Bringing the Perspectives of People to CMMI: Real World Models and Recommendations for the CMS Innovation Center

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0:04 - ANDREW SCHWAB

Good afternoon, everyone and, thank you for joining with us today for what we think is going to be a fantastic discussion with three healthcare leaders, each with very different backgrounds and experiences, both personally and professionally working inside our health care system. United States of Care is a nonpartisan nonprofit organization, we work to ensure that everyone has access to quality, affordable health care regardless of health status, social need, or income. We do this because we know the health care system isn't working for millions of people in the United States. And we keep hearing from people that they want a better health care system in the wake of the pandemic. In fact, there may even be an opening for reforms that weren't possible before. We're also working to create the conditions for long-term change. We know that we need a new national conversation and new innovative solutions to build momentum to federal change that won't be it overturned at every election. To that end, we believe this is a moment for the future of the CMS Innovation Center, which is now just over 10 years old. The pandemic has blown wide open what may be possible health policy and CMMI. What may be possible in health policy, excuse me, and CMMI is uniquely positioned to test the way forward. This is why we set out a few months ago to develop a set of recommendations, which is the impetus for this webinar that got outside the normal one CMMI may here we wanted to see if we could find consensus from folks with all different perspectives on what needs to be done to figure out what works and maybe even more importantly, what does not. But we also wanted to do this from the perspective of people while also giving future policymakers evidence from which they could make policy. And we're so proud of those that contributed to and reviewed our final suggestions, including our three guests today, but also members of our Founders council like Dr. Atul Gawande, former OMB director Douglas Holtz Eakin, and little lobbyists CEO Elena Hung, as well as many others, you can see here. Our final product suggests high-level frameworks for models which could test new ideas for mental health and substance misuse. New incentives for Medicaid, explore more deeply virtual care and provide real data about the outcomes when we allow greater flexibility for at-home and virtual visits for people with disabilities. And of course, we need as much data as possible to test ways we can make the entire health system more equitable so policymakers have the information they need to make bigger changes to that end. And so we're fortunate today to be joined by three of the folks that collaborated on this effort. But first, we're excited to share a message from Congressman Ami Bera of California, a physician and

champion of innovation in healthcare on Capitol Hill. The Congressman is also co-chair of the health innovations caucus in the house. And here's the message from Congressman Bera.

3:11 - CONGRESSMAN AMI BERA

Hi, I'm Congressman Ami Bera and I wanted to thank USofCare for giving me an opportunity to say a few words, as both a member of Congress and a physician as well as chair of the healthcare innovations caucus, the incredible work that the United States of Care is doing, looking at both healthcare innovations, looking at disparities, the best practices that come out of CMMI is incredibly important work. And with today's release of your report, on your findings, and recommendations, it's my hope that members of Congress, policymakers, academics, and others take a deep look at the recommendations. In this unprecedented time of global pandemic, We've seen the power of innovation, the power of investment, research and development, and coming up with incredibly effective and safe vaccines that will help us put an end to this pandemic. It's those types of investments that are hugely important, but it's also incredibly important for us to think about how we deliver that care and make sure we address the health care inequities that this pandemic has exposed and that many of us have known existed for a long time. Through innovative delivery models, looking and identifying best practices, sharing those best practices across communities across state lines, we can not only increase access to health care, but we can also start to lower the cost of that health care. So again, I look forward to going through the recommendations that USofCare has made. I applaud the expert panel that has put these recommendations together, and let's go out there. Let's take care of America's patients. Be safe, be kind to one another and be well, thank you.

4:53 - ANDREW SCHWAB

Thanks, Congressman. And, of course to the Congressman staff, always unsung heroes for putting this together and for Congressman Bera's work in these important areas. What we'd like to do over the next time we have together is to have a discussion, one on one with each of our guests to focus on each of their specialties. Dr. Rick Gilfillan is a doctor, who was CMMI's first Director and a former hospital CEO, will talk to us a little bit about how CMMI works and how it's run. Carolyn McGill is the CEO of Aetion, a digital health company delivering a platform that turns real-world data into the regulatory grade evidence needed to inform health care's most critical decisions. And she'll talk to us with a view towards the private sectors, look at innovation and interaction with CMMI. And Dr. Meena Seshamani, a physician who is currently VP of Clinical Innovation at Medstar Health, but also the former director of the HHS Office of Health Reform in the Obama administration, who will provide the perspective of the physician but also a physician administrator who has experience working in government. And I would be remiss if I did not offer also that Rick and Meena serve on the United States of Care Founders Council, and Carolyn serves on our Entrepreneurs Council. So let's start with Rick. Rick, you were there at the beginning of CMMI, as its first director, are you able to paint a little bit of a picture for our viewers this afternoon, about what the Innovation Center was like at the beginning, what it tried to do from the start and how you see it operating today?

6:43 - RICK GILFILLAN

Certainly, Andrew, thanks for the opportunity to be with you all thanks to the team at USofCare. So, you know, anyone's ever been in the halls of HHS picture, you know, a little office, and Tony Rogers is next to me and he's the first person who's responsible for the Innovation Center, and he's got Kelly, Kelsey Mullard, and Michelle Lynn Warren, in his office, and we come together and Don Berwick walks by and says, "You guys go ahead and start this innovation center, okay? Look at the legislation, see what you can come up with." So we had the opportunity to direct hire 80 people in 90 days to be the Innovation Center, right. So we began a process with such [inaudible] was there as well. [inaudible] had already been hired, who became legendary [inaudible]. And then Mandy Cohen joined us whose now down in North Carolina. And we started a process of hiring, we actually went 24/7 hiring people. And we found a whole bunch of folks to join the team. At the same time, we started putting together a strategy. Don Berwick was very actively involved and we started thinking about how to structure the center, we came up with three centers. The personal care center, of the team, the seamless care, and the population of blended health teams. And that was, by the way in early Africa to try and address some of the drivers of the social influences of health were to come. So that was the start, the strategy was, quite honestly, we, our goal was to drive transformation, and to use the powers of the Innovation Center to create models that drove the healthcare system towards producing more value, the triple AIM, and working closely, frankly, with the SSP, the Shared Savings Program at CMS that was already established in legislation and was beginning. So the initial strategy was to create a set of models that work synergistically with SSP, and they were the Pioneer model, and the advanced payment model, the idea of advanced payment was to give doctors a lot of money to start ACOs. So hospitals would get excited and concerned and have to do ACOs themselves. Honestly, that was a strategy. Then we also began primary care initiatives. CBC initiative to test whether or not a primary care model alone would be sufficient to drive the transformation we're after. And we also create a suite of episode Based Payment programs called BPCI, bundled payment for Care Improvement. And we weren't sure honestly how that was going to fit together. But those were the primary models that we pushed out, as, as our first go around. We also then kind of engaged in a lot of activities trying to create the understanding, awareness, belief, and acceptance, that transformation was inevitable that people needed to get on board that there would be a kind of a prairie fire driving towards, you know, transformation, and people just getting excited about getting on board. So there was this combination of trying to create a lot of excitement through a variety of activities, talks, innovation, awards, etc. And also screening specific miles to test to get people involved. And a bunch of people that are hired to run those the first 80 or so did that shortly or waste into. We also Don and Joe McCannon came up with the Partnership for Patients to address acute body that kept the quality of acute care readmissions and hospital complication. So those were kind of, you know, picture a lot of people think a real sense of urgency and a White House breathing down our neck saying get these things out, get these things out, let's go and Meena and her team upstairs doing the same thing from HHS, right? And these, this team of folks really kind of pushed up out. That's the way it started.

10:55 ANDREW SCHWAB

Great, thanks. Thanks, Rick, when we talked in March, and we were first starting to develop on what became our recommendations that we released just short of a month ago, you were rather firm in your belief that hearing patient input on models that CMMI

runs was really important, and that that should happen from as you describe non-industry stakeholders. And so that came to a recommendation in our document in our product that says that in order to amplify the voices of people enrolled in CMMI models, participating health plans and provider groups should incorporate regular focus group activities that are demographically representative of the larger population experiencing the model. Can you talk to us a little bit to our viewers about why you were so interested in having that as part of our recommendations? And maybe a little bit on why it's necessary and how perhaps patient input is not given the pedestal that you think it should?

12:01 - RICK GILFILLAN

Yeah, I think Andrew, I think it's critical for all of healthcare providers, and institutions, and organizations to be mindful, obviously, of our ultimate goal, which is to provide great care for people and to help people improve their health. And the truth is that we're all subject to the realities of you know, the institutionalization of what we're doing. And we lose sight of the fact that this has to be about the people we are serving. And so you have to work really hard in any realm and in CMMI, and with CMMI models and the organizations participating in them as well. You have to work really hard to ensure that that the work is remains grounded centered in the people that we're serving, I believe. And the other part of it is there's an incredible power inequality that exists in health, within the communities that healthcare is part of right? There's gigantic power in health care organizations and institutions. And there's very limited, frankly, kind of people power in the communities, particularly in vulnerable communities. It's just that it's just the absolute reality that we will all myself and our attorney held where I was in other places, we'll go our way. And we'll think we're doing the right things. And we'll think we will understand it, we all need to take regular people-centered timeouts, we call them a trinity and step back and say, Okay, let's get re-grounded in the needs and the desires and the perspective of the people that we serve. One way to do that is to, you know, do it yourself in a meeting and take that people-centered time and take yourself out of the room urine, but the best way to do it is to be grounded in the community, to have people come in as active, meaningful participants in discussions in planning buildings and planning programs, in planning new care models, as we're talking about today, to make sure that we hear firsthand loud and clear what people think their needs are and what we how we can best meet them.

14:15 ANDREW SCHWAB

Thanks, Rick. And we're aware of the unruly chat box that's happening right now. We'd love for our participants, for our viewers to put questions that we can ask the participants later and we'll try to work on that right now. But part of the game in 2021, of course. Carolyn, I'd like to move over to you, if I may. You've spent your entire career in the private sector, particularly in the private sector, as in devoted to health care. So you know, the importance of innovation and how the private sector is central to that. When we spoke to develop the recommendations use the example of utilizing a Care Manager in Medicare Advantage, as it is, no a Care Manager and fee for service as they are currently used in Medicare Advantage. Now, Medicare Advantage is quickly becoming extraordinarily popular. It's close to 50% of the Medicare system now, but care management is not something that has seeped into traditional Medicare fee for service Medicare, as policy wonks are wanting to say. What are some of the other private-sector

innovations that you think the government may want to test?

15:23 - CAROLYN MAGILL

I do want to pause and give credit to a lot of the public-private collaborations that have happened over the years, and Rick mentioned several of them. So I was actually part of UnitedHealth group's ever care organization, which was putting nurse practitioners in nursing homes and this became as a demonstration project in partnership with CMS, this became the precursor to institutional special needs plans. And then, of course, we expanded to support chronically ill individuals, people with Medicare and Medicaid, we learned so much from experiences like that. And in sometimes it worked really well. So our institutional special needs plans, just positive outcomes for everybody. Our end-stage renal disease, special needs plans didn't work out so well. And look how the world has evolved since then, now, Medicare is covering [inaudible] populations. And you could probably credit those experiments from 20 years ago, with helping to inform how to do that in a responsible way. And of course, then I was at Remedy Partners and participated in the bundled payment for Care Improvement Program. And also and Rick knows this, from his time at Trinity just experimented with different models to try to appreciate what works best. And so this ongoing collaboration is something that we value. And we agree that there are all kinds of opportunities to take innovations from the private sector and apply them in a government context. You know, for us, it feels like the most exciting innovations relate to accessibility of data, and advancements in technology to analyze those data. So we have made some real progress in understanding which data are fit for purpose of their particular research questions of particular things that we're trying to understand. And then the methodology that we can apply so that we can assess safety, effectiveness, and value of clinical treatments in a transparent way that can be replicated across contexts. We are adept now at understanding is it the fact that you took this medication that led to an increase in the total cost of care as an example, or an improvement in a quality outcome? Or was it the fact that you lived in Florida versus Northwestern United States? Or was it the fact that you had diabetes and heart failure instead of just diabetes? And these are the kinds of variations that we need to really understand in order to make better decisions from a policy perspective about what we cover in which patient populations have access to which treatments. And so if you were to review the policy recommendations, that USofCare has thoughtfully compiled. One of them is to test different approaches to things like minimizing maternal mortality, using a doula or a midwife. Let's use data in the access to technology or the access to data that we have and the newer technology that we have access to, to get a sense of the impact that using a doula or a midwife has and that what's that causal relationship between that as an intervention versus other approaches. And then, of course, there are many innovations in terms of the kinds of data that we have access to. We're thrilled about genetic data as an example, the more routine capture of socioeconomic data, the information from wearable devices, and all this access to data, of course, necessitates that we embrace artificial intelligence, machine learning ways that we can apply technological advancements in generating hypotheses to test about which interventions work best for different patient populations.

19:18 - ANDREW SCHWAB

Thanks, Carolyn. That was really great. And I want to share with our viewers that one of the great perspectives that you and the other members of our entrepreneur's council

brought to our recommendations was that the private sector is always testing out ways to deal with medically complex individuals, and certainly has something and a perspective to offer to government health insurance programs and the health care system, in general. You know, very quickly is, Are there things that you see happening in the private sector to deal with medically complex folks that you think all of us should be paying a little bit more attention to?

19:59- CAROLYN MAGILL

Absolutely. And I'll just keep on the data and technology themes. So the first is in the private sector, we are very adept at identifying what's happening with underrepresented populations. So people with different combinations of chronic illnesses as an example, Women of childbearing age, children under the age of 18, what kind of access to care do they have? What do they experience in terms of quality, cost, patient experience with different clinical interventions? And this is especially important for those populations who are underrepresented in clinical trials. And once we use the data to understand what's happening, from a descriptive perspective, then we can commit to assessing impact in a consistent way, so that it's really clear what to do with what we learn. So where is their unmet need? And you know, we have examples, we did a partnership with Horizon Blue Cross Blue Shield as an example, in New Jersey, where they were using our platform to improve interventions for their diabetes population. The first thing they had to understand is who's receiving which medications, what variations and outcomes do we see. And then as they identify which meds or interventions worked best with different subpopulations, be in a position to do something differently, to give people better access to those treatments and interventions that will work best for them. And I think there are all kinds of examples of potential collaborations looking at, you know, the relationship of bone health and frailty as an example, thinking about how to assess the new and improved medical device and the impact that might have on a given population or not. And using that to more systematically drive our decision-making about access and affordability.

21:48 - ANDREW SCHWAB

Thanks so much, Carolyn. So we've heard from Rick about the Genesis and beginnings story of CMMI. We've heard from Carolyn, some perspective on private sector innovation. I'd like to move to Dr. Meena Seshamani, who has worked both inside and outside of government as a physician and a government official, which Rick had alluded to as the Director of the Office of Health Reform at HHS. Meena, given those kinds of very valuable but different experiences, what do you think are the most promising ways in which equity can be intentionally infused into the entire healthcare system?

22:26 : MEENA SESHAMANI

Well Thank you, and thank you for having me here. And thanks to the whole USofCare team, just echoing you know, Rick, and Carolyn, as well for these recommendations and bringing us together. I'd like to pull themes from what Rick and Carolyn have discussed in answering this. Because in some ways how you address equity comes down to two buckets. What do you want to do? What are your goals? And what are the metrics that you want to achieve? And then how do you get there? And so on that first bucket of what is it that you want to do? And what are the metrics you're going to use to measure it? piggybacking off of what Carolyn discussed, there really is a need to improve data

collection, being able to collect information on demographics, socioeconomic circumstances, and to be able to do so in a way that it can become actionable, where it can be incorporated into the day to day practice and workflow of not just healthcare professionals, but also people who are addressing social needs such as food, transportation, housing. So how do we collect that data? And how do we share it and make it actionable for the various people who will play a role in helping populations to achieve health because, as we know, a large proportion of health actually comes down to these other things, as opposed to, you know, just the care you receive in the four walls of an office visit or a hospital. From that data, also looking at what it is you hope to achieve. And here, I think it's important to keep in mind that there are metrics that can be very specific for equity. You know, for example, Carolyn mentioned maternal mortality as a great example, that we have certain areas that you're really only going to be able to move the needle when you address those underlying issues, underlying disparities to be able to improve. But then even for more run of the mill metrics that everybody has been talking about like readmissions, or ambulatory sensitive conditions, where you're getting a hospital admission, there are opportunities for us to look not just at how we're moving the needle on the average, say, of readmissions, but also what is the variation among different populations for that? So being able to see, you know, are you actually reducing variation and readmissions among people of different socioeconomic status, for example. So being able to think about equity from that data side, both in terms of the information you're bringing in to help drive care and to help, you know, evaluate where you're at, but also to set your goals so that equity is a part of everything that you are trying to achieve. So that's kind of that first bucket on the metrics, and then it comes to Well, how do you actually get there? And you know, two points here, first, piggybacking off of what Rick had mentioned about involving people. It's very important that we include and Rick had mentioned including in a meaningful way, the very people who you want to care for who you want to reach out to, because they may have thoughts, perspectives, experiences, that are in your blind spot, right? You don't know what you don't know. And so engaging people not just in a focus group, but actually having them come in to really look at like on the ground, what is going on? And what is their reaction when they see that? And where do they see the opportunities to really engage them as a partner, both in model development, but then also on the ground when you're actually trying to implement these models. And, you know, the second point around that partnership is really being able to create a more facilitated partnership between healthcare and social services. You know, I think I will speak at MedStar. You know, we have done a lot with our community health departments, for example, to establish relationships with our local community-based organizations, local public health, we have community health workers. But there's an opportunity to have more partnerships because at the end of the day, a healthcare organization is really specializes in providing health and housing organization has expertise in providing housing, and we should be able to bring those skills to bear together in partnership. So there's a real opportunity for models to actually encourage such partnerships providing best practices, here are things you should be thinking about these the types of organizations that a healthcare organization should be reaching out to. And here is how you can make these kinds of arrangements so that we are sharing the data. So you know, for us, we are doing social screens in our electronic health record, and we've established a way to do referrals through our electronic health record to these organizations. There are best practices such as these that can really help to make sure that we are addressing the full

gamut of what affects people's health, which gets to issues of equity.

Wonderfully said Meena, of course. I do want to quickly remind folks that if you have questions, one more thing I'd like to follow up with Meena on. But if you have questions for the panelists or USofCare, please put them in the chat, and we will try to address them. Meena, I'm so glad that you touched on data collection because we all talk in health policy land about data collection and the importance of it. But, and this is something that kind of evolved as we developed our CMMI recommendations at USofCare. Um, it became apparent to us that part of what we were doing was recommending things and models that CMMI could test, and then collect data on, particularly in the area, areas of Medicaid and people with disabilities as well as initiatives that could be used to bring more equity throughout the healthcare system. But that eventually, we would hope that that data could then be looked at, by policymakers at the local, state, and federal level to make new policies that would try and fix some of these challenges. And so my, my question to you is not directly related to data collection, but, what has your personal experience been during the pandemic as a physician? We hear a lot on the news about everything that's going on and all the political fights, but as somebody who actually delivers health care, can you talk to us a little bit about what that's been like the past 14 or 15 months?

I mean, where to begin? But, you know, what I will say is that absolutely this pandemic turned everything on its head, right? Everything, you know, you think I'm a, you know, Physician, I take care of patients in a clinic, I go into work, I see my patients, right. Every aspect of that got turned on its head from the PPE that I had to wear and that we didn't have enough N95's. And I have a very small face. And so we had to find N95s for me because there was such a shortage, I guess, of the extra small. I mean, there are so many little ways that care was turned on its head, but then so many opportunities to learn from that. So, you know, umpteen number of examples just to pick up the data side, one of the things that, that we have done at Medstar is we mobilized no pun intended, but we mobilized our mobile health clinics that we have for providing primary care in inner-city, Baltimore, to be able to provide COVID-19 vaccinations. So coming back to this data point that you had made, one of the things that we wanted to do was be able to assess our efficacy in using this mobile platform to provide vaccines to our most vulnerable populations. And we discovered that people didn't always want to share what their race or ethnicity was. Now, in this mobile vaccination program that we set up, we had community health workers from the very communities that we were going out to deliver vaccines. We had community health workers going out in advance to talk to people about you know about the vaccine, answer any questions, help them, you know, with the registration for their appointment slot. And in the process, those people were able to talk to people about, why are we asking these questions, you know, why are we asking these questions about what your race what their ethnicity is? Because that's the way that we can know, are we able to address what your needs are? And in the process, we were able to overcome barriers around, you know, vaccine confidence and vaccine hesitancy and also be able to improve our ability to collect the data that we would need to demonstrate if we're having an impact. So it's just an example of how so much has been turned on its head. But there's so much opportunity there. Because it

really enables you to take a look at what we are doing and figure out how we can do it better. And doing it better, I think really comes down to the partnerships. Because one thing that we've seen through this pandemic, if I take care of a pet like we did in you know, as you can imagine, in a health system, all sorts of protocols around lying patients prone, so they're less likely to need to be intubated. And how do we manage the PPE? And what about you know, the steroid treatment, what about Monoclonal Antibodies? All of which are so crucial for addressing those patients who came into our hospitals with COVID. But if we just discharged our patients, they are stable from COVID, we discharged them out of the hospital, we're all very happy that we helped them. If we didn't provide them with support around how to stay isolated after leaving the hospital, do they have food sitting in their fridge and freezer? Because they may not? And how are they going to eat? Do they need help with their medications? How do they make sure that their loved ones are staying safe, especially if they're low income, and they live in a more crowded housing situation? If you don't address all of those other issues that really make up the full gamut of what someone's health is, you could win the battle of helping that patient when they came into the hospital with COVID. But you would lose the war of how we're addressing the pandemic at large, how are we preventing spread? How are we helping people to stay healthy? And how are we supporting through all of the issues we have, you know, this is uncovered. So I really think that the pandemic has exposed a lot of that and enabled us and I will speak for people, you know, working in healthcare, to be able to think more broadly and really think on our feet. Be able to innovate. And those are all lessons that we absolutely need to carry moving forward to change the way that care is provided.

33:49 - ANDREW SCHWAB

Absolutely, I and as I kind of began in my opening remarks, United States of Care really believes that this is an opportunity to address things and parts of the healthcare system that have perhaps been long unaddressed. And that there are opportunities to do that in a whole slew of areas that maybe didn't exist before the pandemic, but now have become so incredibly glaring, not necessarily to the people who may have always affected, but perhaps to people who they did not affect previously. And so there are new moments and openings for that. I'm going to go open it up to the full panel and start with a question from our audience and maybe this is best directed initially to Rick. The question is, "what can we do to encourage CMMI to develop more payment models for children?" And obviously, it's a government entity and so people can write to the government entity, they can go and advocate to the government entity, but what are ways that you would suggest our viewer might think about that, Rick?

35:02 - RICK GILFILLAN

Well, I think, I think a lot of times what we saw at times when people came in with ideas, they were kind of coming from their perspective, like what are there what is their organization? What is their institution? What does their group need? Right? What do they want to do? I think the important thing is to start with a problem, a people problem, right? A patient problem, a community problem. What is the problem you want to address? What problem do you want to solve? I'll give you an example in pediatrics. There's one of the things we have learned in the COVID epidemic is there's an incredible inequity in outcomes of care and outcomes in COVID, for people with disabilities, and kids and adults with disabilities. Well, there's a whole world of care

needs around kids with intellectual and developmental disabilities, right. So think about what models perhaps of care and models of payment that might address the difficulty people have getting diagnoses at the right time, getting the services they need, integrating their education plans, with their health care plans, with their housing needs, etc. Think about those populations that are most in need. And think about, I would say to anyone coming to thinking about an opportunity with CMMI, and CMS, grounded in the people you're serving, make sure that you understand their need that your approach seeks to address and then conceptualize a payment model that may facilitate the delivery and the implementation of that care model for a specific population.

36:49 - ANDREW SCHWAB

Great, Thanks, Rick. One of the questions that we wanted to address was, "What should private companies know, based on your time in the government?" And, you know, I'd like to start with Meena on that, and then probably go to Rick, and then Carolyn, and maybe you could talk about some kind of frustrations or successes that you've had as a private sector operator. So, Meena, how would you answer that?

37:20- MEENA SESHAMANI

I mean, I think there's, to come back to the theme on partnerships there, Nobody has all of the answers right? Healthcare is extraordinarily complex. There are so many various stakeholders who have who impact a piece of it. But, it really is important to have that partnership and to have that dialogue of what different players can bring to the table to be able to discuss and come together. And that we may, it's in some of the recommendations, we may speak to it, this also comes to the desire for more alignment around various payment models, because you have Medicare, you have Medicaid, you have commercial payers, you have tried care, you have, you know, VA, I mean, there are many different ways that people get health insurance in this country. And where you have the opportunity to align those along similar mechanisms, I think helps from say, the provider perspective, where then things are kind of rowing in the same direction and that's when you're able to leverage momentum to really move the needle, as opposed to having 500 different, you know, models, each by different payers with each with different metrics. Because when someone's coming into, you know, a clinician's office, for example, a clinician is not necessarily thinking, Okay, this is a patient with x health insurance. So, that means these are the quality things that I need to be keeping track of for this patient. And this is what they're going to be looking for, like, that's not the way that those human-to-human interactions happen, right? And, that's not the way that you generate change, you really want to have that kind of groundswell and that momentum, and that requires, you know, coordination and alignment. So there is a huge opportunity for partnership across public and private sectors, both in you know, how do we design these models? And how do we have, you know, basic parameters for how they're going to work. And then also, how are we going to come together so that each organization, each sector, each person brings their area of expertise, their comparative advantage, if you will, to create something that's going to address all the issues that we need to.

39:37- ANDREW SCHWAB

Glad you touched on the plethora of payers that we all have to deal with, and that are just kind of part of the American healthcare system. And something that kept coming up in our discussions, as we developed the recommendations and ended up being one of

the recommendations, is more standard ways of dealing with care across payers because each payer has their own metrics and their own ways of dealing with things and trying to move the needle for their patients. So Rick, what do you think are some things that folks should know about dealing with, CMMI in particular, and perhaps the government in general?

40:20- RICK GILFILLAN

Well, I think Meena's points are great about partnerships and people working together. I would say, [inaudible] , as a group that did a really good job of like building a case for their model, and they're still struggling to get it out and everything, get it working. But I think, you know, for [inaudible], they came together, and they really developed the model, they evaluated it, to some extent they pushed it. I think that's a good example. But their lesson, though, that they learned is also important for other companies. There are no, typically there are no kind of straight rifle shots, at CMMI where they say, okay, you Company X, you get this, right. So it's more about as Meena said, you got to kind of build the groundswell of interest in something that's meaningful, recognizing that it's not going to be just you, as a company that's you're not going to go to them to get a grant and do it right, at least up till now, that has been the way it works. So, I think, it's important to understand that and to build, if that's your strategy to somehow be part of a model and see that as a critical path for yourself for your organization, you need to be realistic and understand that's the process, that's how it works. If I could just, I want to throw one quick thought in on to Dennis's question about rebalancing medical. You know, we all talk about the imbalance between social spending elsewhere and healthcare spending like the dollars aren't right in America, right. Too many dollars and health care. Simple answer: you've got to move the dollars. One way to do that, stop putting so much more money into healthcare, take some of the money from the annual increases and CMS is putting out the hospitals and doctors and other institutions and just say, you know what, no Mas, we're gonna move it over and move it into social determinants spending. So, just a thought.

42:11- ANDREW SCHWAB

And that was a question from Dennis Heaphy, who also helped develop our recommendations and as a member of the USofCare founder's Council and well-known advocate for people with disabilities, about how to transition away from the medical needs, the medical focus for folks who are taking advantage of home and community-based services. Carolyn, kind of let's flip that question on its head a little bit. From the outside looking in, what is it like to deal with the Innovation Center CMS or HHS?

42:50 - CAROLYN MAGILL

Well first, I love this line of questioning and putting Rick on the spot, in this way. It's so fun to hear his perspective, so thank you for that. And you know, we would concur it's about collaboration. And I take the point that there needs to be urgency and there needs to be a shared purpose. It isn't, you know, I love what you said before Rick about jeez, if you just come in with what your company does best and say, therefore, we deserve a grant. That's not going to be terribly compelling. But if we come in with a business case,

as it were with a clear and compelling assessment of the impact this can have on a problem that truly is something that CMS cares about, or that is, you know, wreaking havoc on a patient population as an example, then we're much more likely to get progress. I'd say the main thing that I like to remind CMMI is the successes that we've had, when you do collaborate with innovators, and how innovators, tech companies, in particular, can help you to build the muscle in assessing innovations in healthcare. So when Rick says Geez, take money out of healthcare spend, put it into supporting socioeconomic, social determinants of health and the like, It's easier to say that than it is to do it because we as an industry are understandably reluctant to change unless we know that reallocating dollars from one program to another will yield a better outcome. And that's where I would say that, you know, in the tech and data world, certainly at Aetion and amongst many of our peers, we have a pretty systematized way to determine what good looks like. And we can in partnership with you give you the chance to touch the technology, think about it, you know, have access to new analytic approaches poke holes, so that you can start to get comfortable with the analyses and the way that we're approaching it, and the evidence to then underpin the decisions that you might want to make about funding Program A versus funding Program B. And just recognize that we can be your partners, and help you achieve more credibility and scale as you bring your good ideas or as you make discoveries about ways to support patients and their families, and to do that in a systematic way.

45:17- ANDREW SCHWAB

We have a question from one of our viewers that I'm throw out to all three of our guests. We have been talking for at least 10 years about Value-Based Payment Methods and Value-Based Payment Reforms. And Medicare Advantage has certainly brought that more forward in a robust way than it was a decade ago and is slowly but surely infiltrating into the traditional Medicare system. And CMMI has been the leader in accountable care organizations that policy wonks, call ACOs. Some have been very successful at increasing quality outcomes and lowering costs, some not so much. But this question is about payment reform in general and system innovation, and whether the primary obstacle to innovation and what is the primary obstacle to system innovation and to what extent other factors such as culture presents substantial barriers to system innovation, and I would also probably throw in there, you know, inertia into that system. So if any of our panelists want to start with that, that question.

46:40- CAROLYN MAGILL

I can start with some perspective of my time managing health plans for people with multiple chronic illnesses. So people over the age of 65 with multiple chronic illnesses. And you know, at the time, the conventional wisdom was that and I talked about care management and the value of care management, it doesn't work for everybody. And it is very time intensive and very expensive. And, you know, as a health plan leader, I was meant to ensure that limited resources could get allocated across a broad population and that we were managing the economics in a plan so that it would be sustainable long term. And when we, you know, would look at our medical loss ratio as an example and start to identify, geez, are chronic heart failure patient population is increasingly

expensive, and we're not seeing, you know, our interventions work effectively. The conventional wisdom at the time was, well, let's do care management and if we're not seeing the results we want from touching people telephonically, then let's touch them in person, and if it's not working in person in a doctor's office, then let's touch them in person in their homes with a nurse practitioner. And like I said, Sometimes this works, and it's incredibly effective. And then other times that it doesn't work. And so one of the challenges we have, I think, with the adoption of value-based care is that we try to say, this intervention is something we pay for this measure of preventive care will always work. And then the minute we get examples of when it doesn't, we just throw the whole thing out, or we say, okay, we better not move in that direction. So I think building on what Meena said before and getting a bit more nuanced, and assessing what works when and for which subpopulation is an important way to ensure that we're winning the hearts and minds of stakeholders, and really starting to demonstrate exactly where we can have an impact. And I think this gets to the question about how do we move beyond talk and to action? Let's be, let's not be afraid of iterative advancements. So identifying subsets of the population really testing what works, and then putting a stake in the ground that yes, this approach to value-based care works in this context. And you know, paying for outcomes of drugs as an example, instead of just Fee for Pill is something that I'd love to see CMMI embrace. We can't do that unless we're very systematic and thinking about how we assess the impact of different approaches on these different subpopulations. And then we make commitments when we do find ways that work.

49:15 - MEENA SESHAMANI

So I guess I'll go next building off of, you know, what, what Carolyn said. You know, I think also, healthcare is complex, value-based care and explaining that to people is even more complex. Right. And so, anytime you are creating change, you're creating behavior change. That is difficult to do. To the points, Andrew, you raised about culture. About inertia. about well, when I went to medical school, we didn't learn about what a community health worker is, and what are their roles and responsibilities? And how do you performance manage a peer recovery coach who's, you know, had former substance abuse, you know, has a former substance use history, right? And like, what are the HR implications of that? I mean, there are all sorts of components to this new paradigm or new way of thinking about care. That trickles down into all of these very basic operational, how do you stand this up? And how do you do it? That presents a challenge. And, you know, a lot of times it is a lot easier to stick with the status quo because it's what, you know. It's what you've been trained in, you know, and so there is going to be that movement that needs to happen. And part of, you know, change management or leadership is, you know, being able to explain it to people to engage with them in a two-way dialogue where you say, here's what we're thinking, does this make sense to you? What would you adjust? What would you change? But that requires, you know, taking the jargon out, and even the term value-based care. I think a lot of people, if you said, Oh, are you interested in value-based care, they'd say value what? Right? I think it's not, it's not necessarily intuitive for people, and so being able to make sure you know, that we're bringing it in, we're bringing it forward into discussion in a way that people can understand, wrap their heads around, and then also engage proactively and to make it what they value and what they need, that will help to overcome some of the inertia culture changes. Alongside bringing the right people to the table, having, you know, trainings and sharing best practices and playbooks and things

of that nature.

Andrew, I guess I'd add-in and I would agree that there are these dimensions of culture change. I would say on the analytical side, I think Carolyn has been involved in a number of organizations who have done incredible work, and quite honestly that I think the truth is, our digital capabilities have outstripped our institutional will. There is not an institutional Well if you think of healthcare system, our system we you know, the pieces of it as a system, they function as a system to what end is maybe not what we think but they do function as a system, right? It all works together. It lacks the institutional will to change, right? We have not compelled it to change, and good people, colleagues of all of ours are out there. And absent a requirement to change. They won't change, right? Nobody changes, generally, right? So all of the culture change, digital capabilities, all that's necessary. What's staring us in the face 10 years after, right? We started, you know, a lot of this, if not we've been in the industry, it hasn't happened. And the answer is very simple, I think we have to take steps towards actually making transformation mandatory. We have to say to people, you have to become accountable for outcomes, right? And the old way of doing things is not going to be the way of the future. And I think when we do that, we will begin to see, and I think that has to happen through CMS. And probably to some extent, the federal government forcing other payers because they're not interested in changing either forcing them to actually make change. And move into this different world, whether we call it value, or however we define it. I think, being accountable, giving the people of the communities you serve the care they need, and doing it in an efficient way, without consuming resources that could be used elsewhere. We got to say to people, that's your job. Go do it. And if we don't do that, my conclusion after 10 years of running around in this is ain't gonna happen.

Well, fascinating juxtaposition of the first CMMI Director talking about mandatory versus non-mandatory models, as that's a big debate at CMMI. We have just four minutes left. So rather than starting a whole new line of questioning, I thought we'd just maybe do some quick, quick answer just on something that that kind of took the health policy landscape attention last week or two weeks ago was that a report came out that surveyed a bunch of corporate leaders. Eight out of ten respondents had said in the survey that healthcare costs were unsustainable and that the same number eight out of ten said the government is going to have to do something at some point. In addition, one out of six employees are saying now in a different survey, that they stay in their job for fear of losing health insurance. What are some very, very quick, maybe two or three-sentence explanations from each of them? I know that there's nothing quick here. But we want to end on a high note that you think is going to have to happen in the next 10 years to address the rising and unsustainable costs that have been affecting regular people for a very long time. But that corporate leaders are now starting to say there's just no way. Carolyn?

Pay for outcomes of drugs, how well they work, rather than Fee for Pill. And do a better job at systematically assessing how well different clinical interventions work for specific patient populations, especially underrepresented minorities.

55:41 - ANDREW SCHWAB

The first thing we probably need to do on the drug front on if they work or not, is probably come up with a better phrase. And then comparative effectiveness research. Meena?

55:52- CAROLYN MAGILL

Principal database design and pharmacoepidemiology we have a lot of mouthfuls in our world.

55:57 - ANDREW SCHWAB

Meena, things that you think might, must be addressed in the next 10 years.

56:03- MEENA SESHAMANI

I think this alignment that we have been speaking to. So, you know, there's been a lot of work around the innovations, particularly, you know, with the Medicare, like Accountable Care Organization, etc. And how do we have alignment with the commercial sector, and especially employer based insurance to get at the, you know, concerns of employers and supporting health care costs. So really, that alignment of the payer model so that you can move more systematically.

56:38- ANDREW SCHWAB

Thanks for that, and I appreciate the bringing up of the employer insurance conundrum which USofCare made a priority to be in begin to talk about that and how it can be modernized for as we go deeper in the 21st century, we like to call it job connected health insurance. Rick real quick, next 10 years?

56:59- RICK GILFILLAN

I think, fundamentally, these two issues. You know, growing population of older people are gonna have chronic disease that needs to be managed, we need people to be accountable for that. And to manage that well. But that's gonna be what it's going to be. I think commercial pricing is untenable, unsustainable, and I say if we're going to go, I think we're gonna have to go to a government-administered pricing. I think if we do that we have no need for private health insurance. So I would, because they're not doing anything for us at that point, frankly. And so I would say, quite honestly, bluntly, Medicare for all long term, with a revised Medicare program makes the most sense, in my opinion. It's unlikely politically, therefore a public option administered not as Medicare Advantage but as a straight Medicare program with a good benefit on the exchange, and making that an offering to employers would be the way I go.

57:53 - ANDREW SCHWAB

Well, certainly USofCare would be right in lockstep with you on the public option, what that ends up looking like we don't know. But yet to be determined. We are right at time. I really appreciate all of those who tuned in to listen to our webinar and check out our recommendations that we also have had the honor of presenting to CMMI director Liz Fowler, two and a half weeks ago. Carolyn Magill, CEO of Aetion, Rick Gilfillan, former

hospital CEO and first CMMI director, and Dr. Meena Seshamani of MedStar Health here in the Washington area. Thank you for joining with us and stay tuned for our next webinar. Have a good afternoon.

58:37 - CAROLYN MAGILL
Thank you, Andrew.

58:38 - MEENA SESHAMANI
Thank you, Andrew.

58:38 - RICK GILFILLAN
Great job, and congratulations.

58:39 - CAROLYN MAGILL
Great conversation. Good to see you.

58:42 - ANDREW SCHWAB
Bye bye.