

Eric (Introduction): Race to Value listeners! This week, we have Elizabeth Fowler, Director of the Center for Medicare and Medicaid Innovation–CMMI–on our podcast. Liz is the Director of CMMI, she’s the Deputy Administrator for the Centers for Medicare and Medicaid Services. Prior to joining the Biden administration, she was Executive Vice President for Programs at the Commonwealth Fund. Before joining the Fund, Dr. Fowler served as Vice President for Global Health Policy at Johnson & Johnson. She’s been a special assistant to Barack Obama on healthcare and economic policy at the National Economic Council. She’s occupied key positions at the U.S. Department of Health and Human Services. She’s assisted with implementation of the Affordable Care Act. We have a superstar leader in the Race to Value, and I could not be more happy, Daniel, to have such a powerful conversation with someone that’s really driving health system transformation in our country.

Daniel (Introduction): Yeah Eric, I couldn’t agree more, I’m so excited that we had Liz today on our conversation and I know our listeners are going to appreciate her insights. You know, the Center for Medicare and Medicaid Innovation is launching a bold new strategy with the goal of achieving equitable outcomes through high quality, affordable person-centered care. And to achieve this vision, they’re launching a strategic refresh organized around 5 main objectives: driving accountable care; advancing health equity; supporting innovation; addressing affordability; and partnering to achieve system transformation. And these strategic objectives will guide the center’s models and priorities in the coming years and in the coming decade. we go in-depth with Liz on this Strategy Refresh and I’m so excited to share that conversation.

Eric: Well let’s go ahead and hear from Liz Fowler, Director of the Center for Medicare and Medicaid Innovation as she joins us this week in the Race to Value!

Eric: Liz! Thanks for joining us this week in the Race to Value, we’re real excited to talk about your leadership and the value movement and the great work that you’re doing at the Center for Medicare and Medicaid Innovation.

Liz: Well, thanks a lot for having me. I really appreciate the chance to be here.

Eric: Well Liz, I thought we’d start our conversation today about what’s going on right now to reexamine the CMMI portfolio of APMs. After launching more than 50 alternative payment models that reward healthcare providers for delivering high-quality, cost-efficient care over the last decade, the Innovation Center has really learned a great deal and is ready start building a stronger and more sustainable path forward, and I know there’s been relative dissatisfaction with the performance of the center’s APM portfolio to date. While the reach is very impressive, with models that serve over 26 million patients—at least as of 2019—I know CMMI APMs are not producing the necessary financial and quality impacts to justify expanding most of the pilots. Of CMMI’s 54 total models, only five have ever produced statistically significant savings, and I know the Center is really taking a considerable approach to building a cohesive strategy that drives model development and evolution. And you are leading CMMI in this effort in streamlining the models and reduce complexity and overlap to really help scale what works.

As I understand, one of the major challenges to overcome includes the need to reengineer payment policies where these models do overlap, that often result in conflicting or opposing incentives. This, is in addition to the need to overcome some of the complexities of model design that impede scalable transformation. So I just wanted to ask you as we begin our conversation today, **can you speak to the lessons learned over the last decade and how CMMI is currently reexamining its portfolio of APMs? What are the main takeaways from the track record of performance results and how will changes to payment models further accelerate the movement to value-based care?**

Liz: Sure. I'm happy to have this conversation, and these are great questions and they're questions that we're very focused on.

So, as your listeners probably already know, the Innovation Center was created to generate and test new approaches to payment and delivery system reform in Medicare, and to a lesser extent, in Medicaid—and then, if we succeed in reducing health spending while maintaining or improving quality, we can spread those across the program.

You mentioned the 54 models that we've launched, and that only 4 of the models have met the standard to be expanded in duration and scope. And more specifically, those are: Home Health Value-Based Purchasing; Pioneer ACO; Prior Authorization for Repetitive, Scheduled Non-Emergent Ambulance Services, or RESNAT; and then the Medicare Diabetes Prevention Program.

It's not a bad track record, but I think we can do a lot better. And these models have each made an important contribution, but they're not the innovations that are going to achieve health system transformation. And so, we are taking a look at what we've learned, and as I've dug into what it is we've learned over the last 10 years, really, we have learned something from every model we've launched. And innovation is iterative. So what we're learning is all contributing to future models.

But the difference, I think, that we need to take going forward in the next 10 years, the difference in approach is that we can't throw a lot of spaghetti at some wall. We can't let a thousand flowers bloom. We have to have a cohesive articulation of a model portfolio, and we have to explain how the models fit together. And in my mind, we really have to be driving towards a larger vision. And I think that's what we're trying to do with the new strategy and that's what we're trying to do with the new approach.

And so as we look at models in the future, we'll consider a set of criteria as we determine whether to go forward with those models. Does the model support or advance one or more the strategic objectives that we outlined in the white paper—drive accountable care, advance health equity, support innovation, address affordability, or partner to achieve system transformation? We'll also consider, what is the potential impact on health system transformation, in terms of cost savings, quality improvement, reducing disparities, or achieving delivery system change? And what's the potential for other payers—commercial payers, purchasers, states—to be partners in the effort? And then also, just in terms of likelihood of successful execution, what's the potential for adoption and scaling by non-participants?

We've laid all of this out in the paper that we put out in October. It provides principals and lessons learned for we will be doing going forward, and you can expect us to be using this new framework and set of principles as we prioritize potential new models and improve our existing models.

Daniel: Liz, I'd like to learn more about how the CMS Innovation Center is committed to developing a health system that advances health equity—a goal that's integral to its mission to improve healthcare quality and reduce disparities in outcomes. Healthy People 2030 defines health equity as “the attainment of the highest level of health for all people.” And the Center was very clear in its Strategy Refresh that achieving this goal requires considering equity in all stages of model development, including ideation, model design, recruitment, implementation, and evaluation. The CMS Innovation Center has stated definitively over these last few months that it plans to embed health equity in every aspect of models to increase focus on underserved populations.

I'm particularly interested in how this will come about since models to date have been largely Medicare-oriented, and voluntary models have primarily drawn only those healthcare providers and organizations with the resources and capital to apply and participate, resulting in limited attention to Medicaid and safety net providers. I'd also love to hear your take on how the health value movement has evolved over the years through enlightened perspectives and increased societal awareness of health inequities to now consider the inclusion of equity in the numerator of the “value equation.”

So can you describe how CMMI is preparing to seize this historic moment by redefining the value movement through payment model redesign to include equity as a centerpiece? And how will the Innovation Center find a way to include more providers serving low and modest income, racially diverse, and/or rural populations by shifting the focus of APMs from Medicare to Medicaid?

Liz: Advancing health equity has become one of the most important areas of focus for the Innovation Center, and for CMS and HHS more broadly. When we talk about embedding equity into all aspects of our models—as you pointed out, and I'll be more specific—this means increasing 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. Health providers participating in models such as ACOs continue to have fewer Medicare beneficiaries from underserved populations and generally include beneficiaries who are less likely to live in rural areas. We want to be sure our models are reaching all of these communities and not just well-resourced ones, and that means looking to do more in the Medicaid space.

Other aspects of the strategy: developing new models and modifying existing models to address health equity and social determinants of health; as you mentioned, monitoring and evaluating models with equity analyses; and strengthening data collection and intersectional analyses for populations defined by race, ethnicity, language, geography, disability and sexual orientation and gender identity.

To make this a little bit more tangible, maybe it's helpful to walk through how we're thinking about equity in the life cycle of our models? In terms of model development—and I just touched on this in

terms of who's participating—making sure that we're reaching and recruiting providers and institutions who haven't joined in the past— And we've done analyses of some of our existing models. Who's coming in and what are the reasons why some of the providers who didn't quite make it to the finish line, going back and looking at what tools and resources maybe have prevented them from participating. And who didn't even apply in the first place?

So we want to make sure that our application and selection processes encourage participation of these providers, those who didn't make it to the finish line and maybe didn't even think about applying. And then we need to be providing technical assistance, and maybe financial assistance as well, to ensure a diversity of providers and mix of patients. This might include upfront infrastructure investments—for example, for safety net providers or rural providers. It could include social risk adjustment, benchmark considerations, payment incentives for reducing disparities or screening for determinants of health, and coordinating with community-based organizations to address these social needs. On the technical support side, we're thinking about application support, sharing of best practices for caring for underserved populations, and assistance with screening tools and data collection workflows.

And our strategy's focus on equity to promote accountable care extends to our work in Medicaid. We have a number of models in Medicaid that we currently operate, including a model focused on social determinants of health. I'll highlight a couple of them here:

The Integrated Care for Kids model, or INK, funds 7 states to build a coordinated system of care for kids. It spans healthcare, education, foster care, and justice systems. The model tests whether CMMI investments spur stakeholders to structure their own value-based incentives that improve care coordination and reduce foster care placements for at-risk kids.

The Accountable Health Communities model, which addresses a critical gap between clinical care and community services by testing whether systematically identifying and addressing health-related social needs of Medicare and Medicaid beneficiaries through screening, referral, and community navigation services, might potentially impact healthcare cost and reduce healthcare utilization.

And then the Maryland Total Cost of Care Model has also committed to Medicaid alignment in the primary care program by 2023. So this will further support participation of FQHCs in the model and reach vulnerable populations.

For those who are interested in learning more, we held a Health Equity Roundtable in December. It was a great event, we walked through our equity strategy and engaged stakeholders for feedback. We put the slides in the transcript of the event on the CMS Innovation website, if you want to see what more was discussed.

But let me just say a last few words. We keep talking about equity and what it means for our models, but then we've done some focus groups—specifically with healthcare providers and also with patients—about our strategy and what it means to them, and there's not a uniform understanding of what we mean by health equity and addressing health disparities. So I think we

have a lot more work to do to help educate providers on what it is we're looking for, what's important to us, and the direction we hope to see the system go. So lots more to come on this.

Eric: Well Liz, thank you for your leadership on this important issue. I mean, so many think that value-based care driven only by the economic imperative, but with such a focus on equity, this is a moral imperative as well. I'm excited to learn that closing equity gaps will be considered a form of quality improvement under the statutory criteria by which the Innovation Center models are evaluated.

I wanted to stay on this topic a bit longer since equity is such an important goal from a societal perspective. The pandemic has really highlighted and exacerbated numerous disparities in care impacting patient outcomes and quality of life. To deliver high-value care to diverse populations, to your point, there has to be more intentionality in the design of payment methodologies to support health equity. The solution really begins with acknowledging the impact of social and structural determinants of health on the ability of patients to access care and adhere to a care plan. In the CMMI Strategy Refresh that was recently released, one of the care innovations discussed was to improve pathways for engaging beneficiaries in accountable care relationships so they can receive more person-centered, integrated care that supports social determinants of health and greater access to care in the home and community.

Can you speak to how CMMI will be testing voluntary beneficiary alignment and attribution methodologies, benefit enhancements, and beneficiary engagement incentives to facilitate accountable care relationships between beneficiaries and their care teams? Also, how will the Center look to broaden the reach of model tests to underserved beneficiaries by emphasizing engagement with local communities and public health leaders in order to reach providers who may not have previously participated in value-based care?

Liz: We set a bold goal of moving all Medicare beneficiaries and the vast majority of Medicaid beneficiaries into these accountable care relationships. This could include advanced primary care, ACO models. Could include Medicare Advantage, although I think we want to make sure that those MA plans are providing that sort of coordinated care with better outcomes that we're driving forward to. And then we're also looking more closely at Medicaid relationships, and we don't automatically assume that patients enrolled in Medicaid-managed care organizations are receiving the sort of coordinated care that we're looking for as well.

Part of this, I think, is going to require a better understanding of what patients are looking for out of their healthcare. I think we spent a lot of time, as the Innovations Center, talking to providers, to health systems, to payers. We haven't been spending a lot of time talking to beneficiaries and patient groups. We need to better understand what it is that they're looking for out of their care.

We had a meeting with patient groups recently, where their perception of accountable care is that they might be given less care, and that concerned us. So the message that we're trying to move people into a care system that works better for them may be getting lost, and so I think there's a communication angle here and a beneficiary education angle here that we need to consider if we're

going to be able to achieve this goal of moving all beneficiaries into accountable care relationships by 2030.

And then you asked the question about how to engage local leaders and provide care more at the community level, and I think for that, we have an accountable health communities model which I mentioned earlier that's doing really pivotal work to address social determinants of health. It's really exciting what we have seen from the first evaluation report. Early signs of reducing emergency department use among Medicare beneficiaries, beneficiaries accepting community navigation services at higher rates than anticipated, and implementing navigation services. Really, this has been a work in progress. Our first evaluation report of this model found that 74% of eligible beneficiaries accepted navigation to community-based organizations, but only 14% of those completed a full year of navigation and had any of their health-related social needs documented as resolved. There's a lot of factors that could explain this, including difficulties with data reporting, loss of contact with beneficiaries, difficulty managing large caseloads, and a lack of transportation to needed services, even insufficient community resources.

So I think this is the hard part, and maybe the heart of your question: having the right incentives in place to make addressing social determinants of health the norm is really important, but we also need to make sure that those incentives are coupled with the right tools to make sure that we remove some of the barriers. So we've stressed the need for better data throughout the white paper, and a key milestone of our health equity objective being that new models will require participants to collect and report demographic data of their beneficiaries and, as appropriate, data on social needs and social determinants of health.

So our evaluations are a critical part of our models. They give us an avenue to directly improve data collection and measurement when it comes to health equity. So we're looking at standard evaluation requirements and trying to measure health impact assessments and how those can be used to assess individual models as well as our models collectively. So I think, in other words, this won't happen overnight, but we're really looking to build these lessons learned into other models, into our other ACO models, into our other oncology models for example or other models in other parts of our portfolio. So social determinants of health linking beneficiaries to community resources isn't a standalone model, but it's something we're thinking about how to deploy more globally.

Daniel: Liz, we talked a little bit about that one of the biggest challenges to overcome in this national movement to health value and equity that you're leading is healthcare providers' access to capital. Participants face difficulty in joining or continuing in models due to the investments required for care transformation. And we know that significant infrastructure investments are often needed to participate in models, including electronic health record enhancements, new staff, data analytic support—especially for safety net providers and those serving Medicaid beneficiaries. CMS is definitely sending strong, consistent signals and expectations about Medicare and Medicaid's commitment to value-based care so that participants can more predictably make the necessary investments. But in our work at the ACLC, we hear from providers consistently who tell us that they just don't have access to the necessary capital to effectively prepare for value-based care.

Can you speak to the Center’s experience with the ACO Investment Model (AIM) program, which demonstrated the value of advancing payments to support new ACOs in rural and underserved areas and how that is informing current and future ACO model design concepts? And will there continue to be time-limited upfront funding to especially smaller primary care practices or those with more limited experience in value-based payment models to help them prepare for the transition to population-based payments and total cost of care approaches? And how can CMMI continue to support providers with capital, especially those in the safety net, so they don’t get left behind?

Liz (24:28): Sure. Well, provider participation in our models hasn’t been universal or uniform. Some have sat on the sidelines and chose not to participate, but others are not ready, equipped or resourced to take on downside risk. We need to think about providing options and tools for providers to accept manageable levels of risk. And let me just say, on the other side of that coin, there have to be opportunities for those at the vanguard of value-based care who are comfortable with risk, and we have to provide a space for those risk takers and innovators and disrupters.

So we know that requiring downside risk can be challenging for providers, especially if they don’t have access to care management tools, if they serve beneficiaries with unpredictably high-costs, or if they lack appropriate payment and regulatory flexibilities. And our models often require participants to make significant infrastructure investments to do things like enhance their electronic health record, add new staff, and provide new data analytics support.

So again, at the end of the day, not all providers are ready or equipped or resourced for these models, and so as we think about tools and options to manage levels of risk, this means: making available and increasing uptake of actionable data; learning collaboratives and payment and regulatory flexibilities for model participants; sending strong and consistent signals about Medicare and Medicaid’s commitment to value-based care so we can make sure these investments are more predictable, that the path forward is predictable; and then thinking about the tools providers need based on their level of readiness. For safety net providers, for rural providers, for smaller practices, they may need more financial and technical assistance, while larger systems may need more advanced risk options to continue their trajectory in taking on total cost of care for their patients.

You mentioned the AIM Model, or the ACO Investment Model, and that’s a really good example of meeting providers where they are by giving those who are early on in the glidepath an opportunity to participate in value-based care arrangements and helping transition those who are ready to take on more risk. The model was developed in response to stakeholder concerns, frankly, and available research that said that some providers didn’t have the capital. So we tested this idea of prepaid shared savings to encourage new ACOs to form, and specifically targeted to rural and underserved areas, and aimed to encourage current MSSP—or Medicare Shared Savings Program—ACOs to transition to arrangements with greater risk.

In our view, the model was not only a success in creating meaningful movement to value-based care, but it also showed successful savings. The model saw \$526 million in gross Medicare spending reductions in the first 3 years of the model, and that was back in 2016 to 2018. Even after accounting for some of these upfront payments and additional shared savings payments, the net

savings was \$382 million. So, we are looking at ways of expanding this program, of bringing it back, and providing more assistance to more providers who want to move in this direction.

Eric: Liz, I know CMS has been actively pursuing changes to risk adjustment and benchmarking methodologies to drive accountability and improve accuracy of payments in CMS programs and Innovation Center models. There are well-noted challenges with current benchmarking methodologies, and I'll just outline a few of them for our listeners. I mean, there is, of course, selection bias if participants only opt in if they project that the financial incentives in the model are in their favor, and drop out when potential losses are projected. Additionally, the complexity of financial benchmarks have also undermined model effectiveness since providers may have difficulty in understanding the assessment methodology. Many financial benchmarks and risk adjustment methodologies have also created opportunities for potential gaming and upcoding among participants and reduced savings for Medicare. And then there's also this concern about the "race to the bottom" where benchmarks may penalize providers that were already efficient. I mean, there's a lot of visibility on the challenges with benchmarking, and since it's the only way to maximize provider participation, while sustainably generating savings, limiting spending growth, and motivating continuous improvement, I know this is a big area of focus.

Can you discuss how CMMI is leveraging lessons from models and incorporating input from industry to continue to refine benchmark methodologies? How will this refinement work allow us to properly incent appropriate coding of patient conditions and needs to better relate to local markets and reflect the health of the underlying population with accurate risk scoring? And could you also explain what's being done to mitigate the inadvertent opportunities for risk selection or arbitrage as providers and their consultants analyze which spending benchmark is most favorable to them, instead of focusing on whether the model innovations would allow them to generate meaningful improvements in care delivery for Medicare beneficiaries?

Liz: Well Eric, you've put your finger on a lot of really complex issues that are really having an impact on whether or not our models are successful, and each of these are truly critical issues that we're actively considering. So I'm happy to talk through model design concepts at a really high level.

Let's start with benchmarks. The challenges that we've had in setting financial benchmarks have undermined our ability to achieve savings. And to address these technical issues, we're evaluating options to ensure that we're not resulting in overpayment. So, unfortunately, we have a lot of examples where our model participants are reducing spending with statistical significance, but then the benchmarks end up being too high, and that results in net losses for CMS. This isn't only a financial problem for CMS, but it creates this disconnect, where model participants think they're being successful and they're changing care while CMS is dealing with another reality when we go and talk to our actuaries. And this problem will only grow as our model participants enter higher risk arrangements. So I mentioned we learned something with every model we've run, and we are taking these lessons and applying them to new benchmarking methodologies that we feel will be more accurate.

As an aside, I sent the Health Affairs Blog to my predecessor Brad Smith. He called me almost immediately and said he was so happy to see the focus on benchmarks, he said this is something that he was trying to improve when he was in my role and offered suggestions for improving our process, many of which we're considering.

On the issue of risk adjustment—and we can get into more detail as much as you want—but we're exploring opportunities to improve or replace our current risk adjustment methodology. This is critical because our innovation around care delivery, we need to make sure that the innovation is around improving care and success isn't just around better ways of gaming the system and upcoding. So the focus really should be on care delivery and improving outcomes, and not coding for the sake of higher payments. And as we're thinking about how our models address equity and ensuring that we're engaging participants we want to meaningfully work with underserved populations, this is becoming an increasingly important issue for us.

And then you mentioned how we're working with the private sector, and this is where I think multi-payer alignment is really critical as part of our strategy. We can't change the system without Medicare, but we can't do it alone, and we really need to be working closely with private payers and purchasers and public payers. And we have to think differently about multi-payer alignment, and that includes addressing some of these issues around, for example, risk adjustment. And it also involves looking at concepts like how we measure quality, aligning on key APM design features—clinical tools, outcome measures, payment, policy approaches, strengthening primary care.

So we're trying to think differently about multi-payer alignment, and learning from other payers as well as working in tandem to make sure that some of the changes we're considering are also changes they would consider in their approaches to payment as well.

So you asked about risk adjustment and wanting a little bit more detail on what we're thinking about in terms of risk adjustment, and I think this is really critical. So we've really prioritized risk adjustment and risk score gaming because we recognize that there are true negative consequences of inappropriate risk score growth. We've taken the opportunity to address risk adjustment in the Direct Contracting Model. The risk score growth constraints that we're applying are notably more rigorous than those applied in either the Medicare Shared Savings Program or in Medicare Advantage.

So there are two factors that we're using to try to constrain risk score growth. One is the Coding Intensity Factor (sometimes called a CIF) and the other is a Model-specific Symmetric 3% Cap. So, let me start with the Coding Intensity Factor. We think that protects the Medicare Trust Fund from being compromised by risk score growth for the life of the Direct Contracting Model performance period, and that's 2021 through 2026. Relative to the 2019 baseline risk scores, any direct contracting payments that would accrue as the result of risk score growth beyond a baseline, at an aggregated level across the program, is netted out of total payments across the entire GPDC program at the end of each performance year.

And then in terms of risk-score gaming and levelling the playing field—in order to promote provider participation, we wanted to ensure a level playing field regarding risk score growth across all of the

direct contracting entities who are participating, and that includes DCEs with different practices in care management and patterns of diagnosis reporting. So the combined application of the DCE-specific Symmetric 3% Cap and the zero-sum growth Coding Intensity Factor protects some DCEs from competing super coders, as we call them. It does this by limiting the impact of direct contracting entities' specific risk score growth on the amount of the zero-sum risk score.

So under the model, it's important to recognize good care management of new patients, and the treatment of conditions and appropriate risk score growth. So in constraining risk score growth, however, it's really challenging to differentiate appropriate risk score growth from risk score growth that's triggered by gaming or inflated diagnosis reporting. So while the CIF maintains a zero-sum risk score growth over the life of the model, we apply the Symmetric 3% Cap with a rolling reference year with a two-year gap, and this allows for some DCE-specific risk growth over time.

So it's been pointed out that the Symmetric 3% cap with a rolling reference may lead to gaming; however, theoretical inflation or opportunity to increase risk scores beyond the 3% cap is not expected to be realized until the performance year 2024, so when 2022 becomes the rolling reference year. This is due to the prospective nature of the CMS-HCC risk adjustment model, where PY—or performance year—2022 risk scores (based on 2021 diagnoses) are the first year of risk scores that may be influenced by the DCE's care management and related diagnosis reporting. So we're very carefully monitoring for this potential outcome.

And finally let me just say, regarding limiting Risk Score Growth for Voluntarily Aligned Beneficiaries. Voluntarily aligned beneficiaries may have untreated conditions. They may need increased care management from a DCE in their first year of alignment. And initially, we implemented a policy of only constraining the risk score growth once they became claims aligned, which can take multiple years. In response to this specific coding intensity concern, we are now implementing a stricter guardrail that applies coding intensity constraints to voluntarily aligned beneficiaries in their second year of being cared for by a DCE. So this targets the first and initial performance year risk scores for voluntarily aligned beneficiaries, when the DCE could report diagnoses with the intent of influencing the beneficiary's risk score. The CMS-HCC prospective model calculates risk scores using diagnoses reported in the year prior to the performance year.

So taken together and in sum, relative to fee-for-service, these risk score growth constraints applied in the GPDC Model protect the Medicare Trust Fund using the zero-sum risk score growth policy over the entire Model performance period, while simultaneously allowing DCEs to experience some growth with the intent of supporting DCEs newly treating beneficiaries who have not received good care management in the past.

We view evaluation findings from the GPDC Model as being pivotal as we're thinking about further refining risk adjustment for other Medicare programs and payments. And we're committed to further developing, refining and testing these risk score growth constraints and exploring others that can be adopted in the models, and in MSSP and maybe even Medicare Advantage.

So we appreciate the external support for this risk adjustment work, including risk score growth constraints, and we're inviting feedback as we move forward with these approaches. We're particularly interested in feedback on how these refinements might have broader application in Medicare. So just a note for your listeners—if you have thoughts for us, to share.

Daniel: Awesome. Thank you, Liz, for the detail. I think our listeners will appreciate that and definitely have thoughts and feedback, and so echo the invitation there.

Liz, I'd like to get your perspective on how we can better engage specialists in the health value movement. According to a study published in JAMA in 2018, only 5.4% of total health expenditures in the U.S. were in primary care. In contrast, the same study revealed over three times as much paid for specialist care, at 17.9% of the total. While bundled payments have proven to be an effective method to engage specialists in value-based care, it seems there is an opportunity when it comes to including them in ACO-type arrangements. A major driver of the disconnect is that patient attribution in value-based contracts is based on their primary care provider. As a result, specialists, even those in multi-specialty group practices, continue to provide care to patients who are attributed to other provider groups, and this dynamic leaves them with little or no change in their financial incentives. They can continue to maximize their income by focusing on revenue generation rather than cost control.

How can we increase the capability of primary care providers—as well as specialists and other providers—to engage in accountable care relationships with beneficiaries through incentives and flexibilities to manage quality and total cost of care? Is it possible to appropriately incentivize or encourage participation from both specialists and total cost of care entities to engage in an integrated care model, such that sharing risk is not a point of competition? Or can the specialty care models be replaced by total cost of care models?

Liz: So what you're touching on is really critical to the heart of our new strategy, and that's the alignment of specialty care with primary care. We see specialty care as a critical part of delivering on the promise and our vision for better care for beneficiaries. We recognize that accountable care requires high-quality care delivery from both primary and specialty care providers. We've done a fair amount of stakeholder outreach on how best to integrate value-based specialty care with population accountable care, how to support primary and specialty care collaboration and coordination, and how to align financial incentives and remove barriers to current specialist participation in ACOs and other models. We're also considering models for special populations.

Episode-based models and care will be part of our path forward, and we've been talking about accountable care, but affordability is also a strategic objective of the Innovation Center and we will continue to think through how we reduce overall spending and out-of-pocket costs for beneficiaries. This might include innovative episode-based models that better manage Medicare drug spending for example, or models that reduce disparities in settings of care.

We're doing a lot of thinking in this space. We would like to hopefully publish some of the learnings from these stakeholder listening sessions sometime next year and our thoughts on how to move forward with specialty care models. We have given a lot of thought to how to make sure that we're

not creating competing models where specialty care is competing with primary care and instead they're working together.

It's not a problem we have solved yet. One approach we're thinking is nesting specialty care models within ACOs, for example testing them within the Medicare Shared Savings Program. Doing a fair amount of thinking about that. So rather than a standalone, it really is testing different approaches to making sure that integration is happening and that care coordination and collaboration is happening. I think you'll hear more from us on this in the future, but we're giving it a lot of thought and would welcome feedback from listeners on how to do this better.

Eric: Liz, let's now discuss the Global and Professional Direct Contracting model (or GPDC). You referred to it earlier. Direct Contracting is CMMI's most progressive program for meeting the special healthcare needs of 38 million traditional Medicare beneficiaries. The GPDC model is really a game changer, and it puts us on the cusp of finally achieving for Medicare beneficiaries that all elusive Triple Aim of lower per capita cost, better outcomes, better experience. The program draws on the best elements of prior CMS and CMMI value-based care initiatives, such as MSSP and NextGen ACOs, but it's a bigger step towards both improving care and eliminating \$200 billion of annual excess medical spend in Medicare's \$850 billion budget, helping secure Medicare for future generations.

The program offers enhanced benefits for no additional cost while improving access to accountable primary care for Medicare beneficiaries suffering from a fee-for-service payment system that provides little coordinated or preventative care. It also incentivizes community-based physicians and health systems to provide comprehensive care coordination, accountable primary care and health and wellness services to eradicate the institutional health disparities that have existed too long in our society for our most vulnerable seniors. I'm particularly interested in how it uses many of the same operating levers as Medicare Advantage such as: beneficiary engagement incentives, benefit enhancements, and pass through of benefits to preferred providers. With full capitation, as with MA, DCEs would be responsible for most claims payments as well as medical management.

So all that said, can you help our listeners understand at a high level the importance of creating a model that uses some of these these operating levers like Medicare Advantage? Also, given the announcement earlier this year by CMMI would be halting all new applications to participate in the Global and Professional Direct Contracting APM, are there plans in the future to consider another solicitation for a new set of DCEs to expand the program in 2023 and beyond?

Liz: Well thanks for the question Eric, and we've received a lot of feedback on the Direct Contracting program, both positive and negative, and so I'm glad to have the chance to talk about that program here.

We have two cohorts, one that started in April 2021 and we have another cohort coming online in 2022. And we're exploring whether or not to move forward with another round. That's still under discussion and consideration at the Innovation Center. And I like to think of GPDC as the third generation of Accountable Care Organization Model, with the Pioneer ACO representing the first

generation, Next Generation ACOs representing the second. So it builds on long-standing Original Medicare initiatives and accountable care efforts, like the Medicare Shared Savings Program.

The GPDC Model closely resembles these ACO incentives in that it does not have limited networks and prior authorization as Medicare Advantage plans do. And like many other Innovation Center models, the goal of this ACO Model is to enhance the quality of care for beneficiaries in Original Medicare and to reduce unnecessary cost.

So beneficiary choice is maintained and protected in the GPDC Model. Beneficiaries can retain all Original Medicare benefits. In addition, they retain freedom of choice to receive care from any Medicare provider or supplier and may opt out of data sharing at any time. I think this is really important because there have been some criticism that these models reduce choice, and that's really not the case. But in addition, beneficiaries might have access to additional covered services that aren't otherwise covered in Original Medicare, as well as a reduction in Medicare Part B cost sharing or vouchers for transportation or dental services. In our mind, it's a potential model that levels the playing field between Medicare Advantage and beneficiaries who want to stay in traditional Original Medicare.

So we addressed some of the concerns about unfettered spending in the program due to upcoding, I know that's been one of the concerns or complaints. We have designed guardrails that are aimed at avoiding unjustified payments and increases in costs that might result from inappropriate risk score growth. We talked about those, so I won't repeat much detail about the risk scores.

We think that ACOs have demonstrated promise in reducing Medicare expenditures, and we need to encourage growth in the number of ACOs and assigned beneficiaries. GPDC expands the scope of organizations that can participate by lowering the minimums for number of aligned beneficiaries. It also aligns with one of the objectives in our strategy to drive more beneficiaries into accountable care.

We see a lot of opportunity to focus on health equity in the GPDC model, and that's another central piece of our strategy. We're already seeing our GPDC participants serving underserved communities at a rate that's higher than what we've seen in the MSSP program. So you can expect to see ACOs as a key part of our strategy moving forward, especially to reach goals for more beneficiaries to be aligned to accountable care providers. So ACOs, GPDC are essential to our path forward, and we are trying our best to answer some of the concerns that have been raised about the program, but we think it's a key part of our strategy going forward.

Daniel: Thank you Liz. I'd like to ask you now to speak to the power of peer learning for organizations looking to make the transition to value, and you mentioned it a little bit earlier in our conversation. We obviously here at the ACLC strongly believe that an ecosystem is needed for value-minded professionals to learn from each other and share best practices. In the recently released CMMI Strategy Refresh white paper, the Center committed to leveraging a range of care support innovations that enable integrated, person-centered care and specifically called out peer-to-peer learning collaboratives as one of the primary vehicles necessary for this innovation to take place. And just a few days ago (at the time of the recording) CMS Administrator Chiquita Brooks-

LaSure announced the launch of a new state-based initiative for the Health Care Payment Learning & Action Network to accelerate the movement toward advanced payment models through State Transformation Collaboratives that will start in Arkansas, California, Colorado and North Carolina.

Can you provide perspective on the importance of peer learning and why collaboratives like the ACLC or these State Transformation Collaboratives are so important to drive healthcare transformation?

Liz: Sure. You know, within the Innovation Center, we actually devote an entire group dedicated to identifying and diffusing learnings from our models to other model participants. We sincerely recognize the value of this work in helping model participants make course corrections, amplifying the impact of what is working. Our health system is so complicated, so we really feel like we need to provide as many opportunities as possible to learn from one another. Some of the activities this Innovation Center group organizes for model participants include: symposiums, to present to other model participants about the work they're doing; affinity groups for model participants to meet regularly and discuss implementation readiness before performance period begins; and then knowledge transfer meetings, where participants transitioning from one model to another share key learnings and best practices.

And you mentioned the Learning and Action Network, which is one of our major peer learning groups, and we are really pleased to be part of that. The LAN is a public-private collaboration funded by HHS through the Innovation Center. It's the most public, structured, and significant mechanism that we have for engaging and partnering and sharing goals with external stakeholders. We're working through the LAN to launch a National Accountable Care Action Collaborative to provide guidance and recommendations on key APM design features, including addressing health equity.

And we also recognize that transformation happens on the local level. So you mentioned the State Transformation Collaboratives that we recently announced. We're really excited that this approach can be used to drive multi-payer alignment on the most resilient, effective APMs for those states and hopefully diffuse some of those learnings to other areas of the country.

In addition, the LAN recently established the Health Equity Advisory Team, which is identifying model design principles to advance health equity across the CMS Innovation Center and health care systems as a whole.

And last, we're working closely with the LAN to identify opportunities to strengthen engagement of patients and consumer organizations in APM design and implementation. I think I mentioned this earlier—we're really looking for new opportunities to engage with patients and understand what they want out of the healthcare system and how we can deliver better care and be able to explain why value-based care is a better approach.

Eric: Liz, we've had such a great conversation today, and I thought I would land the plane with one last question and just talk about the future. I mean, we've had 10 years with CMMI and really driving and accelerating value-based care, and in the second decade we're now thinking about the

next decade. Now that CMMI has built a solid foundation of models, results, and lessons learned, I know you're looking to leverage all of that to achieve a bold vision by 2030. And last October, CMMI threw down the gauntlet by setting the goal of having every Medicare fee-for-service beneficiary in an accountable care relationship by 2030. And this goal would not only aim to have all beneficiaries in value-based care arrangements, but for them to be in care arrangements where their needs are holistically assessed, and their care is coordinated within a broader total cost of care system.

In your Strategy Refresh report, it was stated that achieving this goal could lead to an additional 30 million beneficiaries—adjusted for growth in the Medicare population, which would be attributed to organizations such as advanced primary care practice, an ACO, or a similar entity that's responsible for the cost and quality of care. I know many of our listeners out there recall the goal that HHS Secretary Sylvia Burwell made back in 2015 that at least 90% of traditional Medicare fee-for-service payments would be tied to quality by 2018 and at least half of Medicare payments would be flowing through APMs by 2018. And I bring that up only in the context of really looking at the data, I know CMS has tied 90% of payments to value, but right now only about 40% are flowing through APMs.

I wanted to see if you could talk about your goal for 2030 and how achievable that really is for the Medicare program. And how have lessons learned over the last ten years informed this new, bold vision?

Liz: Well, that's exactly the question we want to be answering. So we've spent a lot of time learning what's happened after the last 10 years, we've laid out a strategy for where we want to go for the next 10 years. And I think, I see my role at CMMI as twofold—really, doing as much as we can to be as straightforward and clear about where we're heading. The more clarity we can provide to stakeholders about the path forward, the more we can plan and know where we're heading. And then the other goal I have is really to reinstate this sense of momentum and this sense of inevitability that we're moving towards value, which I feel like we've lost a little bit in the last handful of years. So I want to make sure that we're continuing to pave that path forward and providers know where we're heading.

So we remain committed to the goal of moving away from fee-for-service. We've laid out a vision. We've laid out strategic objectives and the next step is to actually deliver and implement that strategy. And so we're hoping to do that with a series of blogs and announcements, maybe even—if we can get that far—providing a calendar of potential models that might be coming out so people can plan, so providers, health systems know where we're heading. I think that's really important, so we're trying to do that at the beginning of the year.

I'll also say it takes a while to do models at the Innovation Center. It takes 18 months to two years to get models out. So I think there will be this transition period where we're communicating the direction we're going, and we're going to try to keep that train rolling of models, but there is this transition period where I think people may say, well you're not doing enough models, I don't know how you're going to get to the broader health system transformation goal that we've set.

To your point about the goals that we've set—we have set this goal of all beneficiaries in Medicare and vast majority of Medicaid beneficiaries into an accountable care model by 2030. I want to point out that this is a person-centered goal. So it's a shift away from the previous framing of the percentage of healthcare payments in APMs.

But those goals are related, and if we reach our goals of 100% of beneficiaries into care relationships by 2030, that means that 100% of Traditional Medicare payments will be tied to APMs. So those goals— We're not walking away from our previous goals, but I think we're just reframing them. It's a bold goal, and it's intended to send a strong signal to where we're heading so we can make sure there's more predictability.

There was a point made about mandatory models, and I wanted to address that because that comes up fairly frequently. We want to craft financial incentives to avoid risk selection, and voluntary models attract providers who stand to gain financially. On the other hand, mandatory models are controversial, as we've learned. Voluntary models can demonstrate a proof of concept, but they limit potential savings and the full ability to test an intervention, because basically participants opt in when they think they can benefit financially, and opt out (or never join) if they believe they are at risk for losses. If we want to help drive people into relationships with providers that are accountable for patients' costs and improving care, we need to start moving away from voluntary models. However, mandatory models, there isn't universal agreement about moving in that area. So in terms of trying to reach the goals that we've set, we're looking at all options, including mandatory models, but we also realize politically, we may not be able to get there.

So you'll have to wait and see what comes next, and like I said, we're hoping to put out more direction and more signals about where we're heading in the near future.

Eric: Liz, thank you for your leadership in this Race to Value and spending time with us today to discuss the strategy for the CMS Innovation Center in the next decade and beyond. As I mentioned earlier, this is definitely an economic and a moral imperative where we have to win this race to value to stay globally competitive and really deliver the best to our Medicare beneficiaries and those in underserved communities. I wanted to thank you personally again for spending time with us and your leadership in the value movement.

Would you like to provide any parting thoughts? I know we discussed the Innovation Center's Strategy Refresh white paper that was released, we'll have that link for our listeners on the podcast episode, and just generally for anyone out there listening, how can they stay engaged and take a leadership role in leading healthcare transformation in their respective organizations?

Liz: Well, thank you so much for having me. I really appreciate the opportunity. The more we can be out there speaking to audiences like yours, the more likely we are to be successful.

I think if you want to keep in touch with what we're doing, of course, there's our website. We intend to have more listening sessions. We welcome feedback, I've received a number of letters from a number of providers and organizations who want to weigh in on various aspects of our strategy, of where we should be going with models, and we welcome that input very sincerely.

And I'd be happy to come back maybe in a year or so and we can see how far we've been able to move and where we still need to plug some holes and fill some gaps and maybe we can check back and see how we're doing in a few months.

Eric: Well we would certainly love that and I know our listeners would as well. Thank you again for spending time with us and sharing your strategy and your views on the value movement with our listeners.

Daniel: Thank you, Liz. Really enjoyed it.

Liz: Same. Thank you.