**CMMI Strategy Listening Session #1**
November 18, 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 first listening session on the CMS Innovation Center’s strategic direction. Before we start today’s listening session, I would like to go through a few housekeeping items. The listening session today is being recorded. Closed captioning is available via the link in the CC window on the bottom of the screen. Again, that closed captioning link was shared in the chat below. Speakers were notified in advance of the listening session of the order in which they will present remarks, and will be unmuted when it is their time to speak. All other participants will be muted throughout the call. You can, however, provide a written comment using the Q & A window on the bottom of the screen. Your comment may be read aloud during this session and you may be unmuted to answer a clarifying question. 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. Liz Fowler, Deputy Administrator and Director of the CMS Innovation Center. Liz, the floor is yours.

**>> Dr. Liz Fowler, CMS:** Thank you so much, Adam, and good afternoon and a sincere thanks to everyone that took the time out of their schedule to be with us today. As you are all likely aware, the CMS Innovation Center released a white paper in October detailing our vision for attaining a health system that achieves equitable outcomes through high-quality, affordable, patient-centered care. In response to this release of our strategy, we are excited to kick off the first listening session to hear from you about what it will take to make our vision a reality. There is so much we can learn from you. Achieving our vision will require a partnership with beneficiaries and health care providers. For those providers in the audience that have participated, or are participating, in our models, we want to hear about your experiences and where we can make improvements. For providers that have not yet partnered with the Innovation Center, or have been part of one of our models but perhaps dropped out, we want to understand what barriers there may be to participation. Hearing from you, and those receiving care, is something I valued from the start of my role at the Center.

This listening session allows us to keep these conversations going. As we start implementing the strategy we’ve shared, we want to receive continuous feedback from all of you on how we can better achieve meaningful, lasting transformation of our health system. Stakeholder engagement is in and of itself a key part of our strategy. We’re committed to strengthening our communication with stakeholders and soliciting a more balanced set of feedback during our model development process. We anticipate that this is the start of more listening sessions to come, and we sincerely appreciate your time so we can all be working together to shape a health system that best serves our communities.

From here, I'm going to turn things over to Ellen Lukens, our Director of the Innovation Center's Policy and Programs Group, and Dr. Purva Rawal, the Innovation Center's Chief Strategy Officer. They will provide an overview of how today’s listening session will run.

**>> Ellen Lukens, CMS:** Thank you, Liz, and thanks to all of you for taking the time to join us today. I'm Ellen Lukens, and as Liz said, I am the Director of the Policy and Programs Group at the Innovation Center, where I lead our policy function and have co-led the development of the strategy refresh. We

will be walking you through today a brief set of slides that provide an overview of the Innovation Center's vision and strategy, and then what you can expect from us moving forward. We are excited to be officially kicking off our outreach and engagement after the release of the Innovation Center's white paper last month. We are looking forward to hearing from our speakers today and hopefully many comments from all of you to guide our work moving forward.

As many of you know, Congress provided CMS the authority, through the CMS Innovation Center, to test innovative models, as part of the Affordable Care Act. The goal of the models we test is to preserve or enhance the quality of care for beneficiaries in Medicare, Medicaid, and the Children's Health Insurance Program, while spending the same or less. On a tactical level, this means the CMS Innovation Center can, for example, change the way we pay for services and then evaluate whether that change improves quality or reduces cost. In the coming decade, the Innovation Center is focused on building a health care system that achieves equitable outcomes through high-quality, affordable, person-centered care. You see that in the green above where the two people are, and that's our vision for the future. As described in much more detail in our whitepaper that was released on October 20, the Innovation Center is committed to five strategic objectives that collectively will allow us to move toward our renewed vision. I'll describe each of these five strategy objectives at a high level, but for additional details, please visit our website for the full white paper.

Our first strategic objective is to drive accountable care that results in the delivery of whole-person, integrated care with accountability for outcomes and quality, as well as total cost. The goal we have 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 a focus on models that can facilitate accountable care relationships between patients and providers, such as advanced primary care and ACOs.

Our second strategic objective is to advance health equity. We believe that promoting health equity and addressing health disparities are critical to improving health care equity. The white paper details a number of areas the CMS Innovation Center is exploring to embed equity throughout the life cycle of our models. From development to implementation and to evaluation. These areas include ways we must increase participation among safety net providers in our models, and collect demographic data to measure our progress and reduce population level inequities.

The third strategic objective is focused on supporting care innovations that enable the delivery of person-centered, integrated care. The Innovation Center has been working and will continue to support efforts to ensure that model participants have access to actionable, timely, practice-specific data, also access to payment flexibilities and peer-to-peer learning collaboratives, to share best practices. Providers will also need access to tools that support delivering care consistent with patients' goals and preferences, including the settings they prefer, such as in the home and community.

Our fourth strategic objective focuses on ways our models can advance affordability by addressing health care prices and reducing duplicative or unnecessary care. We are exploring how our models can address the sources of waste that drive up direct and indirect patient costs and how CMS Innovation Center models can promote the affordability of high-quality care.

Our fifth and final objective is focused on how we will partner to achieve the system transformation that is our goal. The vision and objectives we have laid out are ambitious, and we will need to collaborate

with you, patients and beneficiaries, providers, health plans, employers and states, among others. We will be engaging with stakeholders in regular and new ways, beginning with this listening session today.

Now I'll turn over the remainder of our presentation to my colleague Purva Rawal who will focus on what stakeholders can expect from the CMS Innovation Center in the coming weeks and months.

**>> Dr. Purva Rawal, CMS:** Thank you, Ellen, for that overview of our strategy and renewed vision. I'm Purva Rawal, Chief Strategy Officer at the CMS Innovation Center, and I'm really excited to be hearing from you all today as a we kick off our stakeholder engagement efforts, which are really key to successfully implementing our new strategy. To achieve the goals under each of the five strategy objectives Ellen described, the Innovation Center will need to undertake key changes.

First, we must strengthen our communication with stakeholders to integrate patient perspectives into our work across the life cycle of models, and to understand barriers and facilitators to providers and plans participating in our models. Stakeholders can expect more listening sessions with existing and new partners, as well as other outreach and opportunities to inform the Innovation Center's work and strategy implementation.

Second, achieving health system transformation will require more dynamic generation of learnings from models, including with external researchers and experts. Our team is piloting efforts to share research identifiable files by the CMS Virtual Research Data Center. We are also identifying and preparing additional files to enhance the data available in the VRDC for further analysis and research. Our goal is to implement our own evaluations with valuable insights that researchers would generate on the impacts of models and design features on quality, outcomes, and costs.

Last, our north star will continue to be testing successful models that can be expanded to reduce program costs and improve quality and outcomes for Medicare and Medicaid beneficiaries, per our statutory mandate. But we also want to mine the other impacts of Innovation Center models, that may not rise to meet the criteria for expansion, but they are nonetheless contributing meaningfully toward health system transformation.

Moving forward, we want to consider the success of our models more broadly. This could include how our models impact beneficiaries in terms of their patient experience, quality of care when it comes to transitions of care, and access to home and community-based care, as Ellen referenced earlier. Our models also impact providers in terms of care transformation, administrative burden, access to more timely, actionable data, and tools that facilitate clinical transformation. And we also want to think about how our models impact the health care market through factors such as new linkages or relationships between providers, consolidation, the spread of successful model elements to other payers, and scalability to other regions or payers.

Part of our commitment to transparency and strengthened regular communication is to send clear signals about where the Innovation Center is heading. This timeline, which is included in the white paper, begins this process. Here we lay out three areas of activity – our external engagement, examples of model types that the Innovation Center could examine to advance the new strategy, and lastly cross-model issues that we also discuss in more detail in the white paper -- that we believe are critical to developing and implementing a more streamlined and harmonized portfolio of models that drive health system transformation.

We look forward to working with all of you to achieve a health system that reflects this vision of higher quality, more equitable care for our beneficiaries.

With that, we now want to shift to why we are all really here, which is to hear from our speakers today. And I want to thank each of them for registering quickly for today's event, for their considerations of the questions we posted, and for the comments and feedback that they have prepared.

As a reminder, these are the questions we posed to registrants and our speakers today, and we are really looking forward to everyone's comments.

**>> Lance Donkerbrook, Commonwealth Primary Care ACO:** Hello everybody. Can you hear me okay?

**>> OIT Operator:** Yes. You're unmuted.

**>> Lance Donkerbrook, Commonwealth Primary Care ACO:** Great. Thank you. Since 2013, as one of the nation's few independent, self-funded, owned, operated and governed primary care ACOs, we feel that CMS and innovation programs, like MSSP, were created to help organize independent physician groups like us, rather than to afford hospital, venture capital, or corporate medicine to dominate these programs due solely to their well-capitalized status. In our market, independent providers and our ACOs have not been eligible for the upfront funding initiatives like Primary Care First, so we have never been provided the single most important need of a solid or stable funding mechanism. From there, add on the equally challenging obstacle of retrospective adjustment with the claims data and lack of timely benchmark updates throughout the year. That lack of detail does not give us accurate nor timely enough information to gauge our progress for our financial status. As we say for an organization that has been in the upper 90$^{th}$ percentile of quality for inception, even the best in quality won't pay your bills. It's difficult to keep the lights on and pay the water bill, which we consider our ACO infrastructure, while you're waiting for a mystery bonus that may or may not happen nine months after the event ended. The need is fairly simple for provider-based organizations like ours. The benchmark is too low to continually compete against ourselves in the law of diminishing returns, while the other ACOs that are in their own market reap the rewards of their past higher spend and therefore higher benchmarks. Even with the new pathways to success or DCE Model, we have not seen enough benchmark normalization to distinguish an efficient performing organization, while somehow rewarding a less efficient one. So once again, the benefits are left to the well-capitalized systems, hospitals, and even now, venture capital, that are dominating the programs.

Even worse for us, in the Phoenix market, we have seen acceleration in aggressive and noncompetitive behavior and outright acquisition towards independent physicians. And now it is not related just to the CMS and CMMI initiatives, it is outwards towards Medicare Advantage. Medicare's push to risk is really only accelerating the acquisition by these capital markets, further leading to the endangerment of independent primary care and ultimately, independent physicians of all types.

Without fixing that, the simple obstacle we are addressing and talking about is the lack of capitalization opportunity for independent physician organizations. The group is kind enough to ask for our opinion on a solution, and here it is. Promote the delivery of an advanced, high-quality primary care system through hybridized payments that encompass three simple things: perspective payment for primary care management of conditions, capitalization and investment in provider and ACO infrastructure, and the alignment of payments and incentives for both quality and outcomes together. Not the current plan for

short-term gratification based on one's ability to game the model or even legitimately achieve short-term cost savings. The CMS and Innovation Center should adopt this hybrid payment and investment approach to find a way to support and create opportunities for these independent provider-based programs to proliferate and thrive, therefore fostering innovation and growth through these channels, rather than through the large systems or firms looking for a way to insert themselves in the process solely because of their well-capitalized status.

Thank you very much for that opportunity. And I welcome questions or comments.

**>> Megan Cardin, CMS:** Thank you so much, Lance. I would like now to turn it over to Misty Drake, who is the Vice President of Clinical Services at the Medical Home Network, coming to us from Chicago, Illinois. Misty?

**>> Misty Drake, Medical Home Network:** Thank you to CMS for this unique opportunity to engage with the panelists this afternoon. Most value-based programs don't yet have experience, proven model, or the right partners to create high-value care networks and whole-person care models really tailored toward low-income, underserved, minority communities. Medical Home Network works with a network of safety net providers, specifically federally qualified health care centers, to accelerate their involvement in value-based arrangements. FQHCs are the heart of the safety net system serving vulnerable Medicare and Medicaid beneficiaries. This is their unique gift with proven outcomes. However, FQHCs face unique challenges when participating in risk-bearing arrangements. My questions today are centered around three areas: financial risk structure, FQHC wrap payment, and FQHC advanced payment models.

First, there is a lack of clarity among some state Medicaid agencies and FQHCs about their ability to enter value-based contracts that include financial risks. Can individual FQHCs create reserve accounts for such risk contracts? Do they need to create or participate in separate legal structures – nonprofit or LLCs – to segregate the risk from the FQHCs? Second, FQHCs must provide more comprehensive services than non-FQHCs primary care providers, so their services are more costly. Although many state Medicaid agencies continue to make direct wrap payments to FQHCs to make up the difference between market Medicaid rates and the non-FQHC primary care provider NPPS rates, some states have decided to incorporate that wrap into the premium. Those wrap dollars are often spread across the shared savings pool of non-FQHC providers, as well as FQHCs. This makes it much more difficult for FQHCs to perform total cost of care contracts, since each primary care visit drains the shared savings pool more. It would help FQHCs' progress in total cost of care alternative payment models if state Medicaid agencies continue to segregate the wrap payment from the ACO premium.

Last, providers and payers, including CMS, are increasingly recognizing the flexibility that primary capitation offers to care access and better use of the full care team, compared to strict fee-for-service reimbursement. FQHCs and their primary care associations, and a few states, have begun creating capitated FQHC APMs, but this planning process and negotiation with the state Medicaid agencies, MCOs and CMS, can take years. Is it possible for CMS to make this a national option for any willing FQHC, using a standardized process? Thank you.

**>> Dr. Purva Rawal, CMS**: Misty, thank you for your perspective and the perspective of FQHCs. Including more safety net providers and creating opportunities for them to join our models moving forward is

really key to achieving our health equity vision and goals that Ellen described. I look forward to speaking with you more, but thank you for that.

**>> Megan Cardin, CMS:** I want to take one step back, because I realized that we failed to fully introduce Lance when he began his talking points. So, I just want to again acknowledge and thank him for his talking points as well. And we will definitely take those under consideration as we look forward to implementation of the strategy. Lance is the Chief Executive Officer of the Commonwealth Primary Care ACO, coming to us from the state of Arizona.

Before we jump to the next speaker, I also just want to once again remind everyone that if they would like to provide or share a comment pertinent to the listen session questions, you may provide that information via the Q & A window at the bottom of the screen. We will be reading some of these comments aloud later in the call, and we'll keep record of all the written comments made during this first listening session.

Now, I would like to turn it over to Kate Freeman, who is the Manager of Payment and Care Transformation at the American Academy of Family Physicians, and who is coming to us from the state of Kansas.

**>> Kate Freeman, American Academy of Family Physicians:** Thanks, Megan, and thank you to CMMI for this opportunity to speak this afternoon. The AAFP represents 133,500 family physicians, residents, and medical students across the country. We are pleased to see that primary care plays a central role in the transition of value-based payment and agree that it is foundational to successful implementation of the Innovation Center's strategy refresh. We appreciate CMMI's renewed commitment to stakeholder engagement to ensure APMs are designed to advance health equity through high-quality, patient-centered care. Acknowledging success requires working in partnership, regardless of payer or geography.

We are also encouraged that CMMI plans to address long-standing challenges with model evaluations that hamper successful physician participation and model scaling. Most primary care practices lack value-based accountable care model options. Primary care practices need a stable suite of multi-payer models across the risk spectrum with predictable prospective revenue streams adequate to meet patient and practice needs. Primary care continues to be hampered persistently by low payments and limitations related to fee-for-service and burdened by the unique requirements of each payer. Streamlined prospective payment models that adequately support and sustain comprehensive longitudinal patient-physician relationships that address the whole patient, including health related social needs, are essential. Payments should also be risk adjusted to accurately reflect patients' clinical diagnosis and HRSNs to ensure practices aren't penalized for caring for patients with increased needs. Previous and current primary care models have been geographically limited in scope and repeatedly tested in the same regions. Since primary care is uniquely qualified to care for patients of all ages in diverse settings nationwide, CMMI should expand models to increase equitable access and avoid further exasperation of disparities. The participation in APMs requires practices to invest significant resources in new staff, data analytics, and modified workflows. Model stability and onramps will encourage more practices to transition to APMs. This is particularly important for practices serving a high proportion of Medicaid beneficiaries or in health professional shortage areas that typically operate on very slim margins. CMMI should invest in technical assistance, shared learning collaboratives, and data

infrastructure to support smaller, independent practices in transitioning to APMs, and do so in partnership with other payers.

Existing models also lack a clear patient engagement mechanism to support strong patient-physician relationships. Actively engaging patients in the process of identifying their source of primary care and using that for payment purposes helps strengthen the patient-physician relationship and increases the impact of new primary care payments. Model design should remove access barriers and drive equity, such as waiving copays or co-insurance for primary care.

Finally, CMMI should explore measuring what matters to patients, physicians, payers, employers, and purchasers. The AAFP strongly supports the person-centered primary care measure and advocates for both public and private payers.

Thank you again for the opportunity to speak on behalf of the AAFP today. We look forward to working closely with CMMI to advance the transition to value-based care and improve patients' access to comprehensive primary care.

**>> Ellen Lukens, CMS:** Thank you, Kate, that was helpful, and I think underscores the importance of primary care and how that really is a backbone to achieving our goal of achieving person-centered, equitable care. I think you probably saw in the white paper, there was also an emphasis on multi-payer. We really look forward to continuing these conversations, because we do understand and have heard from other providers and participants as well how difficult it is to change your care model from one payer and have to have a different care model for another. We want to continue the conversation around some of your ideas in removing access barriers to care and also really measuring what the patient and caregiver care about, what is important to our beneficiaries, and how to make sure we are measuring that. So, thank you so much for the thoughtful comments.

I will next turn it over to Nitin Jain, who is the President of Value Based Care for U.S. Renal Care.

**>> OIT Operator:** Nitin, you can speak now, if you unmute your mic. You can speak.

**>> Nitin Jain, U.S. Renal Care:** Hi, good afternoon and thank you for the opportunity to speak.

We applaud CMMI for launching new value-based care models and to give providers the opportunity to transition away from fee-for-service. We are super excited about participating in these models and look forward to continued engagement with CMMI. We are specifically an organization that's focused on kidney care. We are participating in the KCC Model for patients with late-stage chronic kidney disease, specifically CKD stages 4 and 5 and End Stage Renal Disease Program. We believe this will be highly beneficial for this population, needing specialized care led by a nephrologist. We believe the nephrologist in this case is best positioned to provide the best care for these complex patients with chronic diseases. However, we understand, per CMS rules, that these beneficiaries could be also be potentially enrolled in other competing programs, such as the Direct Contracting Entity Model or other PCP-led models that might be present in the same market. We wanted to highlight this model overlap issue and recommend CMS to move quickly to fix this by aligning kidney disease patients to the KCC Model, which we believe is the most beneficial model for these patients and these patients would benefit most from clinical outcomes provided by a nephrology-led model. The value-based care models made available by CMMI, such as the CKCC Model, also require organizations like ours, which are provider-led, to take significant financial risk on the total cost of care for the beneficiaries. While we are

excited about this opportunity, we are having to take on this financial risk without access to any historical data. This relates to historical claims data that CMS has in its possession, but it is unavailable to us before we start the program.

In addition, just to be prudent financially, we have had to pay third-party organizations with qualified entity status, hundreds of thousands of dollars to access the same data that CMS has in its position and can make available to model participants. Unfortunately, these are dollars we are having to spend to be good financial stewards of our own organizations, but these are dollars that could be diverted away from providing better care for our patients and beneficiaries. Again, we recommend CMS provide historical claims data as part of the application process and to participants in the models so that the participants can use this data to better inform strategies that we develop prior to the start date of these financial risk models and level the playing field to allow for broader participation and reduce the cost of participating in these models.

The last thing I would say is that CMS should provide greater flexibility to providers and participating organizations to provide benefits and services that reduce access barriers for patients and enable providers to structure arrangements with other providers in their local markets to provide appropriate care and services to beneficiaries.

Again, we thank you CMMI for all the efforts to move towards value-based care. We are excited about it and look forward to the continued engagement. Thank you.

**>> Dr. Purva Rawal, CMS:** Nitin, thank you. I just want to start by saying that we appreciate your support of value-based payment and your experience in our models I think will really help us as we refine our work moving forward. I think you raised an important point, how certain special populations, including those with ESRD, the appropriate models for them and the issues that arise when we have model overlap. We heard from other providers this is an issue as well. We discuss it a little in the white paper, but we really look forward to further understanding some of those complexities. It’s definitely an area of focus for us as we move forward to make sure that it is very clear to providers how models interact with one another and that the financial incentives and care delivery incentives are well aligned for patients for those that are participating models. I think you brought up great points about data and the need to understand the patient population that might be aligned to a provider group in a model. And then one of the other things we are really thinking about is how to provide more actionable and timely data to participants to support decision-making at the point of care. We look forward to continuing the conversation and your input, and thank you for your remarks.

Next, we are going to go to Joanna Hiatt Kim who is the Vice President of Payment Policy at the American Hospital Association here in Washington, D.C.

**>> Joanna Hiatt Kim, American Hospital Association:** Thanks. Are you able to hear me? Perfect. Thank you so much for holding this important session today. I'm here representing our nearly 5,000 member hospitals, health systems, and other organizations, as well as the millions of clinicians and other health care leaders we serve. I'm going to focus your second question on what CMMI can do to support APM participants, but AHA will be following up with written responses to all three questions. Before I provide input, let me start by saying AHA strongly supports CMMI's plans to drive accountable and innovative care, advance health equity, and address affordability. We stand ready to serve as one of your partners to implement APMs that best serve patient and provider needs. Regarding how CMMI can support APM

participants and help them be successful, I will first discuss risk versus reward. As they are currently designed, the resources required to participate in models are too great for many hospitals to bear while simultaneously executing their core mission of providing care to all who need it. Therefore, we urge CMMI to balance risk and reward in a way that reflects the significant investments required to launch and maintain APM participation. For example, CMMI could provide more upfront payments to certain providers to help offset the cost of model participation, incorporate more glide paths to higher levels of risk, and ensure risk adjustment methodologies take into account the many factors that contribute to health that are outside the control of providers. We also urge CMMI to work with vendors to encourage them to make their IT platforms automatically and out-of-the box ready for APMs, so participants do not have to expend additional resources building that capability in-house.

Next, I'll discuss administrative and regulatory burden. Currently, model participants have to navigate unique administrative requirements for each model in which they participate, which is a significant burden. Therefore, we strongly suggest CMMI automate some reporting requirements and streamline reporting across models. CMMI could also provide incentives by reducing other burdens, such as relief from utilization management tools, like prior authorization, and additional relief from regulations that hamper providers' ability to place beneficiaries in the clinical setting that they see fit.

Finally, I'll also speak regarding data. The complexity of models' financial calculations makes it difficult for providers to make informed decisions about participation or set themselves up for success, especially when they only have a matter of months between announcements and launch dates. To address this, participants need timely, usable data about their populations. They also need analytic tools that turn that data into usable information. Clinicians especially need feedback as close to real time as possible. Finally, we urge the Agency to support providers' ability to capture patient-reported data relevant to disparities in care, such as on race, ethnicity, and disability status. This will help ensure all patients have access to equitable care.

Thank you again for having me today and for your work to improve provider's experience in APMs.

**>> Ellen Lukens, CMS:** Thank you so much, Joanna. I think you touched on so many things and certainly some things that we want to do better moving forward and I think you probably saw that in the white paper. Just wanted to highlight a couple things. We agree that we want to support providers with this process, and I think some of the ideas that you put out there in terms of thinking about upfront payments, or thinking about more of a glide path, are certainly some things we want to explore more. We are certainly committed to reducing regulatory burden, and I think your comments about complexity are certainly ones we've heard from other providers as well. I think some of our participation agreements, seem extremely complex, and we have heard from some providers, that in a short period of time, they can't make that kind of decision. A lot of your remarks really resonate with us and are consistent with what we've heard from other participants and folks who've decided not to participate. So, really looking forward to that discussion. One final note is data, I think that's is a thread that is woven through a lot of these comments and we agree, data needs to be actionable and as real-time as possible. So, look forward to more discussion on all of those topics.

With that, I will turn it over to our next speaker, who is Mark Lamm, the Director of Population Health for LifePoint Health in Tennessee.

**>> Mark Lamm, LifePoint Health:** Hi, thank you. Can you hear me?

**>> OIT Operator:** Yes, we can hear you, sir.

**>> Mark Lamm, LifePoint Health:** First and foremost, thank you CMMI for the opportunity to share our organization's input and experiences that continue to guide towards value-based care across the country, where we've participated in five different APM programs either with our 30 plus hospitals or 1,000 providers that's been within the APMs. Many of the items that we will share today relate to the challenges faced within rural health care, particularly for our organization, our providers, or our patients. Some of these challenges are deeply rooted in the economic and social, racial, and geographic factors that they say creates a mix of challenges that is either a limit to that care or are also the funding solutions that make it more difficult for individuals to participate. Addressing question number one, which is regarding the greatest obstacle, our organization considers upfront costs or resources the largest barrier. No matter which APM one enters into there are upfront costs associated, with either additional staff, new strategies, and the data analytics that have to occur. Providing investment funds to encourage participation, particularly for rural health providers that have tight margins, would assist in alleviating low participation in these areas. Similarly, we believe funding, reimbursing, and fully recognizing community health workers, or others that do similar-type jobs, that fully impact patient access and compliance to care would be beneficial. This would provide reach into high-risk communities that are often lacking healthcare-provider resources.

The other obstacle that our organization faces is the risk-adjustment methodology that is within the program today. Our organization has found limitations that does not accurately depict the patient population that we serve, and this is either through the HCC Risk-Adjustment Methodology not fully capturing the complexity of the patient's social determinants of health or that the risk-adjustment cap limitation is not tenable when the region's risk is allowed to continue to grow without cap. Correcting or readjusting readjustments moving forward will allow patient risk to be accurately depicted.

Additionally, we would like to also address the question towards what may support clinicians being successful in these models. The initial opportunity for CMMI to support is creating timely and transparent data. Creating an efficient manner of delivering claims data for program participants by streamlining the data processing time and also reducing the need for administrative portions of the claims-data processing would allow clinicians to formulate timely and actionable plans to improve in areas. Moreover, CMMI should allow health care organizations to access Innovation Center or QE data to link claims with other opportunities that are beyond what they are currently receiving. This could allow organizations to move more and determine the feasible of their program, before getting into the performance year.

Lastly, CMMI could support clinicians by creating regulatory flexibility, that are less administratively burdensome or have clear guidance to proper waiver use. This will allow participants to operate within the bounds of their waivers, but also the flexibility to be efficient when deploying them. Introducing new waivers that would allow clinicians the opportunity to provide home care to patients, as well as offer transportation and meals to beneficiaries in high-risk rural areas, would be necessary to improving health equity for these regions.

This completes our organization's high-level input to CMMI's future strategy, but look forward to working with you all in the months and years to come. Thank you.

**>> Dr. Purva Rawal, CMS:** Mark, thank you. That was extremely helpful and I really appreciate your perspective as a rural health care provider. As I said earlier, we have a significant focus in our new strategy on underserved areas and how we expand the reach of value-based payment to more, and hopefully all, of our beneficiaries. And I want to acknowledge that your input is really valuable to us as we think about that. We not only want to be speaking with those providers that have been part of our models, but also reaching out to those who have been unable to participate in our models. And I think you pointed out some of those important barriers that often can prevent providers from crossing that threshold and joining the value-based payment models, especially if they are in underserved areas and rural areas. And if they are able to join, we are looking for ways to make that participation more sustainable and look forward to more of your thoughts there. Also, appreciated your comments on team-based care delivery and how important that is and that is something we're actively thinking about in terms of model development moving forward. Risk adjustment was another issue you mentioned, and we talk a little bit about it in the white paper, but this is an important strategic area for us as well. I think data is a theme that is coming across everyone's remarks today and we're piloting some important work there that we also mention in the white paper. Look forward to engaging with stakeholders moving forward; we know that's a cross-cutting issue for all of the participants to really give everyone a full picture of care delivery. And then last, on regulatory flexibilities, completely understand some of your comments there and we want to better understand uptake of waivers to-date and how to increase update of some of those waivers and also identify what's missing and what kind of flexibilities are missing for providers moving forward. We just want to say thank you.

And with that, we are going to be moving to our next speaker, Lisa Leveque, I hope I said your name correctly. She is a Vice President of Strategic Alignment and Care Transformation at Bandera Healthcare in Arizona. Thank you for joining us, Lisa.

**>> Lisa Leveque, Bandera Healthcare:** Thank you, and thank you to CMMI for the opportunity to be part of this discussion today. Having the opportunity to work with many CMMI models and at varied levels of care, including community providers, acute and post-acute providers, throughout my career, there is one primary obstacle that continues to be one of the greatest barriers to providing real-time resources, care, and support to the attributed member. That barrier is identification of the member throughout the health care system. For instance, the member has an acute episode and is in the hospital and the patient is only identified as a Medicare beneficiary to the providing hospital and other providers, thus as the patient discharges to the next level of care, those developed, accountable partners and resources are not engaged early in the care process. The ability to identify the member's health care CMMI program, attribution, and needs real-time is critical to the success of the member's health and access to the resources from the responsible CMMI program. One solution is the collaboration with each state's health information exchange throughout the health care system. By implementing this partnership and data sharing with the HIE, each level of care provider receives a real-time alert that the member is attributed to a particular program, and thus is able to immediately collaborate on the care of the member and the resources needed.

We've actually worked here locally in Arizona on really engaging more with the HIE, with our CMMI partners in order to help those across that care continuum more quickly to identify and thus provide those resources.

**>> Ellen Lukens, CMS:** Thank you, Lisa. First of all, thank you for participating in our models, I know you've participated in several, and we appreciate that partnership with CMMI. I think your point is a really good one and it's one level down from some of the comments we've been talking about earlier, and it's really consistent with the theme of having more real-time data. I think the patient identification piece is an insight and something we have to think about. Definitely understand the problem, that if you don't know the patient is hospitalized, then it's really hard to then help manage the post-acute care and make sure that the beneficiary really gets the benefit of the ACOs' relationships. I think that's a really helpful note for us and something that we may want to follow up with you afterwards, but really appreciate your participation and the insight into thinking about data and enhancing those capabilities and how it will really change care for our beneficiaries.

With that, I will turn it over to Larry McNeely who is the Director of Policy for the Primary Care Collaborative in Washington, D.C.

**>> Larry McNeely, Primary Care Collaborative:** Thank you so much, Ellen, Purva, and Liz. I want to begin with an appreciation of the person-centered integrated aspects, the equity and affordability aspects of the strategy refresh – they all reinforce one another and depend on one another. But I'm going to talk a lot about payment. PCC is a nonprofit membership organization of 82 -- sorry -- 62 national organizations committed to stronger primary care. The greatest obstacle that we have identified has been the consistent under resourcing and fragmenting of primary care that predates CMMI, yet has continued despite your best efforts. Primary care is foundational to both health equity and value. As you know and mentioned in the white paper, the NASEM report implementing high-quality, primary care advances payment and investment recommendations that include, assessing models based on whether they contribute to high-value primary care; shifting to a hybrid model, encompassing both fee-for-service and risk-adjusted comprehensive payment; and increasing the overall level of investment, not just how we are paid, but how much. PCC has called on CMS to hold and make that report's primary care payment recommendations central to its equity and value strategy. While maximizing cross-payer alignment, CMS, and particularly CMMI, have a few tasks we recognize ahead of you now, in this white paper, including refining the existing population health models, developing follow-on population health care models, considering model interaction, and crucially applying CMMI's learnings to the permanent programs, informing what the rest of the Agency does.

In each of those specific tasks, CMS should consider whether they are bringing the health system closer, and we recommend you consider bringing the health system closer, to realizing NASEM's payment recommendations. The achievement of each of the five strategic objects depends on the adoption and adaptation of those recommendations. Look forward to working with you.

**>> Dr. Purva Rawal, CMS:** Larry, thank you for that. Really appreciate your feedback on the strategy refresh and your comments about the NASEM report, which I think we reference in the white paper as well. I think we've learned a lot of important lessons over the last decade from the original CPC program, CPC+, and now Primary Care First, that's really ramping up. Moving forward, our goal is really to increase participation among all primary care practices in models and really create a pipeline to bring more providers onto the pathway of value-based payment, especially those that may need more support at the start to be able to start on that transformation path. You also referenced being able to pull successful learnings through to other parts of the Agency and to other programs and we agree that's very important and working closely with our colleagues and the Center for Medicare and Center

for Medicaid and CHIP Services as well to make sure that learnings from Innovation Center models are incorporated hopefully more broadly into program policy. Thank you. Next, I would like to turn to Jeff Micklos, the Executive Director of the Health Care Transformation Task Force. Jeff?

**>> Jeff Micklos, Health Care Transformation Task Force:** Thanks, Purva, and good day and thanks to the Innovation Center team for holding this listening session and allowing the Health Care Transformation Task Force to offer verbal remarks. The Task Force will submit a letter addressing all three questions. I will focus my remarks on the first question, which asks about the greatest obstacles to participating in value-based accountable care models and how the Innovation Center can alleviate them. Based on our work, we believe there are three main obstacles to participation. One, barriers to initial entry. Two, barriers to sustained participation. And three, barriers to APM expansion. I'll offer more detail and recommendation on each.

Barriers to entry. Successful participation in ACO models requires upfront investments in staffing, training, and data infrastructure necessary for effectively managing population health. Many providers lack the necessary resources for these upfront investments or missed out on early investments, like the ACO Investment Model. They are now hard pressed to take on the more complex APMs that CMMI has offered recently. The Innovation Center should one, offer technical assistance to providers focused on preparing to participate in APMs; two, create new opportunities for early infrastructure investments, similar to the AIM model; and three, design onramp models with lower risk levels to ease the transition from fee-for-service.

Barriers to sustainability. Current benchmarking methodologies are a serious barrier to sustainable participation in a model. Benchmarking strategies that are based on historical spending with periodic rebasing, create a dis-incentive for APM participants to fully maximize potential savings and ultimately can drive providers to drop models. CMMI should focus efforts on developing benchmarking methodologies that support appropriate spending levels on care, limit rebasing, and do not penalize model participants for the savings they achieve for their assigned populations.

Barriers to expansion. The barriers to entry and sustainability have created serious challenges for expanding APMs into new areas, especially among underserved populations. This is a particularly important issue to address if CMMI is to lead the effort to advance health equity. Providers that most often care for the communities impacted by inequity, such as rural hospitals, critical access hospitals, FQHCs, and community clinics, lack the investment resources and risk tolerance for most APMs. Additionally, current benchmarking approaches generally fail to adequately account for equity, and they assume that the historic spending utilization should or can be lowered, while maintaining or improving quality. This is generally not a realistic expectation for underserved individuals in communities where providing appropriate care would likely require spending and utilization above the historic average. CMMI should develop benchmarking and risk adjustment methodologies that establish reasonable expectations for the cost of providing efficient and high-quality care, and that could adjust for historic under-investment in communities and among specific populations.

Thanks again for the opportunity to offer these remarks, and the Task Force looks forward to working with the Innovation Center on its strategy refresh implementation.

**>> Ellen Lukens, CMS:** Thank you, Jeff. We appreciate that. I think you raised some really critical points. I first want to start with your third point, the challenges to exploring expansion and really thinking about

equity and how we promote equity when we have models that require upfront investments and thinking about those provider types that may not be able to make those types of upfront investments. Definitely hear you on that as well as on risk adjustment. I think we are committed to establishing benchmarks that are fair and accurate for our models and appreciate your concerns about sustainability and also about rebasing and potentially making negative adjustments relative to providers' ability to reduce utilization. I also want to acknowledge that the barriers to the upfront participation, I really appreciate your thoughts on the models becoming more complex. So, for those beneficiaries that want to start now, they are entering a more complex environment and thinking about the technical assistance that may be required to support those new entrants, as well as potentially variations on models that would allow for some sort of onramp with lower risk and/or some sort of early upfront payment. Those are all very helpful ideas that we will certainly take back to our team. Thank you very much for your contribution today.

I next want to turn it over to Aisha Pittman, who is the Vice President of Policy for Premier here in Washington, D.C. Aisha?

**>> OIT Operator:** Aisha, you can speak now.

**>> Aisha Pittman, Premier:** Hi, good afternoon, and thank you so much for the opportunity to speak and holding this listening session. Premier represents 4,400 hospitals and over 200,000 other providers. We work closely with providers participating in numerous Innovation Center models and MSSP. We are committed to provider-led transformation to support the Innovation Center's goal of aligning all Medicare beneficiaries to an arrangement with responsibility for total cost of care and quality. In response to your first question, we see adequate reimbursement as the major barrier to participation in the models. I know Jeff just touched on this a little bit as well, but the race to the bottom benchmarking where participants are penalized for achieving savings and approaches that increase discounts over time are unsustainable. Additionally, most of the models have limited opportunities to improve their benchmarks through risk adjustment and ensure the benchmark is appropriate for your population. This prevents certain types of providers and patient populations from being included in the models. Providers who are paid at cost, like critical access hospitals, cannot achieve savings on top of their historical spend. They are paid at cost with the goal of maintaining access. So, the benchmarking approaches should consider how to ensure stable budget over time, while providing flexibility to innovate care. This would require a refocus of the goal of Innovation Center models with a focus on reducing growth and maintaining access, rather than a huge focus on savings.

Similarly, some of the current approaches result in avoiding patients with complex medical needs. A great example is the Part B drug spending for oncology patients is a significant deterrent to including oncologists and the patients that they serve in total cost of care arrangements. In response to your third question, we think the best way to better address patient needs in the programs are by focusing program policies on the patients that they serve, rather than building policies around the types of providers that are leading APMs. There are several policies and current programs that value one type of provider over another. In Direct Contracting, it's entities without experience that receive a better benchmark, compared to those that have experience in downside risk. In MSSP, there is a high and low revenue distinction that forces hospital-led ACOs to adopt the most significant amount of risk in the program faster than other ACOs. Ultimately, we need a level playing field across providers, rather than pitting one type of provider against another. All providers are working in their communities to improve

the care of their beneficiaries and we need to design all benchmarks and program policies around the patients served by the APM, considering a variety of factors, including their clinical and social risk. And then availability of care in the region and maintaining access should be a goal.

Thank you again for the opportunity to speak and we look forward to continuing to work with you on the implementation of your strategy.

**>> Dr. Purva Rawal, CMS:** Aisha, thank you for your remarks. I think the other theme that seems to be emerging are financial incentives, so thinking about how benchmarks are constructed, what changes might need to occur on the risk adjustment front to again not only make it possible for new organizations to participate in our models but also make participation sustainable for many that are already in these programs. Look forward to continued conversations there as we get further in our work. I also took notes on -- you said, you know, one of the goals should be a stable budget for providers that are participating, perhaps especially safety net providers, coupled with flexibility, so stable budget plus flexibility, and I like how you said that. You also talked a little bit about barriers to specialty participation in total cost of care models. That is something we are actively looking at; we have a team that has been doing some very extensive research to understand the barriers and facilitators to specialists participating in ACOs and total cost of care models. And we would welcome continued engagement with you there as well. Thank you so much.

With that, I'm going to turn to our next speaker, Laura Thornhill, who is the Director of Regulatory Affairs at the Alzheimer's Association. Laura?

**>> Laura Thornhill, Alzheimer's Association:** Great, thank you so much. We appreciate the opportunity to speak today. The Alzheimer's Association leads the way to end Alzheimer's and all other dementia by accelerating global research, driving risk reduction and early detection, and maximizing quality care and support. We are so grateful for the coverage of care for our constituents provided by CMS and for the ongoing conversations we’ve had with CMMI about ways to transform how dementia care is both delivered and reimbursed. As you know, the needs of persons living with dementia are many and varied, ranging from medical, to social, to long-term care. While Medicare fee-for-service of course covers some of those needs, it simply isn’t sufficient to meet all, or even most, of their needs. Nor does fee-for-service incentivize the necessary coordination of care or reimburse health care providers sufficiently. More than 6 million Americans are living with Alzheimer's today and 12.7 million ages 65 and older may have the disease by 2050. It's an expensive disease. Caring for individuals with Alzheimer’s will cost an estimated $355 billion this year alone, with Medicare and Medicaid bearing $239 billion or 67% of that figure. With that, the approaching tidal wave of high-need beneficiaries and the crushing cost of the system, we urge CMMI to develop tests and implement a comprehensive dementia care management model.

The Alzheimer's Association envisions a model that includes comprehensive care management services like continuous monitoring of neuropsychiatric symptoms; an ongoing dementia care plan; psychosocial interventions; self-management tools to enhance the skills of unpaid caregivers, which are absolutely critical to the health and wellbeing of these individuals; medication review and management services, management of related conditions, care coordination, which are all part of the model in our minds. Individuals with dementia we also imagine would be placed on pathways, according to the complexity of their disease and circumstances, and those complexity pathways would then correlate to payment levels for clinicians. And, as it has been a theme today, quality performance is critical to any model's success;

we believe that as well. And this kind of streamlined dementia care would lead to better health and quality of life for individuals and caregivers, better support for clinicians caring for these complex beneficiaries, and cost savings to Medicare and taxpayers.

Once more, thank you very, very much for the opportunity to speak with you today and we look forward to continuing our work with CMMI and hopefully to being a resource to you.

**>> Ellen Lukens, CMS:** Thank you so much, Laura, and thank you so much for the work you do on behalf of beneficiaries with Alzheimer's and dementia. I think many of the characteristics of the model you articulated are consistent with lot of goals of the vision and strategy in terms of really thinking about what we can do to provide comprehensive care and what that actually looks like. Definitely interested in thinking more about how we measure that for beneficiaries and really ensure that the types of changes we are making have meaningful impacts on beneficiaries and that we can measure that progress. You probably saw that reflected in the white paper in terms of really thinking about the metrics that we'll measure ourselves against. Really appreciate the focus on quality but also really acknowledging the importance of the entire construct of the comprehensive care and care management.

We will now move to Kelli Todd, who is the ACO Director of Government Programs at UnityPoint Accountable Care, and she is coming to us from Iowa.

**>> OIT Operator**: Kelli, you can speak now, please. Kelli, you need to unmute your mic on your end.

**>> Adam Obest, CMS:** We are going to go to the next speaker. Kelli is having technical difficulties. Could you go to the next speaker, please?

**>> Dr. Purva Rawal, CMS:** Great, why don't we go to Jessica Walradt, who is the Director of Performance Based Reimbursement at Northwestern Medicine in Illinois. Kelli, when you are ready, let us know, and we can come back to you.

**>> Jessica Walradt, Northwestern Medicine:** Hi, can you all hear me?

**>> OIT Operator**: Yes, we can, Jessica.

**>> Jessica Walradt, Northwestern Medicine:** Ok thanks. Sorry about that. Hi everyone. Thank you so much for having us here today to share some feedback. I'm going to address the first two questions. The first one touches on obstacles to participating in CMMI models and what CMMI can do to alleviate those obstacles. I'm going to highlight two related challenges. First, when models include significant administrative requirements that actually detract time and resources away from pursuing actual care transformation. I'm talking about things like requisite changes to billing or requesting a lot of different quality data submission. The second challenge is when participates are not provided sufficient time to operationalize those requirements and prepare for successful model implementation. That first issue can be combatted by reducing the amount of requisite changes. For example, if CMS is going to request data from participants, be really thoughtful about the type and amount of data that is truly needed. I understand that we are all learning and so the inclination can be to throw in the kitchen sink and get as much data as possible and figure out what is most useful to incorporate into quality measures or target price adjustments. As we are now further along in our learning process, hopefully we can start to winnow that amount of requested data down to the most key pieces. And then the second issue can be addressed by providing as much advanced notice of new models or significant policy changes as

possible. And of course, the exact amount of prep time needed varies depending on the actual model in question, but I generally say that at least one year between knowing you have been mandated to implement a model or change and then the actual effective date for said model or change would be helpful.

And then the second question I'll touch on is what would CMMI do to support clinicians and help them be successful in models. This is a theme I've heard a lot of speakers touch on already: upfront funding for care transformation. That can be through the form of a PMPM or even enhanced funding for certain supportive services, like social work that actually help us achieve some of the types of care transformation that we are pursuing. Secondly, I would say executing policies in a manner that don't make physicians feel like the cards are being stacked against them. A great example is when you're risk adjusting target prices or benchmarks. I can appreciate that this is a really complex task for CMMI, but thinking through how you risk adjust a target such that you're holding providers accountable to the things they can impact, while adjusting for the things that are beyond their control. Another way to make providers feel more engaged and empowered is to avoid major model changes, especially when those changes are announced on short notice, because physicians will feel disengaged and like the goalpost has been moved on them without warning. And then my final suggestion is that CMS should be providing as comprehensive of claims data as possible and to really learn from other pre-existing models and their experience. Northwestern has participated in a handful of different models and interestingly, there has been different data fields provided and different models. In one model, for example, we received rev codes in our claims data, which seems small, but that's how you identify ICU utilization. And in a separate model there weren't rev codes. You are taking advantage of the breadth experience across CMMI models at this point and taking the best lessons from all of them when thinking about what information you can empower participants with.

That's all I have for today. Thank you again so much for this opportunity.

**>> Dr. Purva Rawal, CMS:** Thank you so much, Jessica. That was extremely helpful, and I think you also are raising points that other participants have raised around some of the administrative requirements and the fact that it increases provider and participant burden. And so, I think we need to think hard about ways that we can be deliberate in the data requirements that we're including in models so we are allowing for as much time, energy, and resources to be devoted to care delivery. Also, I think I heard you say that more time was needed to operationalize requirements to join models and to make decisions around the changes that need to be made to participate, and I think Ellen echoed that earlier as well. And so, we appreciate you sharing that point. Also, you offered a number of solutions and so would love to continue to speak with you about your experience as a model participant and how that can help us as we move forward. The second half you talked about clinician support. We are looking hard at how our models can continue to increase the use of team-based care that really enables the delivery of integrated care that meets patient needs. I want to say thank you, and appreciate your participation in models to date as well and hopefully your future participation.

And with that, I'll move to our next speaker, Lalan Wilfong, who is the Vice President of Payer Relations & Practice Transformation at McKesson, speaking to us from Texas today.

**>> Lalan Wilfong, McKesson:** Thank you. Appreciate the time, and I do thoroughly appreciate the engagement that CMMI has had with practices on improving the models that have been there and in designing the models to come. For a bit of background, I'm a practicing medical oncologist at Texas

Oncology, in addition to working for McKesson, the US Oncology Network. We support multiple practices through the Oncology Care Model and have multiple practices that are going to mandatorily be participating in Radiation Oncology Alternative Payment Model in the future. I would say to answer your first question around some of the obstacles to participation, many speakers have already mentioned the things that were on my list around data, attribution, and things like that. I would say, and I would want to again encourage, like the previous speaker, around alignment between models. It is amazing to me as we set up the Radiation Oncology APM, and an organization that had a lot of experience in the Oncology Care Model, that we haven't learned a whole lot. Meaning, the data submission is done on a different platform. It took us a few years to optimize the ability for us to submit the data to you and to alleviate that burden on the practices. The new format is new, and it feels like were having to start over again on that. So, I think the more alignment we have from CMMI on the way that we do things, the easier it is for practices to participate in models. The other thing I want to address, which is a challenge in oncology here, is one of those specialties, and again I agree with the speaker around end-stage renal disease, one of those activities where care typically shifts from the majority of our patients from a PCP-centered network to an oncologist during the time they are getting cancer care. That being said, I think we need to make sure with attribution we attribute the right patients to the right physician. The physician who owns the bulk of the care of that patient at that time should be the one responsible for that care and responsible for the payment methodology in the model and making sure that we don't overlap too much. I'm a little concerned about some of the recommendations from CMMI about having smaller number of models that cover more people. I agree with the speaker before that that could lead to increased consolidation in the marketplace. Especially in the care of patients with cancer, we see that consolidation raises prices, maybe not for CMS and Medicare, but definitely in the commercial market. We see cancer care cost increasing as consolidation happens in marketplaces. And so, we want to make sure that any model that does not encourage consolidation unnecessarily, that encourages continued improvement on patient care activities. The other thing I want to make sure we understand, especially in the care of patients with cancer, how historical benchmarks may not accurately reflect the care that we provide now. Especially in cancer care where for example, we took a cancer-like lung cancer at the start of our Oncology Care Model, which is simple in the management at that time and had tremendous innovation over the past few years to where my care for patients with lung cancer are very complex now, where they used to be pretty simple. What’s very different: costs and outcomes and toxicities that we manage. And how do we make sure that we have appropriate benchmarks starting in oncology to get down to microlevel patient care where you look at a benchmark on a macrolevel across the nation, you might be able to say the care of a patient with lung cancer costs “X,” but on a microlevel, that might be different and again, thus discouraging the smaller practices, particular those in rural areas and other places from being able to adequately participate in a model where, through no fault of their own, the patients that walk through their door, their cost structure for the appropriate care of that patient may be different. That’s something that we need to work on together, as we look forward to the future.

Again, for all of the other comments, I'll submit them online. I do appreciate the time that we have together and the interest in the collaboration that CMMI is showing to partner on new models.

**>> Ellen Lukens, CMS:** Thank you so much, Lalan, and we really appreciate your partnership in OCM. I think that model has done a lot in trying to improve the care for Medicare beneficiaries getting chemotherapy. So, really appreciate that.

I did want to note two things. Your final comment and reflection on how we set accurate benchmarks in clinical areas where there is really incredible innovation and practice is changing real time as drugs are introduced to the market. I definitely hear you there, and I think those are really good questions, and I don't think we have all the answers right now, but definitely agree with you that we have to think about these dynamic specialties and how to accommodate those types of changes when we are thinking about the models. I also appreciate the comments I feel like you were reflecting on the similar challenges that Northwestern articulated in how we are going to accept data and the types of data we will send back to you. The consistency for folks who participated in our models and invested in infrastructure to use those data and submit those data, that we really need to consider those consistencies moving forward so that we ensure that we are efficient, and also that our participants don't incur unnecessary costs. So, really appreciate those reflections.

We will turn it over now to Terry Williams, who is the Executive Vice President, Chief Population, Corporate and Government Affairs Officer of Atrium Health in North Carolina.

**>> Terry Williams, Atrium Health:** Thank you for the opportunity to share thoughts; really happy to see the enhanced vision for change that is part of the recent white paper and really appreciate the efforts of CMS and CMMI to engage stakeholders around the country. Among the family of collaborative providers across our three state areas, there’s a mix of about 6,500 employed and independent providers participating in one of five ACOs. Some of the ACOs have participated in Next Gen for over six years and have performed well and are enthusiastic about a continued and progressive, value-based journey. During that time, the care models have evolved, and more resources have been invested year over year to not only navigate patients and close care gaps, but to stimulate additional community partners, many minority-owned and run to participate and keep parts of the support fabric for patients including community health workers, transportation, social isolation, healthy food and housing, and care at home. And this work to us helps move us toward accountable care community concept, which has been an aspiration for some. We are very committed to health equity and social responsibility and are finding ourselves in this role of managing expectations with dozens of organizations about what's coming in the future and how do we design relationships that are independent together and goal-aligned, preparing for the future. In terms of greatest obstacles to participating in CMS Innovation Center and other contracts, one barrier is a lack of sustainable capitated or infrastructure payments and especially for some of the provider groups, the fee-for-value payments that are delayed for 18 months or more in many of the models is problematic. And models that offer capitation in many cases are unsustainable, or short term in duration, so specifically our six year Next-Gen ACO participant was absolutely committed to more and more progressiveness and found they were disappointed to find there wasn't a good option to continue an aggressive, multi-year journey, largely because of the way the rules were constructed. We think that not only affects the advanced ACOs, but also ACOs that are earlier in the journey and are uncertain about the speed in which they should be investing, as we’re trying to help them pick up speed on this journey.

Also, why we think the current structure of the Direct Contracting incentivizes some new participants, which it should be a good thing, and it’s also activated entities, sometimes with private expectations that have a short-term horizon and actions in the markets, and so we would ask that CMS modify Direct Contracting in a few ways. One, reduce some of the models with discounts; allow second cohort participants the opportunity to participate with the optional claims’ reduction, which is the same

opportunity afforded to cohort one participants for their first year; and remove the coding intensity factor from risk adjustment or reinstate the Next-Gen floor.

In summary, a clearer, more sustainable, multi-year runway for both advanced and beginning ACOs leads to more aggressive participation and investment, and participation from a wider variety of community organizations that want to step up and be a part of these efforts. We really support the health equity focus and believe the current structure of incentives toward new entrants does have some unintended consequences, while also having some positive attributes. Thank you very much for the opportunity to participate today, we desire to be a positive catalyst not only for health systems and providers, but to work with the broader community to improve health equity and social responsibility.

**>> Dr. Purva Rawal, CMS:** Thank you so much, Terry. Thanks for your participation and partnership in CMMI programs, including Next Gen and Direct Contracting. I was really struck by some of your remarks at the top where you talked about increasing your community partnerships and working with other providers out in the community as you've moved up that accountability spectrum. You also talked a little bit about lack of sustainable or capitated payments and I think one of the things we are thinking a lot about is how we create a clear glide path or progression from one model to the next and levels of risk to the next and maybe even integration. I think it is important for us to provide that road map that helps guide the decision making, including the investments that many of you are making on the ground. Also appreciated your Direct Contracting recommendations as well, and hope we can connect in the future and hear a little bit more about your journey through these models as well. Thank you.

And now I would like to turn to our next speaker, Allison Brennan, who is the Senior Vice President of Government Affairs at the National Association of ACOs, of otherwise known as NAACOS. Allison?

**>> Allison Brennan, National Association of ACOs:** Great, thank you so much for having me today and for this discussion. NAACOS represents nearly 400 ACOs across the country and we are very supportive of CMS and CMMI's work to reinforce the shift to value-based care. I'm going to actually start with a question on actionable data and just share a couple recommendations that we have to provide data to ACOs to enable their care coordination efforts. The first one is to provide ACOs with access to HIPPA Eligibility Transaction System, or HETS, data. This type of real-time data would provide ACOs with more information about beneficiary eligibility and where patients are seeking care, so that they can intervene. And we are also supportive of CMS providing substance abuse data for ACOs, which we hope takes place soon, especially after the passage of the Cares Act. We'd also like to see more data for external stakeholders to evaluate models and also support ACOs.

The bigger, more important, question I think is around the obstacles for providers to participate in accountable care models and what can be done to alleviate those obstacles. Many of the speakers today have really shared great points that I had on my list, and some of those that I will quickly reiterate are the challenges around the financing for upfront and ongoing investments to participate and stay committed to the value transition. Also, correcting the balance of risk and reward for model participants. We'd like to see more of an emphasis on rewards and favorable policies. The carrot approach, as opposed to the stick approach. We'd also like to see CMS take action to correct certain program policies that at this point seem be well recognized as having flaws, such as aspects of ACO benchmarking. We've heard a number of folks point out certain flaws related to a race-to-the-bottom approach to benchmarking, and we've repeatedly called on action to fix the ACO benchmarking flaw known as the "rural glitch," and that would really help many ACOs. It disproportionally harms rural

ACOs, so we'd love to see swift action taken to address that, as well as fixing risk-adjustment issues. We'd also like to see program complexity addressed and also a lack of transparency around model overlap. As I was hearing all of these speakers, one thing that resonated with me as an obstacle seems to be that many are struggling with stamina and I think that stamina to navigate this APM gauntlet, which has so many complex rules and some murky overlap policies, and also stamina to understand the ever-changing programs and rules that create this confusion and burnout. I think that we've heard a positive tone from the Agency and really appreciate that and hope that that positive tone will translate into supportive policy changes for providers and ACOs in value-based care. Thank you.

**>> Ellen Lukens, CMS:** Thank you so much, Allison. I think you did a really nice job of wrapping up many of the comments we heard from other folks and emphasizing not only how important it is that the models are not too complex, and they can be comprehended by participants, but also that transparency is so important. Hopefully you saw our reflections on that in the white paper, but it's definitely something we have heard. Thinking about benchmarking and how we make sure that folks don't feel they are being penalized if they perform well, and also really thinking about how we share data broadly so we all glean whatever we can from these models and really improve care and payment for services for our beneficiaries.

Really appreciate your comments, and a lot of food for thought today from everyone. These were excellent comments and very helpful to us as we think through the next phase of work.

We welcome any comments. If you want to move to the next slide, we have the e-mail address there for our inbox. Please provide any additional comments pertaining to this listening session to the CMMI strategy inbox, and if you can put "listening session 1" on the subject line, that would be really helpful to us. If you go to our website, you will see the white paper and also the slides from today.

We encourage you to look out for information from the CMS Innovation Center about additional listening sessions focused on specific aspects of the strategy and we will share more details via our listserv, our webpage and Twitter handle: @CMSinnovates.

I would like to close this session by thanking our speakers again very much for their thoughtful comments. I know we had one speaker that had technical issues and we will follow up with you to make sure we hear your perspective. Really appreciate all of the excellent comments and very helpful feedback as we think through how we move forward. On behalf of the Innovation Center, thank you again for joining us today, and have a great afternoon.

Thanks everyone.

**>> OIT Operator:** The recording has stopped.