS: Thank you so much, and to all of our panelists and to all of those in the audience in the ether, of the black screen. Just thank you so much for joining today's listening session. This was truly a productive conversation.

We all are going to obviously be merging our notes and thinking thoughtfully about what the future holds for us, and certainly commit to and look forward to future dialogue on our advanced primary care footprint. We will be synthesizing today's conversation to curate key insights and feedback, ultimately, this session will inform how we incorporate your perspectives and testing, implementation and evaluation of our models.

Please participate in this survey, you see noted on the screen before you. And you can, I think, if you're technically savvy you can scan with your phone camera that QR code or click the link in the chat window to provide us with your thoughts.

If you have any remarks that you would like to offer us, we welcome them. Please send any additional input on today's session or concepts to CMMIStrategy@cms.hhs.gov with “Advanced Primary Care Listening Session” in the subject line.

And please also take note of following actions to continue our engagement with stakeholders. We have information about our CMS Innovation Center strategic direction web page where you can see more about our strategic refresh efforts for the next decade and our intentions for continued engagement with the stakeholder community.

So with that we will give all attendees eight minutes back and a huge thanks and looking forward to continue dialogue.

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