

**Roundtable on CMS Innovation Center Health Equity Strategy  
December 8, 2021**

**>> Adam Obest, CMS:** Good afternoon. My name is Adam Obest with the Center for Medicare and Medicaid Innovation, part of the Centers for Medicare and Medicaid Services. Welcome to today's roundtable on the CMS Innovation Center Health Equity Strategy. Before we start today's roundtable, I'd like to go through a few housekeeping items. The roundtable today is being recorded. Closed captioning is available via the link in the CC window on the bottom of the screen. We will now post that CC link in our chat. All attendees will be muted throughout this event. You can, however, provide a written comment using the Q&A window on the bottom right of the screen. Your comment may be read aloud later during the session. Please indicate if you would prefer not to have your comment read aloud or to remain anonymous. Again, thank you for joining us today, and I am now pleased to turn it over to Dr. Dora Hughes to provide an overview of the session. Dr. Hughes, the floor is yours.

**>> Dr. Dora Hughes, CMS:** Good afternoon, all. Thank you for joining. My name is Dr. Dora Hughes, and I am the Chief Medical Officer at the CMS Innovation Center. I am honored to be leading our health equity strategy and working with so many dedicated colleagues at the CMS Innovation Center as well as all across CMS to advance health equity through our models and initiatives. As you can see from our agenda, we will hear brief opening remarks from Deputy Administrator and our Director, Dr. Liz Fowler. We will also hear from the CMS Office of Minority Health Director Dr. LaShawn Mclver. I will then give a brief overview of the Innovation Center's health equity strategy. After that, we will hear from the amazing thought leaders who are serving as our roundtable participants today who will share their perspectives, their recommendations for the CMS Innovation Center to advance health equity, and we will then have a discussion. My request for all of you watching is that you'll send your questions, comments, suggestions, recommendations into the chat, which we will be monitoring throughout the session today and certainly reviewing closely after this first roundtable is over. I am now pleased to introduce Dr. Liz Fowler, Deputy Administrator and Director of the CMS Innovation Center. Dr. Fowler?

**>> Dr. Liz Fowler, CMS:** Thanks, Dr. Hughes, and good afternoon. We're really grateful to all of you for making time to engage with us on what the CMS Innovation Center is doing to advance health equity. Thanks to Dr. Hughes, Dr. Mclver, and all of our panelists for joining us today.

Today's roundtable stems from the Innovation Center's white paper that we released in October and details 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. Key elements of this Innovation Center strategy link back to the Agency's broader agenda to make sure that we're all working together to achieve a larger vision for our beneficiaries and enrollees. 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. Advancing health equity has become one of the most important areas of focus for the Innovation Center, for CMS and HHS more broadly and for the Biden-Harris administration. The roundtable is part of a series of listening sessions to operationalize the Innovation Center's commitment to enhance stakeholder engagement and transparency. As we begin implementing the strategy we've shared, including our commitments to health equity, we want to receive continuous feedback from all of you on how we can better achieve meaningful transformation of our health system and our vision of an equitable outcome for all of America. The CMS Innovation Center certainly has more work to do, and I feel strongly that we can learn a lot from you and from all of our stakeholders as we move forward

with our work. Achieving our vision will require partnership with patient advocates and beneficiaries, community-based organizations as well as providers, payers, purchasers, and states.

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, especially underserved populations, so thanks for joining us, and now I'll turn things back over to our important partner, Dr. LaShawn McIver, Director of the CMS Office of Minority Health, to provide an update on their work across CMS on health equity.

>> **Dr. LaShawn McIver, CMS:** Hello, everyone, and thank you, Dr. Fowler and Dr. Hughes, for the invitation to be a part of the roundtable today to share some brief remarks. As the Director of the Office of Minority Health at CMS, it has been very exciting to see the evolution of health equity initiatives emerging across CMS's centers and offices in this last year. Within CMS, our office serves as the principal advisor and coordinator to the Agency for the special needs of minority and underserved populations. We work across CMS to advance health equity in CMS's programs, policies, and operations to accomplish Administrator Brooks-LaSure's strategic vision for CMS, which is to serve the public as a trusted partner and steward dedicated to advancing health equity, expanding coverage and improving health outcomes. Our Administrator has made it clear that CMS must lead the way for the health care system and that our actions on health equity must be concrete. They must be actionable. They must go beyond observations and into direct, explicit steps we are taking to achieve health equity and eliminating health disparities.

To that end, we at CMS are examining our policies and programs to make certain we understand and are mitigating unintended consequences that impact minority and underserved communities and those safety net providers who serve these communities. Over this past year, our office has worked to drive this important priority area by working to strengthen CMS's health equity infrastructure and to inform our efforts, including performing the first ever cross-agency CMS Advisory Council on Equity comprised of executives from across the Agency working cohesively and strategically to promote equity, also conducting an inventory of the health equity activities in the Agency to better understand what is underway and how we can connect the dots to amplify these efforts, partnering with the Center for Medicaid and CHIP Services to conduct a department equity assessment pilot on quality of care in the postpartum period among Medicaid and CHIP birthing persons, initiating ongoing listening sessions and roundtables as well with stakeholders and organizations representing populations that our office serves, and we are continuing to provide health equity technical assistance to assist health care organizations take action to address health disparities.

In closing, I am incredibly excited to see the intentional equity efforts CMS, CMMI is driving to advance equity. CMS's OMH mission and CMMI's strategic direction are working towards making health equity a shared vision and value that achieves equitable outcomes. Thank you so much for the opportunity to share some of the things we're doing at CMS OMH, and I look forward to hearing from those gathered here today. Thank you so much.

>> **Dr. Dora Hughes, CMS:** Thank you so much. Thank you, Dr. Fowler. Thank you, Dr. McIver for those remarks. We recently had our very first general listening session and launch of it on the CMMI Strategic Refresh, and we are excited to dive deeper into implementation with this first roundtable on CMMI's health equity strategy. As many of you know, just taking a step back, Congress provided CMS authority through the CMS Innovation Center to test innovative models that may preserve or enhance the quality of care for beneficiaries in Medicare, Medicaid and CHIP while spending the same or less. On a tactical level, this means that the CMS Innovation Center can, for example, change the way we pay for

services and then evaluate whether that change improves quality or reduce cost. As described in much greater detail in our white paper entitled "Driving Health System Transformation: A Strategy for the CMS Innovation Center's Second Decade," which can be found on our website, the Innovation Center will be focused on building a health care system that achieves equitable outcomes through high-quality, affordable, person-centered care.

To achieve this vision, the CMS Innovation Center is committed to the five strategic objectives pictured here in this graphic. Today, as you know, we are focused on the advancing health equity strategic objective. As we move to the next slide, health equity is a critical component of health care quality as Dr. Fowler mentioned, also as described by many experts and leading institutions dating back to more than two decades ago. Equitable care has been defined as one of the six aims of a high-quality care system by the landmark report, "Crossing the Quality Chasm," which was released by the Institute of Medicine in 2001. Yet, despite all of our efforts to improve care and outcomes and as underscored by the stark inequities that we've seen during this COVID-19 pandemic, whether we're talking about maternity outcomes or behavioral health among so many other conditions, we have not achieved this aim. That is why this Administration and our CMS Administrator, Chiquita Brooks-LaSure, have elevated equity as a top priority. The Innovation Center will focus on equity in four domains as you see from this slide. First, CMMI will develop new models and modify existing models as feasible to address health equity and social determinants of health. Second, we will increase the number of beneficiaries from underserved communities in our models in part by increasing the providers that serve them, including Medicaid providers and those in FQHCs. Third, we will monitor and evaluate our models with health-equity analyses. And last but not least, we will strengthen data collection and intersectional analyses for populations defined by race, ethnicity, language, geography, disability, and sexual orientation/gender identity. We believe these efforts individually and collectively will help to ensure that all of our beneficiary populations derive maximal benefit from the transformational work of our models and initiatives.

If we move to the next slide, the CMS Innovation Center has already begun operationalizing our health-equity agenda. However, we think it is critical that we reach out to experts in the field who can inform our work. This roundtable is the first of many equity-focused events in the pipeline over the next few weeks and months that will ensure that we are hearing from as many leading individuals and organizations in this space as possible. And so, if you believe your issue or primary concern won't be discussed today, not to worry. We will absolutely be seeking additional perspectives and elevating other priorities in the weeks and months ahead.

Today, we will anchor our conversation around the following three questions. Number one, what approaches or interventions should the CMS Innovation Center prioritize when building models to eliminate health inequities. Two, CMS is currently exploring options for expanding collection of self-reported demographic and social-needs data. What could the CMS Innovation do to support collection of self-reported data? What are successful approaches for such collection? And three, what are the most significant obstacles for safety net providers who want to participate in a CMS Innovation Center or another value-based, accountable-care model, and how do you recommend the CMS Innovation Center help these providers overcome these obstacles?

Each of our experts will provide brief comments on at least one of these questions, and I expect that our panelists will have the opportunity to weigh in on additional questions in the discussion period. We ask when you're not speaking as a reminder that you mute yourselves individually using your phone or the Zoom platform, and for our other attendees, as a reminder, you are welcome to share your

comments in the question-and-answer box. For sake of time, I'm going to provide the briefest introductions for each of our speakers, but we do note that their bios can be found online and through the links that you'll see on the slides that will come up when each of our presenters begin. And so, if we're ready, if we have Dr. Walker, seeking confirmation she is on, our first speaker is Dr. Kara Odom Walker, the former Secretary in Health for the state of Delaware and current Executive Vice President and Chief Population Officer at Nemours Health System. Dr. Walker is responsible for the development and implementation of innovative models of health care delivery that lead to high-quality children's health outcomes. Dr. Walker, thank you so much for joining. The mic is yours.

**>> Dr. Kara Odom Walker, Nemours Health System:** Thank you, Dr. Hughes, and thank you, Dr. Fowler, for all that you're doing to support children, youth and families and promote equity during this conversation today. We believe this work is so critical, particularly for children and youth where early life exposures and experiences impact a lifelong health trajectory. Starting early around equity is really central to how we can create better momentum. So as mentioned, I had the honor before joining Nemours to think about these issues as Secretary of Health, and I will tell you that, considering the levers of Medicaid and considering the levers of the federal government, we can start with equity in mind at the beginning.

First, I wanted to say that I have three specific approaches although I could go on beyond my three minutes for much longer. First, I would suggest creating a standard approach to measuring disparities in health care that measure access, quality, experience, and outcomes but provide technical assistance to those of us in the field who want to make sure we're following the best evidence for high-quality data collection and the best evidence around social screening. Unfortunately, the reason this is a gap is because we know that sometimes these health and social service programs don't connect. We don't have the underlying infrastructure. We're building it as we go, and this coordination of services is critical to achieve and improve social safety net. I think that the most frustrating times that I experienced as Secretary of Health is that we could not necessarily connect the critical data and these data systems needed to be in place for COVID, for equity and for health. If we can use this data and the right technology systems to merge identification of high-risk populations, reveal where those disparities exist, we have better opportunities to engage community partners and think about engagement by race, ethnicity, and zip code.

My second recommendation is that we think about ways to make evidence-based investments through the CMMI levers in equity-focused interventions that are truly cross-sector, bring people together to think about early care and education, nurse-family partnerships, or the mental-health crisis that's in front of us. These investments can go a long way in bringing people together and then creating stakeholder momentum. I think that that's where these multipayer approaches may be more feasible, and when we think about SNAP dollars being leveraged with Medicaid and some of those same families and individuals who would benefit from multiple programs often didn't have access. So, create that sustainable financial model that includes total costs of health care and then close inequities in the short and the long term.

Third, think about finding new state models for alternative payment that commit to closing those gaps in health equity. Make those federal investments that are linked to progress in reducing health disparities and moving to value and risk. This sounds easy, but it's very hard, and CMMI has tremendous levers and capabilities to make sure models are built with equity in mind at the beginning, and states like Delaware, partners like Nemours are just examples of those who are ready to come together with the right expertise to improve health equity. We're trying this with some payers, but the

ability to pull all payers together around multipayer strategies would be tremendous and lift up ACO payment models.

Finally, I would suggest creating a financial incentive for innovation and value-based care, delivery-system reforms and whole-person care, and I'll emphasize that last part, whole-person care, making sure we have partnerships that address the whole needs of an individual: physical health, behavioral health, oral health, which is a longstanding challenge. Long-term services and supports and community-based services around social needs would go a long way to addressing those inequities and the social needs, and COVID has shown how interconnected the family unit is to risk and social needs, yet most of our models are based on risk identification at the individual level and not the family or the community level. So, these overlapping methods to create risk adjustment and social stratification would go a long way to whole-person approaches with new financing methods. So, with that, I'm sure I'm out of time, but thank you so much for the opportunity to share three key recommendations, and I look forward to the dialogue today.

>> **Dr. Dora Hughes, CMS:** Thank you. Thank you so much, Dr. Walker. Our next speaker will be Ms. Mayra Alvarez, who will share her expertise on improving children's health outcomes. Ms. Alvarez is President of The Children's Partnership, a nonprofit advocacy organization working to advance child health equity by ensuring all children have the resources and opportunities they need to grow up healthy and thrive. In 2021, earlier this year, she was named by President Biden to the COVID-19 Health Equity Task Force, and she has a wealth of expertise also from her former HHS and CMS positions implementing the Affordable Care Act. Ms. Alvarez, please go ahead.

>> **Mayra Alvarez, The Children's Partnership:** Thank you, Dr. Hughes. Good afternoon. Thank you for the opportunity to join you today and for hosting this important discussion. Again, my name is Mayra Alvarez. I'm President of The Children's Partnership, and I'm honored to be a part of this discussion. As I thought about this discussion and what I would say, first, I am so honored to be part of this good fight alongside you, and I think about what we need to do to advance our shared goals of advancing health equity. I have three overarching messages to inform the Innovation Center's approaches. That's disrupt, defer, and demand.

In moving forward, we must find ways to disrupt oppressive systems and old ways of thinking in order to better serve children and families. As we have seen from decades of research outlining the persistent inequities in health status and care, while it's essential, it's not enough to highlight racial disparities. The time is now for us to step back and really question the underlying assumptions, shaking the systems that perpetuate such inequities and the policies they implement and, in doing so, move to abolish racism from every institution, every policy and every social norm in which it operates and often, too often, hides. Progress for health equity requires addressing the broader capacity and culture of health care institutions, including collaboration with community partners and those outside of health care, the cultural humility of clinicians, and antiracism training of administrators and staff and government structures. As we seek to advance equity, for example, supporting community health workers, community health workforce moves us further, because it shifts power through partnerships in which people who directly experience the conditions that cause inequities have leadership roles and avenues to share those perspectives and influence health care delivery. However, supporting a community health workforce like Promotores is only possible with fundamental changes in payment and performance measurement.

My second message is to defer. Defer to the knowledge, expertise, and power of communities, including young people. Out of necessity, historically underserved communities created networks of care. They trained community health workers, and they integrated care into the community because the traditional health care system was not meeting their needs or, worse, was mistreating them. Advancing health equity requires building on these efforts and identifying ways to meaningfully incorporate community voice in our care delivery from ideation to execution. Identifying opportunities to strengthen meaningful community engagement is essential, requiring community advisory groups, listening sessions, community leadership and investing in the power of community-based organizations through compensation and through grants as well as developing a process for community input to be considered in decision-making and reporting and reporting back how that decision-making was impacted by community input. This will help ensure our system is responding to the needs of our communities more effectively.

My final message is for us to demand different, demand better for our children, for our communities and for our country. While our health care system cannot address every challenge in society that impacts well-being, it can evolve itself to work in greater collaboration with other partners and emphasize prevention. Advancing health equity requires moving upstream to address social determinants of health, such as housing, transportation and food access, finding ways to strengthen investments made in community-based collaboratives, including medical-legal partnerships, accountable communities of health to assess and prioritize attention to community needs run by community-based entities and partnering with health plans to address those social drivers that require new approaches to funding and greater flexibility, especially in our Medicaid program. I will close by encouraging the Innovation Center to focus on a strength-based approach to advancing health equity, emphasizing the protective factors of race and ethnicity and valuing culture as a health intervention in and of itself. I look forward to continuing to work alongside you to further today's conversation into concrete steps for transforming our health care system. Thank you.

>> **Dr. Dora Hughes, CMS:** Thank you so much, Mayra. I so appreciate your focus and your comments on the importance of our focus on community. We will now move on to our third speaker. Is Dr. Sequist with us?

>> **Dr. Thomas Sequist, Mass General Brigham & Harvard Medical School:** Yes.

>> **Dr. Dora Hughes, CMS:** Thank you so much. I'll introduce you just very quickly. Dr. Sequist is the Chief Patient Experience and Equity Officer at Mass General Brigham and the Professor of Medicine and Health Care Policy at the Harvard Medical School. Dr. Sequist is particularly interested in health-policy issues affecting care for Native Americans and has worked with the Indian Health Service. Dr. Sequist, thank you so much.

>> **Dr. Thomas Sequist, Mass General Brigham & Harvard Medical School:** Yeah, thank you. So, what a wonderful set of comments so far. I will just add a few additional thoughts on top of this.

One is, I think, for CMS and CMMI as you're thinking about programs to advance care broadly, whether -- but in particular when you're thinking about value-based care programs and accountable-care organization models, one of the first principles we should all keep in mind is to, like in medicine, first do no harm, and we need to make sure that we understand that the structural racism and other elements of the health care system that have disadvantaged patients and the facilities where they

received their care for decades don't get further disadvantaged by innovation programs that get in place. We don't want to see payment models, pay-for-performance models and accountable-care models that get implemented and that subsequently or in retrospect are found to have worsened disparity. And a lot of that will involve, I think, some analyses around the potential impacts of the differential payment models and knowing what the performance is on the current quality measures and how they may be impacted by social risk factors.

The second thing I would say is, I think it is going to be really important as we move forward is for payers, including CMS, to work with the provider side of the delivery system to understand, how can we design payment models that help providers and public health systems address the social risk factors that are preventing achievement of high-quality care on some of the metrics that we all value so much, whether that be, you know, how do we fund and enable programs that treat food as medicine? How do we fund and enable programs that allow distanced care televisits, remote blood-pressure cuffs, things that may seem straightforward as an innovation but when they are not funded and our patients can't afford them on their own, they become prohibitive to achieve high-quality care, and I think there are some pretty innovative ways we could think about incorporating different strategies that we know work into payment models that will help address some of these social risk factors that then prohibit performance on quality.

I think that the third area that I think is going to be really important to think about inequity gets to the notion of digital health. I think, you know, all of us saw over the past couple of years just how important digital health is during the pandemic, but unfortunately there have been many, many studies now that have shown that there is a pretty substantial digital-health divide that exists across our patient populations, and that digital-health divide is going to lead to longer-term problems in access to care and eventually quality of care and outcomes. And so how can CMS, the broader payer community partner, again, in a broader sort of coalition sense to address the significant challenges to that digital-health divide, whether they be in terms of core infrastructure at the federal or state level like broadband access or could be in terms of the provision of hardware, iPads, smartphones or software, understanding whether or not the technology embedded in an iPad, let's say, is multilingual or is at a user level that is open and appealing to the broader patient population? There is a lot of work to be done in that digital-divide space, and we have definitely learned across the nation that this is a really critical area for equity, and it is an area that probably is only going to get wider if we don't have a proactive stance on how to address it.

The last thing that I would say is, I'm going to shift gears a little bit and talk about American Indian health care. I think that CMS, CMMI play a very, very critical role in the provision of health care for American Indians. The Indian Health Service receives a substantial proportion of its funding from CMS and Medicare and Medicaid programs. One of the things that is going to be really important is to figure out, how do you partner with the Indian Health Service in a way that does a few things? One is enables better data collection. How do we really track and monitor health outcomes and quality of care for the American Indian population across the country? That is going to require some innovation and integration of data sets and data collection across multiple areas that are both within and outside of the Indian Health Service. And then the second is that we need to innovate in ways that address the very, very unique challenges that exist in many tribal communities that don't exist to that extent in other communities, the lack of, you know, that a third of communities lack indoor plumbing, lack electricity. You know, the high -- the very, very high prevalence of poverty and joblessness and homelessness and other factors, I think, is going to require a little bit of a different lens in working with

the Indian Health Service and other providers of care for American Indian communities, and I would love to see a specific focus on that. Thank you.

>> **Dr. Dora Hughes, CMS:** Thank you. Thank you so much, Dr. Sequist. Now we are ready for our next speaker, Dr. Cara James. Dr. James is President and CEO at Grantmakers In Health. Prior to joining GIH, she served as Director of the Office of Minority Health at CMS where she championed the first CMS equity plan to improve quality of Medicare, its first rural health strategy and supported the increased collection and reporting of demographic data. Thank you so much, Dr. James. I'm turning the mic over to you.

>> **Dr. Cara James, Grantmakers In Health:** Thank you so much, Dr. Hughes, and also to Drs. Fowler and McIver for this session and for being able to speak. I'm not going to be quite as pithy as Mayra with her disrupt, defer, and demand, but I do have several recommendations for how CMMI can support the collection of data on race and ethnicity as well as the social demographics.

Similar to your model in your paper, I would encourage you to first build it in at the beginning, to think about building on some of the strategies that CMMI has used in the past, for example, with the Disparities Impact Statement to make sure that model participants are building that data-collection strategy at the beginning as well as in a strategy to utilize the data as it is being incorporated throughout the model life.

Second, I would encourage you to use the data throughout the model life, to look at it, to hold people accountable for the collection, the missing data, and encouragement and resources to be able to understand what's happening with disparities as the models are being implemented.

Third, I would say to make sure that you're providing the technical assistance and resources that are needed, and fourth is to collaborate and lead, and to just delve into those a little bit more, as we think about the Disparities Impact Statements as that opportunity to incorporate and build into the model, how will the data be collected, utilized, maybe partnered throughout different sources of information that can be leveraged to understand who's being served in the models, including the providers that are participating in those models and how they represent the needs of diverse communities as well as what is missing and how quality is changing or outcomes are improving throughout the life of the model. Encouraging both CMMI and the model participants to utilize the data that is coming through, incorporate that in conversations around model check-ins, how that's going with the participants in cases where there may be recruitment issues or other challenges. Have that be a routine part of the model check-ins with the participants to know that -- to signal that CMMI thinks that this is important and is leveraging that information to make sure that we are holding people accountable for equity throughout the model course and not just at the end when we do an evaluation.

Third is to provide that education and technical assistance. We just in collaboration with NCQA released a report a month ago and recommendations of how we can improve federal data on race and ethnicity, and some of the challenges that we heard from the stakeholder interviews that we did representing health plans, providers and others across the health care system and sector is that there is a lack of understanding of what is legal and also possible in terms of data collection, that people sometimes lack the resources in terms of those best practices of how to collect the information and to express the importance for the participants in terms of the need for providing that information, be it race, ethnicity or other social demographic characteristics. I think that CMMI can help to lift up some of the resources that are available to promote that education and help provide technical assistance to



some of the model participants. One of the other barriers that we heard is sometimes in speaking to your third question in cases with some of the safety net providers who may not have necessarily the resources to do the analysis themselves to think about ways in which CMMI can partner and collaborate with those participants to utilize that data to help inform some of the conversations and the programming that's going forward.

And then finally I think I would lift up as well the need for CMMI to collaborate, to make sure that it is not only cross-agency collaboration across partnerships with other centers for Medicaid and CHIP services or CCSQ or CM but also to lead and collaborate across the federal government. One of the biggest challenges that we have with regards to data and race and ethnicity that we've heard over and over again is the lack of state and federal standards, making sure that those standards reflect the needs of the current population as well as those challenges and that opportunity to work across so that the work that's being done by CMMI and the model participants, we're going to have to make that investment, isn't viewed just as for the life of the model but as something that is throughout the programming that they're going to be having, which will help to increase that incentive for collecting that information. I think that CMMI can help with the lessons learned in the models that can be shared across other sectors in the government to improve that collection and collaboration and to push for updated, more current standards and clarification around what is possible to promote also that interoperability. Again, thank you for the opportunity to speak today and look forward to the further collaboration and partnership.

**>> Dr. Dora Hughes, CMS:** Thank you. Thank you so much, Dr. James. So, our next speaker is Ms. Cancio. Just to introduce, I just want to do a check. Is Ms. Sinsi Hernández-Cancio -- Is she here?

**>> Sinsi Hernández-Cancio, National Partnership for Women & Families:** Yes, I am. Thank you.

**>> Dr. Dora Hughes, CMS:** Okay. Thank you. Just to introduce, she is Vice President at the National Partnership for Women & Families where she leads the Health Justice team. She is a national health equity policy and advocacy thought leader with more than 20 years of experience advancing equal opportunity for women and families of color and advocating for increased health care access and improved quality of care for underserved communities. Thank you so much for joining. I'm turning the mic over to you.

**>> Sinsi Hernández-Cancio, National Partnership for Women & Families:** Thank you so much, Dr. Hughes, and thank you for this invitation to speak about this incredibly important issue, and that is ensuring that health-system transformation that we all understand is desperately needed in this country, actually advances health equity and does not inadvertently expand and deepen racial and ethnic health and health care inequities. I think my first point is -- It's really important to be explicit about addressing the impacts of racism and other inequities, both in health care and outside of health care, and by that, I mean we are really -- we understand that there is a big difference between -- There are income inequalities. There is intersectional identity that has a real impact on how people interact with structures of oppression and differential access to resources and differential exposure to risk, and it is still really important to ensure that we are focusing on how racism specifically is affecting outcomes and health for a whole host of different communities and understand that in a intersectional way, which is why I was very excited about in the presentation earlier that one of the points is about doing more of this intersectional analysis.

For us to be able to have a bill-payment system that actually advances health equity, there are several things that are needed. First, we need to have better and more inclusive and transparent evidence and be very clear about the fact that there ... the evidence for a lot of care is lacking in terms of its diversity and also in terms of focusing on the kind of outcomes and measures that patients care about. The second point is that it's important to have better and more stratified measures, and that is where the collection of self-reported data on race and ethnicity and other demographics is super important. Number one, we know that there is a lot -- There are many challenges in not having your race self-reported or ethnicity self-reported in that you can't -- We need to make sure that it's not like the front-desk person or a nurse or a doctor making assumptions about a person's background based on what they look like. The other thing that's really important is to ensure that we totally understand the importance of having kind of index and kind of composite measures for things like, rating programs and so forth, but it does not -- It's not a substitute for actually having disaggregated, stratified results for -- to be able to deeply to deep down dig into, what are the specific disparities and inequities that a community or a group faces in a particular condition or for a particular outcome and also to help track and have accountable on how you're doing to improve them.

Other things that are really important, and folks have already talked about this, is that it's not enough to just have partnerships with community assets. It's really important that they are resourced and funded, right? Yes, we need to make sure that these systems are talking to each other and that the warm handoffs happen when you do use the social screeners, et cetera, but we also need to understand that, for a lot of these communities, the infrastructure in terms of the entities that are there to be able to provide culturally centered, high-quality care and address social needs, are entities that are incredibly underfunded and cannot be expected to be able to provide, add people to their roll, so to speak -- as CMMI and CMS have stated that we want to end up eventually in a place where all payment is value-based. How do we make sure that, in doing so, we are supporting safety net and small community providers to be able to participate in that, in those kinds of models when we know that those providers and those safety net entities have been underfunded in some cases for generations?

So, in sum, I would say that our number one priority is to ensure that we have accurate data collection that -- and that results in anything that we are measuring is -- are stratified demographically. You measure what you treasure, or something that I also learned representing the government of Puerto Rico for a while was, if you're not counted, you don't count, and for many of our -- And we saw this at the beginning of COVID. We saw how there was a lot of improvement depending on the state, but there were some improvements, and we need to make sure that we build on that so that we are really able to target and find where we're lacking and so that resources and efforts can be targeted accordingly, and we can make sure that there's accountability. And so, the last thing that I will say, and I'll end on before -- I'm not sure how I'm doing on time, but the other thing I would say from being an organization that has -- or the first organization that was patient-centered, community-centered, engaged in health and transformation is that you need to engage patient and families early and often. It's not just at the evaluation stage. It's building it. It's identifying, what are the problems that you're trying to solve for. It's resourcing that engagement. It's reporting back and continue -- having continuous engagement is the only way we're going to be able to address some of the biggest barriers that a lot of communities face and that we've seen in -- especially in COVID, which is the lack of trust between patients and communities and the medical industrial complex, and that's not just people trusting science and their doctors. It's also, how do the system function in a trustworthy, trust-earning way. Thank you very much. I very much look forward to continuing this conversation, and I send it back to you, Dr. Hughes.

>> **Dr. Dora Hughes, CMS:** Thank you. Thank you so much for your comments. I think measure what you treasure is a new variation that I've heard and will certainly have to -- That's a keeper. So, I would next like to unmute our sixth speaker, Mr. Benjamin Money. He is a Senior Vice President at the National Association of Community Health Centers. Prior to joining NACHC and just in June of this year, Ben led the North Carolina Community Health Center Association and also served as a Deputy Secretary for Health Services. He was recently awarded the 2021 Foundation for Health Leadership and Innovation Community Achievement Award for his impact on health and equity across North Carolina. We are so pleased to have you join us today. The virtual floor is yours.

>> **Benjamin Money, National Association of Community Health Centers:** Thank you, Dr. Hughes, for the opportunity to share the perspective of community health centers regarding obstacles and opportunities for safety net providers and value-based APMs. CMS and health centers share a common berth and mission. We began in 1965 to bring about health equity in communities systematically excluded from health services due to race, ethnicity and income. Health centers, also known as FQHCs, are patient-governed and grounded in health equity for marginalized communities. The COVID-19 pandemic demonstrated that stark disparities continue to exist. We must work together on our mutual goal of health equity. Today, health centers serve as the largest primary care network in the Medicaid program, providing care to some 13 million Medicaid beneficiaries or one in five nationwide. Twenty percent of our patients are uninsured. Ninety-one percent are low-income, and 58 percent are racial or ethnic minorities. Our patients have higher rates of chronic conditions and require greater care coordination. We save Medicaid \$31 billion a year. Most health centers operate on thin financial margins, and all reinvest revenues back in patient care. We support value-based reforms focused on investments in comprehensive primary medical, dental, pharmacy, behavioral health and enabling services, allowing us to operate outside the walls of our clinics to address upstream causes of social drivers of health. Unlike other providers, health centers have federal requirements ensuring services regardless of a patient's ability to pay or insurance coverage. Our PPS system must be preserved and protected as a foundational payment. Managed care organizations often don't align their value-based payment models with the LAN APM Framework.

CMS should direct MCOs towards consistent value-based models designs to reduce administrative burden. The most common problems include patient assignment, varied requirements for credentialing, performance, quality measures, reporting and billing, also inaccurate and late payments. Short timelines for progression along APM models are also common. There is no one APM that will meet all of our needs. We request the opportunity to develop and present to CMMI models that will address our variation in size, locality, and scope. Value-based care APMs must build upon the unique comprehensive features of FQHCs, provide upfront investments in operational data and analytics infrastructure, adjust payments for social drivers of health and chronic disease burden, recognize the FQHC as a medical home, not just assignments based on cost of care, promote team-based care and patient empowerment, invest in successful strategies, such as telehealth, e-visits, remote patient monitoring, group visits, community health workers, 340B pharmacy and community paramedicine.

We should also allow time for learning and refinement of processes and self-paced progression, provide access to all available real-time clinical and claims data, use common race and ethnicity measures, and promote multi-payer alignment and reduce administrative burden. Federal statute requires health centers to have formal agreements for referrals at discount services for sliding-fee patients. Please honor these agreements and not force health centers into networks. In states that have not expanded Medicaid, we are less able to invest in the infrastructure or value-based payment

to necessarily manage the risk and particularly manage downside risk. We hope that FQHCs will continue to have these opportunities to participate in programs. FQHCs hold a unique risk in providing services to all without the assurance of additional federal support if economic conditions shift. CMMI should consider alternative approaches to downside risk for FQHC, and in conclusion, we welcome the opportunity to partner with CMS to develop APMs to advance the quintuple aim through investments in community health centers. Thank you.

>> **Dr. Dora Hughes, CMS:** Thank you so much, Mr. Money. Now we will turn to our seventh speaker, Dr. Veronica Mallett, who serves as the President and CEO of Meharry Medical College Ventures. In addition to her contributions on addressing health disparities, Dr. Mallett has also served as the executive director of the Center for Women's Health Research, with extensive research and care delivery as a board-certified obstetrician and gynecologist. Dr. Mallett, thank you for joining us. Please go ahead.

>> **Dr. Veronica Mallett, Meharry Medical College Ventures:** First, let me take the opportunity to say - my camera is on. I'm hoping to be seen and heard. Am I being heard?

>> **Dr. Dora Hughes, CMS:** We can see and hear you. Yes.

>> **Dr. Veronica Mallett, Meharry Medical College Ventures:** Oh. Excellent. Okay. To express my appreciation for the invitation to Dr. Fowler and you, yourself, and to the other panelists for their excellent ideas and presentations this morning.

There are several obstacles to safety net providers entering into the value-based pay space, and I am going to address a few. Most community-based providers have, even Meharry as an academic health center, many barriers to entering into the care and serving marginalized and vulnerable communities. The primary barrier for entering into the value-based space is the capital needed to respond to the increased staffing, training, and the data that is required in order to respond to the needs of most of the programs. The additional challenges are that the safety net providers and their staff require technical assistance in preparation for participation, and early investment from CMS similar to the AIM model, to overcome the barrier of the lack of capital, and design would help. Designing models that sort of provide an on-ramp with lower risk levels to ease the transitions would be very helpful. Lack of appropriate and timely data prevents appropriate risk adjustment initially and often leads to a cycle of losses and inappropriate premiums to start. Once enrolled, safety net providers encounter numerous barriers to sustainability, starting with the practice of re-basing, which happens to disincentivize those who are able to fully realize savings once created, and these really are challenging for safety net providers if they are able to meet the metrics. Many providers express frustration and often drop out of these programs, and CMS had modified this methodology so that providers are rewarded consistently for appropriate spending and outcomes. And lastly, the current benchmarking really isn't designed with equity in mind. It's based on the assumption that historic spending utilization can always be lowered while maintaining or increasing quality. I would submit that in marginalized and vulnerable populations, that is often not the case. In fact, in order to achieve the desired outcome, more spending, more services are often needed, especially initially, and those services would include things that are often not covered, like was mentioned by the prior speaker, community health workers, remote patient monitoring, social workers, oral, and digital health, culturally appropriate nutritionists, and community investment in innovative approaches to overcome barriers steeped in adverse social determinates of health. CMMI should consider incentives for specialists so that in those states, like Tennessee, where I am, that have not expanded Medicaid, there are many challenges to finding

specialists that are willing to take our patients and provide continuous care for the whole patient, and this would require that CMMI develop a risk adjustment methodology that considers the historical under-investment in our communities as well as the adverse social determinants of health. Thank you so much for your willingness to listen to new ideas and hear our challenges, and we look forward to working with you towards the goal of health equity.

>> **Dr. Dora Hughes, CMS:** Thank you. Thank you so much. We will now move ahead to, I believe, our eighth speaker. Miss Carrie Cochran-McClain, are you on?

>> **Carrie Cochran-McClain, National Rural Health Association:** Yes. I am here, Dr. Hughes.

>> **Dr. Dora Hughes, CMS:** Excellent. Miss Cochran-McClain is the Chief Policy Officer at the National Rural Health Association. In this role, she is responsible for driving the policy agenda for rural health for the 21,000-member organization. Miss Cochran-McClain has more than 18 years of experience working on federal health policy development, including leadership roles at the US Department of Health and Human Services and the Federal Office of Rural Health Policy. Thank you so much for joining.

>> **Carrie Cochran-McClain, National Rural Health Association:** Thank you. So, it's my job today to talk about question number three, and as I jump in, I think I just want to echo so much of what the other panelists have said. I really appreciate the time and attention you are spending on this issue and honored to be part of the conversation.

So, similar to what a lot of the other folks said, rural communities have been really systemically and generationally underfunded, I think, inadvertently frequently due to policies at the state and federal level, and so, when we start to have this conversation about introducing programs and services and moving into the space of social determinants of health and really trying to tackle issues around chronic disease and vulnerable populations, I think it's really important for us to remember that it may take years, maybe even a decade, before you really start to see the kind of change you want to see, especially in the cost savings arena, and without kind of that realistic perspective, I think there is a real concern that how you're calculating savings and success of a model may be short sighted. So, with that, I'm going to talk a little bit about a few of the obstacles that rural safety net providers face when participating in new value-based programs.

So, first, I think is issues around structural and eligibility barriers. As many of you may know, rural alternative payment model types, such as critical access to hospitals and rural health clinics, haven't been engaged in model development in the same way as others to date, and because of that, may not have the same readiness to purchase a pay in innovation. Secondly, kind of a predominantly fee-for-service payment system makes it really challenging to shift only part of your care delivery and payment to be part of these models. So, one of the more promising things we've seen in the rural spaces of global payment, but it's challenging to really engage payers in a meaningful way across Medicare, Medicaid, and when you start factoring in Medicare Advantage and MCOs and then private insurance, that's a big hurdle for a lot of rural providers, and it's not done easily. I think similar to others, although a bit unique, rural struggles with patient volume, right? It's just part of how we're created, as we have low volume. And so, frequently, there aren't adequate numbers to participate in demos or for, like, significant evaluation, so we really want to think about practices with small patient populations, thinking about the kinds of measures that are used. Think about as many others inside the patient population being served, being more complex, and potentially more expensive, and just what that means to care for those folks when you're talking about geographic locations that may require long

distances or special supports to really engage in adequate care. And last, in terms of challenges, is just thinking about inadequate financial sustainability for these folks. They have limited capital, both monetary and human capital, to engage in efforts, and so, models really need to have kind of a front-end investment, and the need for delayed downside risk and lack of immediate cost savings doesn't mean that it's not successful. It just means that we may need to think about how we define success and look at performance in ways other than cost savings, such as increased access or increased quality. I think, just my closing remarks would just be to think about when we're designing these programs, rural is different than urban. There is just a different makeup of the patients and the providers there, and so really thinking about factors considering model design, like number of beneficiary enrollment to participate or the volume and quality pieces, the cost of those needed, and really to focus on areas where rural thrives, which is small communities, laboratories of change, thinking about the small, rapid-scale implementation that we can do in these communities and how there's already a natural kind of tendency towards care coordination and engaging interdisciplinary teams and alternative models like community health workers, and really building on that and then paying that adequately for population health improvement. I'm going to turn it back. Hopefully, I stayed within close to my three minutes.

>> **Dr. Dora Hughes, CMS:** Thank you. Yes. And I will have to say, unfortunately for the last two speakers, we will strongly encourage you to stay within your three minutes, as we are now looking at the time, so we have a little bit of time for discussion. So, it's the unfairness of going at the end of a series of speakers. Next up, we have Dr. Karthik Sivashanker. He is the Vice President of Equitable Health Systems & Innovation in the Center for Health Equity at the American Medical Association and a Medical Director in Quality, Safety, and Equity at Brigham Women's Hospital. He is a psychiatrist at the Justice Resource Institute and serves as a faculty member at the Institute for Healthcare Improvement. Dr. Sivashanker, thank you so much for joining us. Please, go ahead.

>> **Dr. Karthik Sivashanker, American Medical Association & Brigham Women's Hospital:** Thank you, and just want to express my appreciation for CMS and leadership for taking this so seriously and approaching this so thoughtfully, and I'm here on behalf of the AMA Center for Health Equity and the AMA broadly. As mentioned, we are very committed to advancing racial justice and equity within and across all aspects of health care. So, maybe I'll just begin by highlighting some of the unintended consequences that we've seen with past efforts as a step toward then talking about approaches and interventions, and I know that some of this is stuff we already know, but, you know, there was some emerging evidence that physicians who are currently for our most historically disadvantaged patients, as an example, dually eligible patients had some very lower MIPS scores, so just encouraging us to be thoughtful regarding alternative payment models that may unfairly financially penalize clinicians who treat patients who are historically disadvantaged and/or oppressed, who are, as a result, more likely to be medically complex as well. And then along the same lines, I'm thinking about how more affluent organizations may have unfair advantages in having the necessary resources to invest in quality improvement programs or to adopt alternative payment models as compared to, for example, safety net organizations or other lower-resourced organizations that actually take care of the disproportionate share of our historically marginalized patient populations. And then finally, just thinking about CMS's transition to the Medicare shared savings program measure set. We're a little bit concerned about the movement to all-payer data that may penalize practices that actually treat patients that have a higher proportion of social risk factors and potentially force them to drop out of the program, in assuming that all insurance coverage is equal, and that patients have access to equal coverage and benefits regardless of the payer, and also compounded by the fact that there is no risk adjustment models to make sure that the scoring methodology and the measures are equitable.

So, in terms of approaches and interventions to consider, we were encouraged by CMMI's refresh strategy in terms of having a commitment to improving risk adjustment with accounting for social and structural drivers of health, and we'll just say that it's important that we reimburse physicians adequately -- to incentivize care for and devote the resources needed for key good outcomes for historically minoritized patients and communities. We were also encouraged by some of the proposals mentioned, the APM proposals for emergency physicians and oncologists, to help fund patients to safely transition back to the home or community and wraparound services. We would also encourage CMMI to provide adequate resources to physicians since practices and health care organizations caring for patients and populations who are systematically disadvantaged actually achieve better outcomes, including considering the use of up-front payments, and this gets back to another speaker's comments about how we're evaluating impacts because we know there's a mandate to reduce cost without lowering quality. That might require reevaluation of the models and looking further out than a year, because it may take many years to actually assess the savings. And then finally, really thinking about whatever approach your intervention, being proactive and developing a robust strategy for monitoring for unintended consequences to historically disadvantaged populations and intervening if unintended harms arise and really thinking about what are focused approaches that are maybe needed to meet the needs of communities, and at minimum, avoiding causing differential harm with any new programs, and ideally, improving outcomes for historically minoritized and marginalized populations. Thank you.

>> **Dr. Dora Hughes, CMS:** Thank you. Thank you so much for those important points. And next, and I believe we are at our final speaker, so I would say last, but certainly not least, our tenth speaker, Dr. Alice Chen. Dr. Chen serves as the Chief Medical Officer at Covered California after serving as the Deputy Secretary for Policy and Planning and Chief of Clinical Affairs at the California Health and Human Services Agency. Dr. Chen, thank you so much for joining us. We're turning the mic over to you.

(Delay)...Unfortunately, Alice, we're not able to hear you.

>> **Dr. Alice Chen, Covered California:** Can you hear me now?

>> **Adam Obest, CMS:** Yes.

>> **Dr. Dora Hughes, CMS:** Yep. Thank you.

>> **Dr. Alice Chen, Covered California:** Okay. How many years has it been? Alright. I can figure this out. Can you guys see me?

>> **Dr. Dora Hughes, CMS:** Yes, we can see and hear you perfectly. Thank you so much.

>> **Dr. Alice Chen, Covered California:** Okay. Thank you, Dr. Hughes. First, I want to thank CMMI for your prioritization and leadership on health equity. I heard that you wanted me to keep it brief so we can have our discussion.

So, I have three general recommendations, and a couple specifics under each one. So, top line, we need to focus on data, on alignment, and on new partnerships. So, for data, a lot of your previous -- or I heard a few speakers have sounded similar themes, but data is foundational. We have to move to a place where a collection of self-reported demographic and drivers of health data is routine for all

programs. We need to be clear about why we're collecting it and how we're using it. So, in some instances, like language, transgender status, disability, and drivers of health, we need it for point of care, but equally importantly, we need to stratify our data to understand how we're doing and how to prioritize and target investments and adjust our payment models. So, I'm just going to get granular on you for a second because I think this is so important. We need to revamp our framework for collecting race and ethnicity data because it's currently confusing, and it leads to incomplete and inaccurate data. Specifically, we have to move towards a combined race/ethnicity framework. Here in California, where we have large Latinx and Asian-American populations, the current OMB 15 framework just doesn't make intuitive sense, and then on the drivers of health side, we need to take what we've learned from successful CMMI models that had screened for drivers in health and make them universal across all programs, and I just want to flag that this is a really timely discussion because next week, NQF -- National Quality Forum -- is going to be voting on what I believe are the first drivers of health measures, and if we're serious about equity, we need to both screen people for health-related social needs and understand what extent of that need is, again, so we can really figure out where do we invest our resources.

The second point is alignment, key to improving population health, and I want to call out two specific elements on alignment. The first one was mentioned by one of the previous speakers. We need to align on purchasers because it's too fragmented for the front-line providers. As big as Medicare and Medicaid are, each of them only covers about 20% of Americans, and so I understand that CMMI's primary charge has been to focus on Medicare, but given how segregated our health care financing and delivery system is, Medicaid has to be central to any work on equity, and I know you're moving there. And then I would argue, and obviously, I'm biased here, that the marketplaces have a key role to play as well. We pick up where Medicaid leaves off. Here at Covered California, more than 60% of our enrollees are below 250% of federal poverty level, which is a little bit more than \$30,000 a year for individuals. So, still people who are really living on the margins, particularly in a high-cost state like California. So, I would say that CMMI should start with the three Ms of Medicare, Medicaid, and Marketplace and invest in multi-payer models that are geographically focused, because particularly for vulnerable communities, health happens locally. And then the second piece of alignment is we need to align on measurement. There are just too many measures at play and just too much variation across programs, and the sad truth is that health care providers, again, are not equipped to improve on more than a few things at a time, so while each program has different populations -- you know, Medicaid is moms and kids, Medicare is over 65 -- and will need to have measures that are specific to those populations, we need a person on this, and I'm saying fewer than 10 that are core across all the programs and tied to both key drivers of morbidity or mortality and stratified and targeted for disparities reduction. So, I would just say, hypertension, diabetes, colorectal cancer screening are no-brainers across all these programs.

And then lastly, if CMMI wants to not only make health care more value add -- you know, cost and quality -- but actually create models that improve health, we need to think about new partners, and I know you're going there already, but first, particularly in the context of historic investments and infrastructure -- so, the infrastructure investment and JOBS Act, you know, the proposed Build Back Better Act -- there are a lot of investments in the social safety net, and CMMI should really fund provider organizations not to directly provide food, transportation, or housing, but to build linkages to community resources that have expertise in these services. And then lastly, I would urge CMMI to think about having engaged health plans. As a nation, we've migrated to using health plans as our intermediaries. Almost every state has transitioned to mimicking managed care. Medicare Advantage is now 40% of Medicare, and of course, the marketplaces are predicated on working with insurers in



the individual market. Traditionally, CMMI hasn't worked with health plans, which I think leaves a lot of potential levers unused. So, I'll stop there, and I look forward to the discussion.

>> **Dr. Dora Hughes, CMS:** Thank you. Thank you so much. I just wanted to just take a moment and thank all of the panelists for their remarks. It's already been a brilliant conversation, and certainly on our end, we've been taking frantic notes. I will, and I'm trying, if everyone wants to turn their cameras back on, we could start the discussion. We have less time than we hoped, but we still have a good 20 -- or perhaps just 15 minutes -- to talk.

I'm just going to go over the themes super, super quickly that I've written down, and not in any particular order. Many of you have touched on the critical importance of data collection, having clear federal standards for disparities and data collection. A number of you have touched on the importance of community. I'm not going to be quite as pithy as Mayra's statement, but just the importance of it, and also partnering with them from conceptualization all the way through to evaluation. I think we heard quite a bit about, and we intend to, include greater numbers of safety net providers in our models, but there's some very practical challenges, whether that's through infrastructure, payment, etc. I think Dr. Mallett was also talking about benchmarking, re-basing, just our general payment approaches that others have focused on, the need to think about risk adjustment. That is just a major area of conversation that we need to be mindful of. I think the time commitment and also thinking about how are we measuring success beyond cost savings would be critically important. A few other issues that I also just want to mention -- the partnerships, I think that, in many ways, ended on a really critical point -- how can we engage not only community partners, social service safety net, but also more plans?

I just want to start off with a first question, and feel free to unmute yourself and weigh in. Across all of the different conversations that you heard, knowing that you only had three minutes technically -- we're going to put an asterisk by that for a few of you -- but are there any other issues that you think are considered to be top priorities that no one has touched on today that you think we should talk about for the next one to two minutes before we move on to our specific questions? (Silence....) Okay. So, I'll take the silence as everyone thinks that everything has been covered. So, then, I would also flip the question in a little bit of a different way and say we've heard a lot over the last hour and a half, and is there a way to prioritize the issues that you would think CMMI should especially work on, and as a starter, I would say clearly data has to be among the top priorities, just thinking about the number of you who mentioned data collection regardless of the bent of your comments. What would you consider the other one to two priorities that we should especially focus on moving forward?

>> **Mayra Alvarez, The Children's Partnership:** I can start. I think in addition to data collection and the who, the why, the what, the how, I definitely appreciated my fellow panelists' specifics around that. I think really centering community experience, and what does that actually look like? Part of the opportunity that the Innovation Center has is to explore new approaches, is to really use innovation in a way that responds most effectively to our communities in need, particularly marginalized communities, and really working in partnership with marginalized community -- what does that look like? Particularly from the federal government's perspective. This is really thinking outside the box and ensuring that we are being responsive to community voice, community leadership. It's going to be critical. The past couple of years living in this pandemic has demonstrated that without community partnership and leadership, we cannot be successful in fighting health inequities. We cannot be successful in education and promotion of vaccines, in anything without working in partnership with community, but to do that meaningfully is more than just, you know, putting out a grant program. We

know that. That is absolutely important to put out those resources, but who receives those resources, how they're selected, the reporting structure associated with it, the application process -- there are many different elements that really have to challenge our federal government and how we work with community more effectively, and I think the Innovation Center can really be in that.

>> **Dr. Dora Hughes, CMS:** Thank you for that. And so, I would love to see, Dr. Sequist, as the Chief Patient Experience Officer, if you had 30 seconds of additional comments to build on Mayra's comments and also, since perhaps with your perch at the partnership, also, if you want to provide any more detailed thoughts on the community experience, patient experience, and how we should we thinking about that here?

>> **Dr. Thomas Sequist, Mass General Brigham & Harvard Medical School:** Sure. I totally agree that the notion that we can address some of these quality issue without taking into account all of the community-based factors that are at play is sort of -- it's an impossibility, right? And so, what we need to figure out is if -- and this is sort of maybe what I was talking about before -- if we are to deliver these social risk important care plans, we have to have the resources and the connections and the partnerships available to actually do that. So, the first really important step is to acknowledge whether your patient has electricity or not or stable housing or food, because if you don't acknowledge that at all, then all is sort of lost, but the second question is, "Okay, what is a reasonable plan, a partnership plan, between the delivery system and the community and public policy officials and public health officials?" And then the third is, "Okay, have we created the funding mechanisms and pathways to implement those paths?" I think that, like, as a nation, we're probably not very far along in that pathway, when you think about, you know, we probably don't even do a good enough job at step one and collecting the information about whether or not our patients have food hunger, food scarcity, or other risk factors, and then going through those other steps, I think is going to be, you know, work for the next several years.

>> **Dr. Dora Hughes, CMS:** Thank you. Sinsi, do you have 30 seconds? 30?

>> **Sinsi Hernández-Cancio, National Partnership for Women & Families:** I would endorse everything that Dr. Sequist said. Absolutely. I think it's important to also acknowledge that there is additional challenge when it comes to the -- it's not just the social needs that need to be assessed, but also where people are kind of emotionally and spiritually and mentally, right? There is a deep cost of existing in this country in a Black or Brown body that is often overlooked, and that's not about race being a social construct. I mean, it is a social construct, but nevertheless, that social construct hurts us, and so how do we address the undoing of that in ways that are cognizant and respectful of where people are coming from in terms of their culture and the assets and supports that they have in their families and in their communities?

>> **Dora Hughes, CMS:** Thank you. Thank you. I have two other quick questions that have come to mind. They're different, so I'm going to say them both, so then you'll have a 30-second heads up to know, then I'm going to ask.

Kara, Dr. Walker, I would love to -- with as much as we're focusing on working with community from the hospital health system side, I would love to hear your thoughts in terms of engaging in these multi-sector partnerships and reflecting on CMMI models. Are there ways that we can better facilitate that? And then, Dr. James, in terms of data -- I'm going to pick on you because you were at CMS, and so you know this area deeper possibly than some of the operational challenges. Understanding the difficulties

or the timeline, really -- well, difficulties and timeline with collecting self-reported data, but knowing that we want to get started now with our equity work. So, there's a bit of a mismatch. We want the data now, but we know it'll take some time. What are some of the bridge mechanisms -- what are some of the interim ways that we can use data that you would consider to be acceptable or recommended, whatever the right term you can choose to use? So first, Dr. Walker, I'm going to turn to you to tell us just some practical advice and experience briefly from the health system perspective and working with communities.

>> **Dr. Kara Odom Walker, Nemours Health System:** Absolutely. I think that health systems have a unique opportunity to provide as a gathering and convening point to think about social determinants in the role with communities, whether it's more broadly as kind of an anchor institution where we're thinking about our role in those communities that we serve and bridge the gap with the relationships and the community-based partnerships. I think the incentives have to be there for health systems to do that work, to build the workforce around community health workers and other types of programs that allow us to create the inner connection and do the social screening and make sure we're actually not just screening, but we're actually intervening. I think there is a lot of opportunity there, but I think there is also a gap in making sure that the financial incentives are flexible enough for health systems to make that transition, and I think that's where we often, as health systems, get caught, because you sort of need to put up up-front investments to make the transition, but you also need to continue to have sustainable financial models that go forward and often are much beyond a one-year contract cycle with your payer partners. So, the levers that exist to create these multi-payer models, I think are great incentives, particularly when we're thinking around equity and measuring those inequities and creating alignment in those metrics, because if it's 50 measures that are all different inequities, we will have a very difficult time focusing and prioritizing where to get started. And so, I think that's a place that CMMI can play a role to make sure health systems are empowering, to think about bridging the gap between what they do inside their walls and how they do that work outside their walls.

>> **Dr. Dora Hughes, CMS:** Thank you on picking up that important point, Dr. Chen, being parsimonious with measures and thinking about those that are most important. Dr. James, on the hot seat, what are we doing interim? And be very specific.

>> **Dr. Cara James, Grantmakers In Health:** Okay, so, one, I just want to build on that collaboration piece as well, that I think there's opportunity to engage philanthropy and funders. We're part of the health funders network before joining CMMI, and I think there's that opportunity to engage with philanthropy early on in the conversation to support and also to help with dissemination of best practices.

On the data hot seat, I think one of the questions that has to be kind of answered is what's now, what's possible, what do you need, building blocks for the future. I think in the now, when you look at the model participants and who they are, many of them are already collecting a lot of this data, so maybe it is not necessarily that CMMI needs to be collecting the data, but leveraging those model partners participants who already have that data, to get that submission to you so that you can also use the data to evaluate the models and thinking about how you bridged that. So, that would be one, I would say. Everybody is focused on this at this point, so again, giving them the guidance, standards, opportunities for making sure that people know that there are data standards out there that can be used. They're not perfect, but at least that gives you some uniformity of comparison. I think also, working, as we said, cross-collaboratively across the different centers within CMS that have different capabilities to leverage that data opportunity to collect, to put that in there, or maybe reporting

through other places that could support that. So, I would say CMMI may not have to do it all, but working with some of those existing channels. And then I think, again, the one big push that we would love to have that you've heard is those standards. How do we update the standards so that we can get better data that's more reflective and also across all of the communities, payers, providers so that collaboration, working with, you know, Carrie at HRSA and other -- IHI, NRHA, other providers and groups out there so that there is an all-hands-on-deck push on the data.

>> **Dr. Dora Hughes, CMS:** Thank you for that. In our final few minutes, we have talked about unintended consequences -- avoid all harm or do no harm, I think, was how it was phrased. I really think and know, certainly when we talk about payment methodology, that is a classic case where we want to make sure we're not causing any harm or exacerbating any inequities that we've seen. So, with that, I know my colleague, Purva Rawal, who is our chief strategy officer at CMMI, has been giving a lot of thought, particularly in this safety net context, and so I can imagine Dr. Mallett, Mr. Money, Miss Cochran -- I mean, many of you may want to jump in, but I'm going to turn the mic over to Purva just to perhaps ask the final question, and then we can do another round robin before we close out.

>> **Dr. Purva Rawal, CMS:** Thanks, everyone. I really appreciate the opportunity to listen today, and to ask a question. You know, I think there were themes that Dora had laid out in her questions for today - - data, intervention, and options for safety net providers being the three big buckets, and we heard a lot about a lot of the challenges, especially Dr. Mallett and Mr. Money, about some of the challenges facing safety net providers, and I'm just wondering if you can maybe talk about what you think maybe the most significant one or two challenges are for safety net providers and participating in value-based care and payment, the complexity of the capital, and then one or two ideas for addressing those challenges.

>> **Benjamin Money, National Association of Community Health Centers:** You know, I think I alluded to that, Dr. Rawal, in my comments, that there is a lot of disparity among the safety net providers in terms of their resources and capabilities, and particularly those safety net providers in our own states that have not expanded Medicaid, they've got significant percentages of uninsured that they care for.

So, I think that CMS should recognize the fact that safety net primary care providers are an investment and do just that -- invest -- particularly invest in systems and resources to help these providers not only learn how to be successful in APMs, value-based arrangements, but also invest in the analytics and the capabilities to access, ingest, and utilize data effectively to improve patient care and outcomes. The other thing I would say, as APMs evolve, they really need to evolve towards team-based care. Team-based care will allow health centers and other safety net providers to move care outside of the four walls of the clinic to really go into the community to address upstream, social drivers of health. They'll also be conducive to providers in terms of recruitment and retention. Continuing to put providers, strictly safety net primary care providers, on the hamster wheel of, you know, encounter-based visits are really just a recipe for long-term disaster. So, we've got to migrate towards value-based APMs and focus on team-based care, but do it in a way that supports the foundational payments for health centers and other safety net providers while making that transition.

>> **Dr. Veronica Mallett, Meharry Medical College Ventures:** And I would just echo everything that Mr. Money said, and also just by warning that we are at risk if we don't move to that, to be eaten up by these corporate structures and innovators that are capitalizing on the opportunity to really game the system, but leave our patients behind, and leave the safety net providers behind, and we know that our patients are better served by the people in this population who are dedicated to serving this

population and have dedicated their lives, both emotionally are part of that community and will do a better job. So, we just need to provide them the tools to do that.

>> **Dr. Dora Hughes, CMS:** Thank you. Thank you so much. We're out of time. Of course, we need more time, and we are, again, planning to have additional health equity roundtables in the days ahead, so we will be able to pick apart some of the commentary we heard from today, and that will help inform the next sessions in terms of diving deeper, which could be on data, it could be on safety net providers, it could be on the payment methodologies. We just touched on some of these different important topics. In the slide, just for the sake of time, I'm not going to go over the details, but this is more information about ways that you can stay in touch with us and also have an understanding what's coming forward.

My final request for you and for any who are still watching is if you could put into the chat box or email us with those organizations or individuals who you think we should be talking to. Or, if there's any white papers or briefs that we should be reading, we would love to know about these important resources, so that we could be as prepared as possible and informed as possible about what's going on exciting in the field, and that could inform our work here. I would be remiss, if we go to the next slide, if I did not mention that on December 15<sup>th</sup> and 16<sup>th</sup>, with the Healthcare Payment Learning and Action Network, the summit will be happening. The new Health Equity Advisory Team, the HEAT, will be presenting their recommendations for how to advance equity through APMs. It's going to be an excellent conversation. The LAN Summit is open for all to register and it's free to attend. That will be our next opportunity to talk about advancing health equity through our models and initiatives here at CMMI.

So, with that, again, thank you. Please join me in providing a virtual thank you to our roundtable panelists, again, for just their brilliant comments and perspectives. We are so appreciative, and please know that we intend to call on you again. So, with that, we will end the roundtable. Thank you so much again.