The Future of the CMS Innovation Center

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02:04 - NATALIE DAVIS

Hello, everybody. Welcome to our webinar today. I'm Natalie Davis, and thank you all for coming today. We are so thrilled to have such a large group as we talk with Dr. Liz Fowler, the Deputy Administrator for the Centers for Medicare and Medicaid Services, commonly known as CMS, and the current director for the Center for Medicare and Medicaid Innovation, often referred to as CMMI, or the Innovation Center. We'll get to talk with Liz in just a minute and take your questions as well. But first, let me share some background on the United States of Care. As I said, I'm Natalie Davis, CEO and Co-Founder at United States of Care. We are a nonpartisan, nonprofit organization committed to ensuring that everyone has access to quality, affordable health care. And we do that work in a lot of ways, but it always starts with understanding people's true needs for their health care system. And that research started over two years ago, talking to thousands of people and continuing every day guides us in our vision for the future where all people have dependable health care that meets their unique needs, at a price they can afford. When we talk to people, this means building a better health care system based on four goals. People have the certainty they can afford their health care. People have the security and freedom that dependable health care coverage provides as life changes. People can get personalized care they need when and how they need it. And they can experience a health care system that is understandable and easy to navigate. United States of Care's work and what we hear from people is the North Star we believe as changemakers in health care, which is why all of you are here today can focus our efforts and the reminder of why we're building a better health care system. And of course, this includes how we pay for health care differently. And that's the work of course that Liz and CMMI lead. We share a lot of common goals, of course, with improving the health care system, and have been engaged with CMS, CMMI, and other parts of CMS since this new administration. We work to bring together different voices from across the general public, our health care system providers, advocates, industry, as well as all of our lessons from our public engagement and work across the country to inform their strategy. We provided recommendations on grounding the work in people's needs and keeping equity at the forefront, all of which we can see reflected in the strategy. And we recognize that making meaningful change requires bringing United States of Care's unique perspectives and all of our partners. I am sure Liz will share in her remarks CMMI's work directly affects ten of millions of people with incredible flexibility to try new things to make sure that care can be dependable, affordable, personalized and a system that we can understand. And we're here today because as many of you know, the innovation center just rolled out its refreshed strategy for the next decade. Liz has built a

remarkable health care policy career. And both the public and private sectors having worked in high level positions at the Commonwealth Fund, Johnson & Johnson, the Obama White House, Department of Health and Human Services, Senator Max Baucus's office, and so much more. And we're so excited to have you here today, Liz. Thank you for your service to this country, and I'm pleased to hand it over to you to talk about the strategy and how it centers equity to meet the needs of people.

05:42 - LIZ FOWLER

Thank you so much, Natalie. I'm really happy to be here and really appreciate the opportunity to talk about our strategy. And I don't know if it's possible, I think, I think yes, slides. There we go. Thank you. Just a few introductory remarks and then I'll get to the slides. But since joining the Innovation Center in March, we've spent a lot of time reflecting on what we've accomplished over the last decade and tried to use those lessons to inform our direction for the next 10 years. And coming into this role, I really see my purpose in my role as twofold. First of all to provide as much clarity as possible about the direction we're heading, and then also to work as hard as I can, and in partnership with the rest of CMS leadership and organizations like USofCare to regain that sense of inevitability that our health system is moving away from fee for service and toward Value Based Payment. As you mentioned, Natalie, in October, we released a white paper on the Innovation Center website that built on the vision and ideas we outlined in an August *Health Affairs* blog. The goal with the paper was to provide more specific details on where we're heading. Some of you might have been able to make it to our rollout event in October, or maybe one of our subsequent listening sessions, but in case you missed it, I'll provide some high level takeaways to orient everyone at the top of our time today. So, next slide. As part of our effort to define and execute against a refresh strategy for the future, as I mentioned, we look back to understand what we had done well and what we could have done better. We've had a substantial impact over our first 10 years, implemented over 50 models that have touched millions of beneficiaries and hundreds of thousands of providers and health plans. Those lessons from the last 10 years we've taken to heart, we've listened carefully to experts, reviewed literature, including the USofCare report, and we've outlined a vision for the next 10 years. And we've identified five strategic objectives to guide this work and achieve our vision. The vision is straightforward, a health system that achieves equitable outcomes through high-quality, affordable person-centered care. I'll go through each of those individually and talk about how it's going to guide our work. I also want to say that what we're building here at the Innovation Center fits in really closely with what Administrator Brooks-LaSure has outlined for CMS more broadly. So we're right in line with where she wants us to be going and really happy to have her support and be able to have our strategy supports her strategy. So, next slide. So, the first pillar is driving accountable care. We've set a central goal for the Innovation Center to increase the number of people in relationships with providers that are accountable for their patients' costs and improving their care. This will require increasing beneficiary access to advanced primary care and ACO models that coordinate with or are integrated with specialty care to meet the full range of patient needs. And when we think about entities that are accountable for patient care, that includes physician group practices, hospitals, other health care providers, Medicare Advantage plans, PACE plans, even Medicaid managed care plans. We've set a goal for ourselves that by 2030 all Medicare Fee for Service beneficiaries, and a vast majority of Medicaid beneficiaries, will be in a care relationship with accountability for quality and total cost of care. Next slide. Advancing health equity has become one of the most important areas of focus for the Innovation Center for CMS and HHS more broadly, and for the

Biden and Harris administration, and as part of our strategy to improve quality, which is part of our statutory mandate. We're committed to embedding equity in all aspects of our Innovation Center models and increasing our focus on underserved populations. This includes a focus on health equity across the lifecycle of our models from development to application and selection processes, implementation and evaluation, and this could also include providing technical assistance to ensure that a diversity of providers and a mix of patients participate in our models. Next slide. So supporting innovation, the Innovation Center can also do more to support model participants that are looking for ways to innovate care delivery approaches. Some of these supports might include actionable and practice specific data, technology, dissemination of best practices, peer-to-peer learning, collaboratives and payment flexibilities. Next slide. Addressing affordability. In addition to our payment models, reducing expenditures in Medicare and Medicaid, our models should also have an impact on lowering patients' out-of-pocket costs. This is a priority for our CMS administrator, and we'll be looking at strategies that target health care prices affordability and reduce unnecessary or duplicative care. Next slide. Partner to achieve system transformation. The last part of our strategy is aimed at furthering the reach of health transformation. We can't do it alone. We need to align our priorities and policies across CMS and work in tandem with commercial payers, purchasers, states, and beneficiaries to achieve our vision. By 2030, we're hoping that all of our new models make multi-payer alignment possible. And in the past, we've called it a victory when private payers joined our models or state Medicaid agencies, and that's made a difference, but as much as it was a victory, we believe we can have a greater impact. And so it's not just about joining our specific models. Next slide. I want to close by offering a few thoughts as to what comes next for the Innovation Center. As part of our commitment to stakeholder engagement and partnership, we've been conducting listening sessions. If you go to our website, you can find information about the two listening sessions we held at the end of last year. One focused generally on the strategy and the second focused on health equity. We're planning a more more topic specific listening sessions, hoping the next one will focus on perspectives from patients. Your feedback and the perspectives on this new direction are very important to us, and it's one of the reasons I'm excited to be here today. So, I hope you'll share your ideas with us so that together we can help make a meaningful difference in our health system. And maybe, Natalie, on that note, I'll end my presentation and look forward to engaging in a dialogue with you and the rest of the audience.

12:25 - NATALIE DAVIS

Great. Thank you. One of the questions I'd like to start with really is providing a quote that was recently in a blog post from you, Administrator Chiquita Brooks-LaSure, and Medicare Director Meena Seshamani, which included the line, 'As women of color who have dedicated our careers to improving the health care system in the US, we know that disparities have been especially magnified during the COVID 19 pandemic and have put an enormous strain on families and individuals.' I'd love to hear more about this and about how your life has really influenced how you look at the Center's ability to make change and really have an equity focus strategy.

13:12 - LIZ FOWLER

Thanks, Natalie. Well, I would say my career path was shaped by the two most important people in my life: my father, who was a primary care physician, and really inspired an interest in health and health care policy, and my mother who moved to this country from Taiwan without a college degree and a new

baby, that was me, and worked her way through college and became an accountant. And, so from her, I learned you can do anything you set your mind to. As I think about equity, I think about my grandmother, who was a non-English speaking, dual-eligible who lived in Texas. She had a number of health conditions that weren't very well managed. Coordinating her care required the support of my mother, aunt, and uncles, who had to help navigate the health system on her behalf, and had to go with her to all of her appointments to help translate for her doctors. And so when I think about some of the models of care delivery and how they could have helped her and her care and coordinated her care better and been sensitive to her specific needs, I think that's what inspires me and what I think about when I think about health equity.

14:15 - NATALIE DAVIS
Great. And as you think back over, you know, we're a decade into the launch of Innovation Center, and you were in the room when the ACA was written and then in the administration when CMMI was created. You know, I'm pretty regularly relaying in the United States of Care origin story where I was, the notebook I wrote in, you know, those moments and feelings of really starting something new. I'd love to hear how you, you know, your version of the CMMI origin story and how the Innovation Center was created, why it was created, and what are some of the things you're the proudest of?

14:51 - LIZ FOWLER
Sure, well, first, I love that you have a USofCare origin story, and someday you'll have to share it with me because in all the meetings we've had, I have not heard that. So, I'd love to hear more. For the Innovation Center, the rationale really dates back to 2009 when we were all of us staffers working on the Affordable Care Act. And, I would say there were just as many members in the Senate – where I worked for the Senate Finance Committee – who wanted to find ways of bending the health care cost curve as there were members who wanted to expand coverage to the uninsured. Of course, there were folks that were focused on both, but really, I think, as we looked around for policies that would reduce health care spending and increase quality and increase outcomes, there really weren't a lot of ideas that had been tried and tested and could be implemented. And some of the Innovation Center was created to generate and test new approaches for payment and delivery system reform and Medicare, and to a lesser extent, Medicaid. And if they worked, they could be spread across the program, expanded in scope and duration. And so when ACI passed and the Innovation Center was created, there was a lot of momentum around getting away from fee for service and towards a system that rewarded value instead of volume. And we carried that momentum forward, like I said, and launched more than 50 models. I think the proudest accomplishment was really, you know, a legislation, the ACA that all fit together, that the pieces were all supposed to be working in tandem. You know, personally sitting on the Senate Floor and in the House Gallery and attending the signing ceremony when ACA was signed, I think it's made a tremendous difference for millions of people who now have health coverage.

16:46 - NATALIE DAVIS
I very much agree and was a part of the other part of the CMS that was started during that time where the federal marketplace was created and launched. And it was, like you said, such an impactful moment in someone's career to be a part of that. So as you said everyone's biggest concern really is

the cost in the system, both the cost to the individual, and we hear stories about that daily of people unable to afford the care that they need or the insurance that they need. But as well as the cost of the overall health care system. As you think about your strategy and the future of our overall health care system and the work that we can do, how do you think about kind of wrangling the overall costs which really is part of the mandate of the Innovation Center?

17:36 - LIZ FOWLER
Well our statutory mandate is to test payment in service delivery models with the intention of reducing costs while preserving or enhancing the quality of care. We hope that our models improve quality and reduce costs. But we also consider it a success if a model is able to do one while holding the other constant. And a model that meets one of these three criterias can be expanded in duration and scope through rulemaking. That's a long way of saying that our center was created to be part of the solution in holding down overall health care costs. There were arguments as to whether we have done so successfully. Only six models have generated statistically significant savings to taxpayers and Medicare, and only four models met the standard to be expanded in duration and scope. Those include the Home Health value based purchasing model, the Pioneer ACO Model, the Medicare Diabetes Prevention Program, and prior authorization for repetitive scheduled non-emergency ambulance services. So this was really one of the indices for engaging in the strategy refresh, we really wanted to take a step back and figure out, you know, what have we accomplished and how to amplify our impact. And I think getting more people into relationships with providers that are accountable for their care is really a key to holding down overall costs and really improving care and quality for patients. But you also have to think about costs from the perspective of people, and that's where the affordability objective comes in. We want our models to have an impact on people's pockets, their pocketbooks, as well as the government's.

19:16 - NATALIE DAVIS
Great. So you laid out in the direction of the Innovation Center that there was a real focus on embedding equity throughout whether that was, you know, using models that help specific populations that have been underserved, testing models that address social determinants of health, including under resourced providers and tests, stronger data collection, analysis, and so on. Can you say more about how the Innovation Center is thinking about putting these sorts of things into practice? And what's in motion to make that all possible? What do you need from the health care ecosystem etc.?

19:53 - LIZ FOWLER
Well, first, let's start with the definition of health equity at CMS. We've defined health equity as attainment of the highest level of health for all people — where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes. CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating an avoidable differences in outcomes experienced by those who are disadvantaged or historically underserved, and providing the care and support that our enrollees need to survive. And specifically to the Innovation Center as part of our strategy to improve quality. We're committed, as I

said, to embedding equity into all aspects of our models, and increasing the focus on underserved populations. Our work in this space will include increasing the number of beneficiaries from underserved communities in the models, in part by increasing their providers that serve them, including Medicaid providers, and those in FQHCs. We need to be thinking about who participates in our models, and we need to make sure we're reaching and recruiting providers and institutions who haven't joined our models in the past, for example, increasing participation of safety net and rural providers and others that serve patients in underserved communities. And then additionally, our application and selection processes should encourage participation of providers and not be a barrier. We need to look at our previous models to identify the barriers and challenges that safety net and rural providers have faced and in participating in our models, try to think about ways of engaging them moving forward. And then finally, we need to be providing technical assistance, financial assistance, to ensure diversity of providers and mix of patients. Upfront infrastructure investments might be needed for safety net providers to succeed in value based care arrangements. This could include social risk adjustments, benchmark considerations, and payment incentives for reducing disparities, or screening for social determinants of health. On the technical support side, we're thinking about application support and sharing best practices for caring for underserved populations, and assistance, maybe with screening tools and data collection workflows, and strategies that focus on equity and promoting Accountable Care extends to our work in Medicaid. And that Innovation Center will continue taking advantage of significant opportunities that Medicaid alignment provides to reach vulnerable populations. For those who want to learn more, we did, as I mentioned, hold an equity roundtable in December. It was a great event that walked through our strategy and engaged stakeholders for feedback. And the slides in the transcript for the event are available on the CMS Innovation website. So if you want to hear what we discussed, I would suggest taking a closer look at that.

23:05 - NATALIE DAVIS

Thank you, Liz, it really is amazing and great to see how much you and the Administrator and Meena are really having these listening sessions and inviting people to come in both when you create the strategy and now to the part of the refinement and the feedback and the implementation part. You know, I think, as I mentioned, listening to people really is part of our approach and belief and how we can fix our health care system. But you know, we don't hear people talk about ACOs, or bundles, or CMMI models. They really do talk about the system that is affordable, dependable, personal, easy to navigate, you know, wrapped up in that is respectful for their lives and their bodies. And, you know, there's so much room to do better in our health care system and to really meet those needs of people. As you think about specifically navigating the health care system – which is so complex and confusing – how do you picture the work that you can do at the Innovation Center to really help people and make a system that is easy to navigate?

24:14 - LIZ FOWLER

That's a great question. And I will say USofCare has done a really great job of listening. You've got a great antenna for priorities, fears, hopes across the U.S. health care landscape, and not just with people but providers as well. I said we wanted to listen more closely with patients, and I'll tell you at the Innovation Center we have spent a lot of time talking to providers and health systems payers and purchasers. But, you know, to be quite honest, we haven't done enough to talk to patients and hear

from them what they want from their providers and their health systems. So we're working on a strategy that mirrors what we've been trying to do with health equity. If we were to build in a patient perspective into our models from the very start, what would that look like and where would we start? As we're measuring quality, for example, we need to understand whether the measures that we're using are meaningful to patients and thinking about ways of aligning measures with goals that matter to patients. And they align with their patients' values like increasing years of active living. Similarly, when we talk about cost savings, and I mentioned this earlier, we've been thinking about it from a trust fund perspective, Medicare spending, and that's important, but those sorts of savings don't necessarily accrue to patients. And so in the strategy when we're talking about affordability, we also want to consider patients and thinking about models, for example, like drug spending. As a first step to figuring out what patients care about, we convened focus groups on the new strategy and what we found was that the language we're using doesn't really speak to patients. The term 'accountable care' was interpreted as skimping on care, not better care or care coordination. When you have patients with chronic conditions, they understand the value of coordinated care, but patients with fewer health care needs don't understand that concept. And the term health equity also doesn't resonate. So, we have a lot of work to do, frankly, starting with how we talk about our work, our goals, and our models. We're hoping to have a listening session about the strategy that will focus on patients and consumers and get their perspective, so more to come on this part of the strategy as the year unfolds. But, in the short term, we'd welcome participation in the learning sessions and our website will provide details when we have them.

26:34 - NATALIE DAVIS

Great. And another part of your strategy that you laid out really was so intriguing to me that brought in the work beyond the whole of government approach. And in that you said that that means partnerships with employers, health plans, and states, as well as patients, caregivers, providers, and community organizations. I'd love to hear more about that and this idea of the whole of, you know, work beyond the whole of government approach.

27:01 - LIZ FOWLER

Yeah, well, we are thinking about multi-payer alignment. It's a critical part of our strategy. We know that Medicare is a catalyst for change and the health system won't change without Medicare playing a significant role, but we can't do it alone. And we need to be working more closely with other payers in the system and including Departments of Health at the state level and Medicaid agencies. And we need to think differently about multi-payer alignment. As I mentioned, we used to think of it as a success if a payer joined one of our specific models. But, what we've heard is that joining our models is not an easy lift, it's actually quite burdensome. And, you know, it requires a certain level of performance, and reporting, and timing, and it has to align with our timing. So you know, in terms of what an effective approach to multipeer alignment looks like, probably somewhere between broad concepts and principles and model specifications. We're thinking it might mean aligning on APM design features, that's alternative payment model design features like clinical tools, outcome measures, payment policy approaches, and strengthening primary care. There's a role for driving alignment through the Learning and Action Network or the LAN. We've launched a national Accountable Care action collaborative that includes recommendations on key design features. We're thinking about geographies that are best

suited for innovation models where there might be a convergence of innovation, maybe a critical mass of potential partners, a willing State Health Authority, and other factors that might combine to make these efforts more successful. And this ties in with our December launch of the LAN's state transformation collaboratives. And also, we're thinking about becoming a convener. We can be a convener, like we're doing with the LAN, but also a joiner. Maybe we can borrow from or build on other organization strategies. So, it's not an approach that we've used in the past, but something we're looking at for the future.

29:08 - NATALIE DAVIS
I'm excited to hear more about that. And speaking of the future, you know, closing us out, we're 10 years into CMMI. You have the roadmap for the next 10 years. Fast forward to 2030. What does success look like, you know, for our health care system and how can CMMI help drive that?

29:27 - LIZ FOWLER
Well a core part of our strategy is really thinking about a more streamlined model portfolio, and we're really committed to a more cohesive articulation of how all the models fit together. So, we want to make sure that we're advancing our objectives that we've laid out in the white paper. And we also want to make sure that we're actually having an impact on health system transformation in terms of cost savings, quality improvement, reducing disparities, achieving delivery system change, and also in terms of likelihood of successful execution with a strong potential for adoption and scaling by non participants, as well as model participants. And we also, as I mentioned and you referenced, working more closely with other parts of CMS, the Center for Medicare, and the Center for Medicaid, and CHIP Services. So their work should inform our models and not necessarily the other way around. We've sort of been a little bit siloed, sort of doing our thing, but really if we want to be successful in what we're doing, if it's successful, it needs to be transferred and part of other parts of the program. So we're thinking about model tests that we could have in place by 2030. Model tests that include accountability for total cost of care and outcomes, advanced primary care model tests, specialty care model tests that support integrated, whole person care, and then state total cost of care model tests.

31:00 - NATALIE DAVIS
Great, well thank you, Liz, for your thoughts today, for really discussing the future of the Innovation Center through your strategy document. And as I said, thank you for your service to our government. Right now, we will hand it over to our Communications Director at United States of Care, Laura Smith, who will read questions that we received in the registration process and in this webinar. Over to you, Laura.

31:30 - LAURA SMITH
Thank you, Natalie. And as I begin to ask the questions of Dr. Fowler, please feel free to go ahead and submit your questions for her using the Q&A function. So, go ahead and start doing that if you haven't already. Thank you. Okay, so this first question is related to federally qualified health centers, commonly known as FQHCs. Dr. Fowler, does CMMI have any plans to develop initiatives specific to FQHCs? And what are they?

32:01 - LIZ FOWLER
Well, I think this gets back to trying to make sure that we're incorporating providers that maybe hadn't participated in our models in the past and those serving underserved populations, and FQHCs certainly count, as well as rural health clinics and other safety net providers. So we are actually thinking about how to do this. We're thinking about the barriers to participation now. What is it? Why haven't they come in? We're looking closely at participants who may have tried to come in but didn't quite make it across the finish line. What was it that kept them from succeeding, and then also, you know, those who didn't even try to apply? And I think this is going to require some outreach and some listening. We have heard from some FQHCs that are interested in coming into models. And we want to know, you know, why they hadn't in the past. So, it's part of our strategy to think about safety net providers, and I think more to come on that in the future.

33:00 - LAURA SMITH
Great. This next question is about behavioral health. Specifically, how are you thinking about addressing the need for more value based care in behavioral health?

33:12 - LIZ FOWLER
Yes, behavioral health is a really important area and it's been a priority for the Secretary as well as for CMS, and I think there's a whole internal working group that's thinking about behavioral health. And especially in this time, at this particular moment, when we hear a lot about behavioral health and mental health. I talked to you a little bit about our strategy and how we're thinking about streamlining and harmonizing the portfolio. We are trying to think about how we can incorporate these services into something bigger than just a disease specific model. So rather than doing a behavioral health standalone model, how is it that we can bring them into our other models? How is it that we could integrate that care into a primary care model, for example? So I think that's a question we're asking whenever we get sort of a specific area where someone's saying do a model in this specific area. Rather than a specific model, could we think about how to incorporate it? And so that's how we've been thinking about behavioral health. And we know we haven't done a lot in this area.

34:21 - LAURA SMITH
Great. The next question is about stakeholder engagement. How is the administration thinking about engaging stakeholders in support of your priorities? In other words, how can stakeholders help?

34:35 - LIZ FOWLER
So, we have thought about doing all sorts of things. So, we've been doing listening sessions, as I mentioned, we thought about doing like an RFI request for information where we throw out there like, ‘Help us think about this.’ But, if we were able to travel at this point, we're not able to travel, I would love to do more site visits. And like I said, actually going on the ground and talking to people on the ground, because I think the listening sessions are helpful, but it's sort of who knows about them and is able to, you know, sign up and join. And I'm not sure we're touching all parts of the system that we need to be listening to and particularly patients. So, we are doing listening sessions. We are soliciting feedback. We've gotten a lot of feedback through our website, and we're tracking that pretty closely. If at some

point we get to where we can actually go out and hear from people, I think, I'd really appreciate the opportunity to do that.

35:25 - LAURA SMITH
Someday we hope.

35:35 - LIZ FOWLER
Yeah, maybe. And, you know, I think for all the folks on the call, too, we're interested in hearing from you. So you're a part of this tour as well.

35:46 - LAURA SMITH
Wonderful. Moving on to Accountable Care, what are CMMI plans for your Accountable Care portfolio?

35:54 - LIZ FOWLER
So we are looking closely at Accountable Care as that's a key part of the strategy. We think that it's a way to drive better care. For people who have a physician who is actually looking out for their care. We've been working across CMS, working with the Center on Medicare, to have a more, I guess, coordinated portfolio on accountable care models. And that means working with the Center on Medicare and thinking about making sure that what we're doing is relevant to the Medicare Shared Savings Program, and that we're reflecting what they think they need to learn and incorporate more providers in their model. So, I think it's sort of a shared approach. We're also looking down the road of more advanced primary care models. And I think there's work going on on that front as well. You know, I think we're at a little bit of a transition here as we think about what's in the pipeline and what we want to do differently. So, hopefully, you'll hear more from us soon.

37:05 - LAURA SMITH
Thank you. The next question is on risk adjustment. How is the Innovation Center considering risk adjustment in the future models?

37:14 - LIZ FOWLER
Yeah, I think that's a really important question. There's been a lot written about the ability to engage in coding and upcoding games. And it's a way of maybe getting better payments or higher payments without actually delivering care. And we're very well attuned to some of the trends that we're seeing. And the CMS Innovation Center is looking at opportunities to improve or replace our current risk adjustment methodology. It's really crucial to ensure that innovation is really around care delivery and not just better ways of gaming the health system and upcoding. We really want the focus to be on care delivery and improving outcomes, and not not on coding games. So this is especially important as we're thinking about models related to addressing health equity, and how we're making sure we're engaging participants that want to work with underserved populations rather than just seeing these populations as opportunities for higher payments. So, as a result of this focus, we've taken the opportunity to address this challenge in our ongoing models that we have in one of our models an overall constraint on risk score growth that's applied across the entire program and applied individually to specific model

participants. And some of these lessons, if they are successful, could be applied to the Medicare Shared Savings Program or the Medicare Advantage plan.

38:51 - LAURA SMITH
Thank you. When you think about the role of people receiving and giving care, how is the Innovation Center focusing on patients and caregivers?

39:02 - LIZ FOWLER
That's a great question. And I've seen some of that in the chat too and really ways of focusing that. And as we're thinking about engaging more with patients, I think that also includes our partnership with caregivers and thinking about those who are spending a lot of their time and energy and effort caring for loved ones. It's not an area where we've spent a lot of time. I think we have some models focused on palliative care, or, you know, end of life care, but I think we could be doing a lot more in this area. And thinking about changes we have to make to incorporate caregiver voices as well as patient voices. So we haven't brought these voices into our process early enough, but I think I really believe that that's an area where we could do more. And so I think that's why we're going to focus the next listening session on these topics in particular.

40:04 - LAURA SMITH
Thank you. And the next question is a bit of a follow up. So they asked, 'The move to include more patients in the strategic planning process is laudable. How will the Innovation Center integrate patient perspectives into its work? How will you help patients successfully engage with the center?'

40:22 - LIZ FOWLER
So that is the crux of what we're trying to do. I think you heard, you know, I think we learned a lot from doing a series of focus groups that the way that we're talking to patients doesn't resonate, the language we're using doesn't resonate. Unless you're a patient with chronic conditions that has trouble navigating the health system, coordinating care, and better coordination and navigation doesn't really resonate if you're not somebody that uses the health system regularly. So we are, I think, starting a series of listening sessions and trying to do more outreach. I think we're building those relationships with patient organizations. We've talked about doing regular listening sessions, even just touching base with 'here are the models that we're doing, help us think about who we should be talking to.' As we're thinking about oncology care models, for example, as we think about quality metrics, what are the metrics that matter most for patients with cancer? It's, you know, not always the question we've asked. And then where we have asked the question, where our evaluations have asked questions about patients, I don't think we're bringing those lessons out enough. So, we're also looking back at all our previous evaluations to see where we do have some of these learnings that could be applied to other models and potentially putting more out there publicly as well.

41:55 - LAURA SMITH
That's really exciting. So how is the Innovation Center thinking about nesting or integrating specialty care and episodes into accountable care organizations?

42:07 - LIZ FOWLER
That's also, you guys are starting to get the real crux of what we're grappling with. You know, I think, as we did a listening tour, you know, what's worked over the last 10 years. What we found is that some of our models conflicted with each other, or collided as someone explained. So you might be a health system that is involved in bundled payments and involved in an ACO, and there's competing financial incentives. So they're not necessarily aligned even for the same provider. So rather than trying to, this is what I meant when I said we're trying to harmonize our models, we're trying to think more closely about how the models can work together. And I think if we're putting Accountable Care and this notion of Accountable Care at the center of what we're doing, I think we can't continue to do models that focus on individual episodes or specialties. But we really need to think about giving tools to primary care providers and Accountable Care organizations to be able to manage that care. And so that's the notion of nesting. So can we test those episodes within the context of, for example, the Medicare Shared Savings Program? I know it's really complicated and the evaluation team tells me it's very complicated. But this is what we're trying to do going forward. And, I think, there's a related lesson in here because I saw a few questions coming in about social determinants of health, which we haven't talked that much about. We had a separate model on the Accountable Health Communities that's coming to an end later this year. We've learned a lot about social determinants and referring patients for community services and the relationship between providers and those community organizations. But rather than have a standalone model that just does that in one model for a very limited set of providers, are there lessons that we could bring from that model into what we're doing, for example I keep bringing it back to the ecology model, but should they be asking about social determinants? You know, access to nutrition, transportation, housing, is going to impact the outcomes for those patients. And so we're thinking about how to embed those lessons from social determinants models into what we're doing in other models.

44:29 - LAURA SMITH
That's great. And you got right into the next question we had. So I'll go to the next one, which is how is the CMS Innovation Center considering increasing value based care adoption in rural areas, particularly those with physician shortages?

44:44 - LIZ FOWLER
Yes, we see rural areas as part of the underserved population. So when we talk about health equity and reaching underserved populations, it's not just about areas where there have been historically low access to care but also thinking about rural areas. And as somebody from who grew up in Kansas and went to school in Minnesota, I have a very keen interest in making sure that's part of our strategy. So we do have one model that's focused on rural areas, the CHART model that was launched last year. I think we're, you know, still seeing how that goes. And looking for other opportunities to engage with rural health providers in our health equity efforts.

45:34 - LAURA SMITH
Building on that, many of the models require large populations to test, which can be hard for small population frontier states. So how can CMMI include smaller states in your innovation efforts?

45:48 - LIZ FOWLER

So in terms of the states that we're engaging, I mentioned that we launched a state transformation collaborative in December, and we purposely look for states that weren't always the big states with the big populations with a lot of providers. But Arkansas is one of our states, North Carolina, Colorado, as well as California. So, California is still in there. But, we are looking for opportunities to go in places where we haven't been before. I think that's part of, you know, if you look at our map of where models have been conducted, there are gaps in those places. And it's our goal to try to fill in some of those gaps and find models that can engage providers and participants in those areas.

46:33 - LAURA SMITH
Switching gears a little bit, but sort of related. They're all related. But, can you share your thoughts on how models can support non medical needs for Medicare beneficiaries, such as meal delivery?

46:46 - LIZ FOWLER
Yeah, we do have one model. That is the Value Based Insurance Design model that gives Medicare Advantage plans the flexibility to be able to provide medically nutritious meals or medically recommended meals for patients that may be facing, you know, hunger or specific nutritional needs that are related to a diet that's part of their care. You know, moving it out of that model into others I think is what we're thinking about next. Keep in mind that we have looked at whether we can do those types of models in other care settings. And I'm not sure, we have to go through the actuary at CMS. And they have to say, 'Yes, this is going to save money.' So we've been in conversations with the actuary that if we provide, you know, medical food as medicine in these models. Could we generate the level of savings that would allow us to go forward? And so we're still working through some of those conversations. But it's sort of an ongoing interest of ours, but we haven't quite got there yet.

48:03 - LAURA SMITH
Thank you. We've recognized that primary care is important for quality and to manage total costs. So how is the Innovation Center thinking about enhancing primary care?

48:15 - LIZ FOWLER
Well, if you follow closely, we're on our third primary care model. We have the Comprehensive Primary Care Model, which is the CPC model, we have the CPC Plus model, and last year we launched the Primary Care First model, which is an Advanced Primary Care model. The team is looking at how that model is doing. I think we have another cohort that started this year. And we're looking beyond that. I think the teams that have been working on the primary care models are thinking about the next generation. So I think we've decided that it's important to double down on primary care. There's been a lot of interest in primary care. I know USF care, the National Academy of Sciences, National Academy of Medicine, has a whole report on the role of primary care. If you look at other countries' health care systems that have, you know, better outcomes at lower costs than our health care system, a lot of them have a very prominent role for primary care. So we think that's really fundamental to building a better health care system.

49:18 - LAURA SMITH

Thank you. There are questions about how total cost of care models might impact underserved populations, those with disabilities, or other needs. How can models mitigate these concerns?

49:32 - LIZ FOWLER
Yeah, I think and, again, this is getting back to I'm not sure we're using the language in the right way. When we say total cost of care, it's not necessarily a capitated approach where you only get this much money and manage the care within that. It can involve capitation, but it really is about somebody who's looking across the spectrum of your care and trying to coordinate that care. So having responsibility for not just the primary care needs but also thinking about what are those social determinants and also thinking about specialty care, and making sure that patients are going to specialists that are providing better care, having an understanding of where those high quality providers are, and making sure that they're paid appropriately, and that we're seeing the better outcomes. So, I think, it's not about skimping on care, which is something that we keep hearing people are misunderstanding how we're thinking about it. It's really about looking across the spectrum of care, and trying to do a better job of coordinating that care.

50:40 - LAURA SMITH
Thank you. Can you talk a little bit more about the intersection between housing and health?

50:47 - LIZ FOWLER
Well, this is going back to the social determinants. And, you know, this is, I think there are a few areas where the Secretary of HHS has expressed a very keen interest. I'd say social determinants of health, behavioral health is another one, health equity as well. And I believe that we are tasked with helping patients think about housing in our models, but also across HHS, there are efforts ongoing to think about housing. I know my colleagues in other parts of the department and the Assistant Secretary for Planning and Evaluation has built connections with HUD, with the housing department, to think about how we might work together where patient care might depend on having better housing, more affordable housing. So I'm not part of those conversations, but I know that they're ongoing. And I'm just as excited about them as the secretary. So I know that we're thinking about that. And I know that that's part of the overall strategy. And some of it we have insight into and some of it we're eagerly awaiting more instruction and more guidance.

52:01 - LAURA SMITH
Okay, so you're doing great with the rapid fire. We'll fit in a couple more and then wrap up. So the next one is, 'Can you talk more about how CMMI is thinking about how clinical services and community services might work together to better improve care for patients with high medical needs and complex social challenges?'

52:21 - LIZ FOWLER
Yeah, I think this is related to the social determinants question. And I think one of the things that we learned from our model is that providers don't always know where to send patients. And in some cases, if those community organizations are to be adequately reimbursed for the services they're providing, sometimes making that linkage has been a challenge as well. I'll give you an example. Our Diabetes

Prevention Program uses community based organizations, including for example YMCA, organizations to deliver that care. Trying to get them in and process them as providers has been a challenge to get them licensed or whatever they need to be accredited to be paid under our model. And sometimes that's just us. We don't know we haven't been the best at dealing with them. And they haven't necessarily known how to deal with us and all of our requirements and paperwork. And so I think we can can do more to make that a more smooth process. And those talking to Administrator Brooks-LaSure, I know she wants us to figure out a way to work more closely with community based organizations. And so, you know, that's part of ongoing work that we need to do.

53:44 - LAURA SMITH
How is CMMI thinking about helping rural hospitals who do not have a good infrastructural foundation to be able to participate in Value Based Payment Models?

53:53 - LIZ FOWLER
Well, I think that looks at, you know, we had a model called AIM which was providing upfront money for investments into what providers might need to be able to participate in models. We're looking at refreshing some of those mechanisms. So if providers need upfront funding in order to participate, maybe we can give them advance payments in anticipation of their participation looking at mechanisms like that. You know, we have to make our models work from a financial perspective, but they also have to work for providers as well and participants.

54:41 - LAURA SMITH
Okay, here's your last question. And I apologize to all those who we couldn't get to because we've got so many great questions that were submitted. So here it is, 'Is CMMI thinking about launching new models? Or is it really about revamping and reorganizing your portfolio?'

54:57 - LIZ FOWLER
I think it's both. So we have pulled back some models. We had, for example, a Part D monetization model that didn't, it only had 1% of plans participating, it didn't have enough participation to be able to evaluate it. So we ended up pulling it down. We pulled down, there was a geographic, direct contracting model, we put that one on hold. There were a lot of questions and concerns about that model. So that model is on hold. We're looking across the portfolio where the models look to bring success and have enough participants to be able to evaluate. And then going forward, we're using a very specific criteria to consider new models. So they've got to align with the strategy. They've got to align with the direction we're going. And so, you know, the other point, and maybe this is a little bit inside CMMI, but we want the teams to be working together and not reinventing the wheel. So part of what we found is that some of the models were sort of coming up with their own unique way of doing IT and the strategies they were building. We need to be able to share learnings across the models a little bit better. So I guess it's three things. So where the models might not be robust enough, we'll sort of pull them back or we have a new strategy to move new models through the pipeline that align with the strategy, and then sharing learnings across all of the models to make sure that we're as efficient as possible.

56:35 - LAURA SMITH

Thank you so much. And I'll now hand it back to Natalie, for some closing thoughts.

56:41 - NATALIE DAVIS
Great, thank you. And thank you everybody who submitted questions, and we'll do as much as we can with technology to download those and share them with Liz and her team because I know there are a lot we couldn't get to. Like I said, thank you everyone for joining us, Liz and your team for spending time with us today to really discuss the future of Innovation Center and how you will undoubtedly have wide ranging impacts on our health care system. As we conclude this webinar, I'd like to invite you all to join our next virtual event coming up on January 25 at 3 .pm. Eastern, where we will talk about the conclusion of the healthcare.gov open enrollment season, hosting a discussion to assess emerging enrollment strategies, and highlight the latest innovations and strategies to enroll people in health care coverage. We hope you can join us. We as so many of you I know who are participating here with us today have ambitious goals for making our health care system more affordable, dependable, personalized, and understandable. And we can't do our work without partnerships and support. So thank you all for joining us and this work together. Thanks again to Dr. Liz Fowler and our federal partners and state lawmakers who are really working with us to make the health care system better. As we continue our work we appreciate your support and partnership. Thank you very much. Everybody stay safe and healthy.

58:09 - LIZ FOWLER
Thanks Natalie.