



Developing The Health Care System of The Future: The Role of CMMI

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Welcome

Stuart Altman, Ph.D., Sol C. Chaikin Professor of National Health Policy, The Heller School for Social Policy and Management, Brandeis University Chairman

Stuart Altman welcomed the conference participants to the 28th Annual Princeton Conference and thanked the generous sponsors and the broad group of advisors that helped shape this year's theme. He explained that this conference would focus on the Centers for Medicare & Medicaid Services (CMS) Innovation Center efforts in the area of "Value Based Delivery Systems" with special emphasis on activities which promote social determinants of health, improve healthcare quality, and lower healthcare spending.

Conference Keynote: Past, Present, and Future CMMI Priorities

Elizabeth Fowler, Ph.D., J.D., Deputy Administrator and Director, Centers for Medicare and Medicaid Innovation (CMS Innovation Center)

Fowler grounded the conversation in defining the Centers for Medicare and Medicaid Innovation Center (CMMI) as an entity designed to test new health care value-based payment and delivery system models. The primary goal of CMMI is to generate evidence-based models that could be integrated nationally into Medicare and Medicaid from test models.

What has CMMI achieved thus far?

Fowler provided a retrospective summary on CMMI work to date, including the launch of 50+ value-based care models reaching roughly 28 million patients and nearly a million health care providers. Models focused on coordinating care across settings like accountable care organizations (ACOs), disease-specific and episodes of care, and social determinants of health. She had six takeaways and lessons learned from the past ten years of CMMI:

1. CMMI could do more to advance health equity since many of the innovation models did not collect data on race and ethnicity and did not report whether interventions helped reduce disparities. Additionally, most of the innovation models have been based primarily on Medicare and only tangentially related to Medicaid primarily due to CMMI's authority over Medicare-based models.
2. While CMMI has launched many models, some are unnecessarily complex and overlap, creating challenges for providers managing shared savings.
3. CMMI needs to craft financial incentives to avoid risk selection more carefully; voluntary models attract providers who will financially gain.
4. At the same time, mandatory models are controversial, and many providers are not ready or willing to take downside risks. CMMI needs to offer options and tools for providers to accept manageable levels of risk.
5. Challenges in setting financial benchmarks have undermined the ability to achieve savings and address technical issues around benchmarks. CMMI needs to look at options to transform the current risk adjustment methodology to ensure that models are not overpaying.

6. CMMI needs a broader outlook beyond certification and statistically significant savings and look more holistically at health care delivery system change. Only six models have generated statistically significant savings to taxpayers and Medicare, and only four models have met the standard to be expanded in duration and scope. These include the Home Health Value-Based Purchasing Model, the Pioneer ACO Model, the Prior Authorization for Repetitive Scheduled Non-Emergency Ambulance Services, and the Medicare Diabetes Prevention Program.

While the four successful models discussed are essential, they will not achieve large-scale health system transformation and cost-effective care alone.

Where is CMMI Going?

Taking advice from key stakeholders on lessons learned, Fowler noted a new outlined vision for CMMI for the next ten years. This vision includes five strategic objectives to guide their work and was published recently in a [Health Affairs blog post in August 2021](#) and is also a pending white paper:

1. Advance and integrate health equity as a central focus of improving quality overall in all CMMI work. This requires gathering better patient-level demographic data and standardized social needs data for better impact evaluation.
2. Drive accountable care through increasing the number of people in accountable care programs like advanced primary care, ACOs, and Medicare Advantage, by reevaluating CMMI's portfolio of models. This requires launching fewer and more targeted models that impact more people to create more lasting and scalable transformation.
3. Support innovation in care delivery by filling gaps in person-centered care and looking at integration in issues like behavioral health or social determinants of health. To support this innovation, real-time data to support decision-making and payment rule waivers to increase flexibility.
4. Address affordability by reducing program costs and increasing quality and lowering patients' out-of-pocket costs. This requires examining models that target low-value care, curb drug prices, and waive cost-sharing for high-value services.
5. Work with commercial payers, purchasers, and states to achieve system-level transformation. Multipayer alignment should be thought about differently through a broad look at clinical tools, outcome measures, payment and policy approach, and focus efforts on a specific geography.

Fowler reiterated their refinement in the definition of model success includes impact on the health system to include both cost savings and achieve the five goals laid out above. This process will require increased transparency of CMMI including sharing more data to allow outside researchers to help investigate these models more. Additionally, CMMI will aim to solicit more balanced stakeholder feedback during model development from patients and beneficiaries.

Panelists

Robert E. Mechanic, MBA, Senior Fellow, The Heller School, Brandeis University & Executive Director, The Institute for Accountable Care

Mr. Mechanic covered three central themes in examining the current and future outlook of two types of value-based care; Accountable Care Organizations (ACOs) and Bundled Payments:

1. Review of recent evidence about the impact of ACOs and bundled payments on spending

In reviewing the recent evidence on impact of ACOs on healthcare spending, he shared that CMS evaluations found statistically significant gross savings (meaning savings generated by ACOs relative to their benchmark spending target) in four different ACO models (Physician Group Practice model, Pioneer ACO model, Next Generation ACO model, and ACO Investment model) relative to clinically and geographically matched patients who were not in ACO models. Two of the models, Pioneer ACO and the ACO Investment model produced statistically significant net savings to CMS after the shared savings payments to ACOs were subtracted from the estimated gross savings.

The Medicare Shared Savings Program (MSSP) is Medicare's largest alternative payment model with 11 million assigned beneficiaries. Since the Affordable Care Act established the MSSP as a permanent program, CMS has not conducted a formal evaluation as is required for models piloted by CMMI. However, MSSP has been evaluated by independent researchers that have shown statistically significant gross and net savings for MSSP of one to two percent annually. Overall Mechanic felt ACOs are the most successful category of Medicare alternative payment models, which, he believes, justifies strengthening and growing such models.

CMS has conducted numerous evaluations of various episode payment models (including the Bundled Payment for Care Improvement (BPCI), Oncology Care Model [OCM], Comprehensive Joint Replacement Model [CJR], and BPCI Advanced). These evaluations all showed positive gross savings, however, all models except CJR had statistically significant negative net savings to the government after bonus payments. Medicare takes a two to three percent discount in establishing target prices for bundled payments, and then the participants are at full risk, meaning that providers keep 100 percent of any savings they earn relative to the target prices, but must repay the government for 100 percent of any losses. Overall Mechanic felt bundled payment models are beneficial for certain clinical services and specialists (like orthopedic surgeons), however because they are voluntary, bundled programs provide significant opportunities for gaming and selection bias as evidenced by the dramatic dropout rate in BPCI. This concern could be eliminated if episodic payments were put underneath "a total cost of care" umbrella.

One interesting finding was patients who were dually enrolled in bundled payments and ACOs had statistically lower spending for medical episodes than patients enrolled solely in bundled payment. Mechanic noted the possible distortion of financial incentives and evaluation when the same patients overlap in multiple models.

Finally, for patient centered medical homes (including the Comprehensive Primary Care and Comprehensive Primary Care Plus Practices) evaluation found small non-significant gross savings and negative net savings. Mechanic felt savings are not the right measure for evaluating the performance of primary care models given the historic underfunding for primary care. He thought more investment is still need in primary care.

2. Future options for improving performance

In 2018, Seema Verma, the CMS Director, wrote a [blog post](#) concluding that ACOs were not making money based on the simple math of total Medicare ACO benchmarks minus total spending and that ACOs needed more skin in the game. Looking at more recent ACO performance (2017-2020), however,

Medicare ACO's savings have grown. Beginning in 2017, MSSP began to phase in a new form of setting ACO spending targets which incorporate a blend of the ACO's historical spending and its region's average spending. Today, new ACOs have a spending target that is one-third of the regional average spending and two-thirds of their own historical spending. For ACOs with costs higher than their region, the share of historical spending was lower than the two-thirds. The pathways program accelerated this and by the second performance period, there was fifty-fifty mix of regional and ACO spending (with benchmark changes capped at five percent). The result has been that expensive ACOs have dropped out of MSSP while lower cost providers have joined the program. So while ACOs' savings have increased, it is highly likely that the government's savings have diminished. Introduction of mandatory downside risk beginning in 2019, plus the weak incentives for high-cost providers to participate in MSSP, has led to stagnant program participation. Mechanic felt CMS should articulate a more coherent long-term vision for the MSSP program that includes changes that make participating in an ACOs more fiscally attractive than remaining in fee-for-service (FFS).

3. Future challenge considerations

Mr. Mechanic believes that Medicare's APM portfolio needs to be simplified with ACOs at the center. He believes it is essential to establish new risk adjustment models that reduce the benefit of aggressive diagnostic coding. Finally, he supports the need for a clear long-term vision for the MSSP. Most, ACO programs, he indicated, are operated on top of traditional FFS reimbursement, and most ACOs still have a relatively small portion of the services they provide under "total cost of care" contracts, making a shift into population health challenging. This is also a chronic problem with large, self-insured employers that are frequently more focused on payment rates rather than total cost of care. Finally, new direct contracting entities backed by health plans and venture firms are displacing some ACOs, adding further complexity.

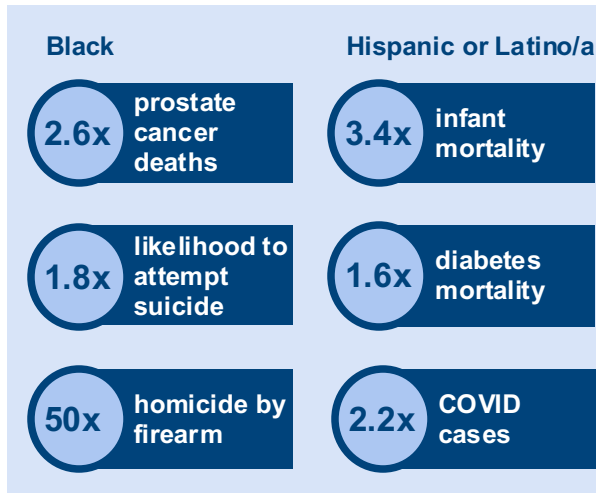
Thea James, MD, Associate Professor of Emergency Medicine, Boston Medical Center/Boston University School of Medicine

Dr. James from Boston Medical Center (BMC), spoke about the challenges safety-net hospitals face and offered insight into how issues of inequity might be addressed. She described how many BMC patients cannot prioritize health because they need to focus limited resources on survival. In response, BMC created the first prescription-based food pantry in the country, a rooftop farm, and other resources to fill these survival gaps. Unfortunately, these efforts only provided temporary relief to patients and did not enable them to escape the underlying conditions of poverty. So, BMC asked themselves- what is the role of a safety net hospital? Is it charity? Or is it equity?

She suggested that ,patients are stuck in a vicious cycle, where they enter the safety net hospital to reset their health but are then thrown back into the cycle of poverty where their health declines again. While BMC has many models of care that address social determinants of health, none were explicitly focused on equity. This, she concluded, remains a major problem in Boston and throughout the country. While investment in social determinants of health in recent years has been helpful, without addressing the central causes of disparities, the cycles continue. As illustrated in the slide below, more upstream efforts are needed to address healthcare inequalities.

Why does Racial Health Equity matter?

Despite our collective efforts, there are huge racial health inequities in Boston



We need to intentionally remove the structural barriers that perpetuate inequities, such as:

- Barriers to access jobs, housing, education, or the economic mobility
- Insufficient adaptation to cultural / social context (e.g., recommendation to physical distancing to those with must-be-in-person jobs)
- Unintentionally discriminating protocols (e.g., vaccine prioritization based solely on age)
- Untrustworthy institutions (e.g., vaccine hesitancy)
- Un-relatable systems (e.g., lack of diversity among health providers)
- Impact of unconscious bias (e.g., delayed symptom recognition)
- Asymmetry of information (e.g., assume friend / family can help navigate telemedicine)

SOURCE: 2019 Boston CHNA, 2017 Health of Boston Report, SAMHSA, CDC

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Dr. James stressed the need to create more opportunities for patients to engage and participate in the economy. The linkage between health and wealth is well proven. Dr. James shared a map of redlining in Boston neighborhoods in the 1930's compared to a map of the public transportation today and a direct correlation of segregation and outcomes. The map of redlining in Boston also overlaps with those most affected by COVID in Boston. The majority of COVID patients seen came from those historic redlined neighborhoods, had a high school education or less, had comorbidities, and were in their 40's and 50's.

Given the historical oppression of those communities, when BMC tried to respond to COVID-19 with vaccines, they faced hesitancy and access problems for their patient population. Early polling showed Black patients were two and half times more likely to be undecided or negative about the COVID-19 vaccine, and the hesitancy persisted for Black employees of BMC as well.

To address this hesitancy, BMC partnered with leaders of Black and Latino communities, shared information in multiple languages, conducted outreach including door to door campaigns, and added volunteers at high traffic areas such as grocery stores. Door to door volunteers included an educator and a nurse to educate about the vaccine and provide vaccines directly in real time. Information was geo-targeted to further engage key audience by language and culture. Internally they also made sure that their diverse staff could see themselves in information about the vaccine. All these efforts were equity based and focused.

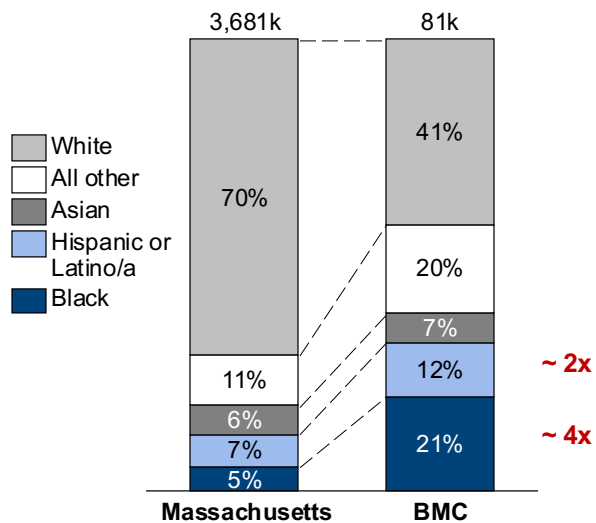
The outreach provided education about the vaccines, answered questions, and asked the community where the vaccination sites should be and what should they look like. This allowed BMC to create a

targeted network of vaccination sites in the communities. BMC collected data, including vaccinations by race and by site and they used this data to switch operations to high need areas as needs changed. By engaging the community through an equity-based approach, BMC was able to proportionally vaccinate more people of color compared to the state on average. See the slide below.

COVID VACCINE DISTRIBUTION

... and our efforts have shown that we can make progress towards equity when we focus on addressing racial inequities: Intentionality

Vaccinations by race / ethnicity
MA through 4/27, BMC through 4/27



Local leaders visited our community vaccination sites, including:



Governor Charlie Baker at Morning Star Baptist Church



Attorney General Maura Healy at Russell Auditorium



Marty Martinez at the Menino YMCA

¹ Reflects first doses administered. For MA, "All other" includes multirace, NH/PI, AI/AN, and unknown/ other. For BMC, "All other" includes declined and other.
SOURCE: Mass.gov, BMC data



BMC began its equity journey by looking for “inequity.” In the fall of 2020, they convened work groups of 80+ leaders and explored 100+ analysis of baseline data, conducted in-depth patient interviews, and developed a long-term vision with a prioritized list of 60 initiatives across all areas of the system to progress in the first 12-24 months. They chose five areas and began by looking internally at itself, and interrogating disparities in those five areas to see how they might inadvertently be complicit in actions that do not represent equity. Their system wide equity approach included clinical care, community and social determinants of health, research and education, and advocacy to cover five targeted areas of transformation: maternal and child health, infectious disease, behavioral health, chronic conditions, and oncology and end stage renal disease. They subsequently course corrected throughout their analysis. Their approach included a focus on economic mobility for communities. Dr. James believes that this should be a model for safety net hospitals nationally and should inform greater efforts to address health disparities.

David Meyers, MD, Acting Director, Agency for Healthcare Research and Quality (AHRQ)

Dr. Meyers acknowledged that the American healthcare system faced significant challenges pre-pandemic. He noted that CMS was already trying to integrate the digital revolution with new players, and healthcare systems were growing in size and complexity with both increased vertical integration and horizontal expansion. The pandemic, he emphasized, exacerbated these existing problems and revealed the consequences of an understaffed and underfunded public health infrastructure.

In 2018, AHRQ posted a compendium overview of systems in the U.S. seen below:

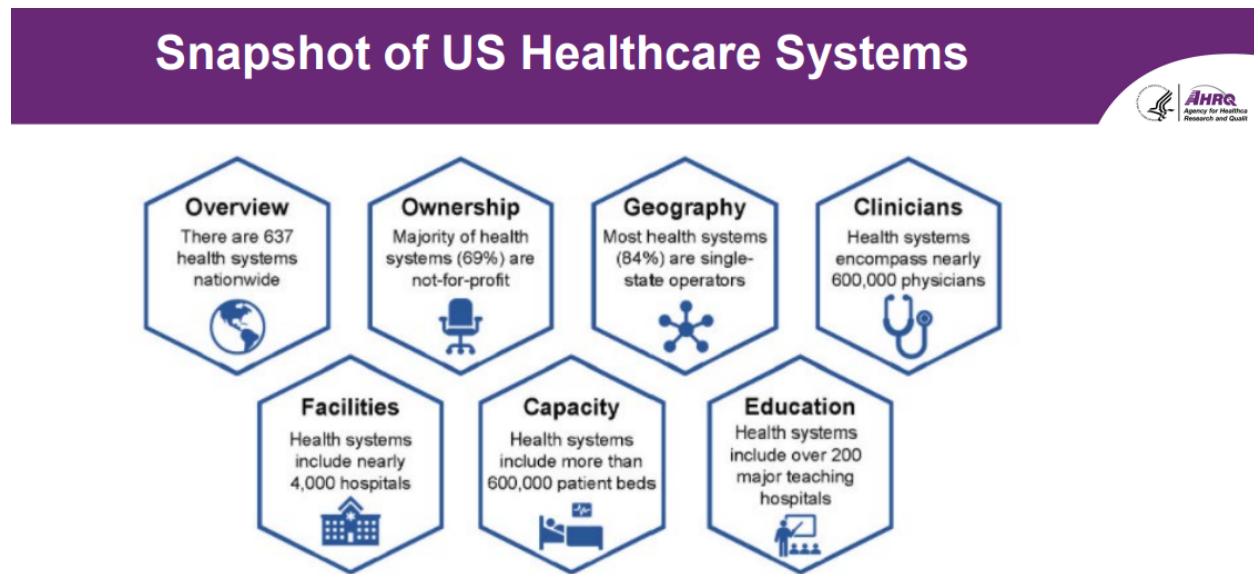


FIGURE 1 | Landscape of U.S. Health System
 SOURCE: Figure includes data from Compendium of U.S. Health Systems, 2018. Content last reviewed March 2021. Agency for Healthcare Research and Quality, Rockville, MD.
 Available at: <https://www.ahrq.gov/chsp/data-resources/compendium-2018.html>

<https://nam.edu/care-systems-covid-19-impact-assessment-lessons-learned-and-compelling-needs/>

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These systems represent about six out of every seven hospital beds in the U.S., and accounted, at the time, for two out of every three physicians. This group is where he focused the remainder of his talk outlining what happened to these systems during COVID-19.

Healthcare System Response to the Pandemic

Dr. Meyers highlighted three central changes in response to the pandemic that he believes were major changes and might not change back in the future.

1. *Reconfiguration of service delivery:* The initial focus of the pandemic was increasing hospital and ICU bed capacity, creating hospitals without walls, new offsite healthcare sites, using increased flexibilities and canceling elective surgeries. Also, reassignment of staff. Supporting this initial response, the federal government opened up controls to allow a massive expansion of telehealth in primary, specialty, post-operative, nursing home, and post-COVID care. It appears to Dr. Meyers that systems with higher pre-paid revenue streams were faster at and better able to reorganize how they delivered care.

2. *Financial disruptions:* There was an immediate loss of revenue in both inpatient and ambulatory care because of decreased service delivery in a FFS world. There was also supply chain disruption from the operations side, including just-in-times supplies including PPE, ventilators, immunoglobulins and even vaccines. The federal government provided financial relief to providers; however, he concluded, the relief was more beneficial to larger better-integrated systems. It was easier to get money to groups the government already knew and worked with and who were good at applying for funds. It was harder for the federal government to get resources to smaller systems and outpatient practices that cared for many of the most vulnerable.

3. *Limited adoption of public health functions:* Healthcare delivery systems started to deliver public health functions, such as being some of the first entities to deploy COVID-19 testing and contact tracing for their communities. This happened again with vaccine distribution, where large systems were better able to roll out vaccination programs for their staff members and then their communities. Many large systems recognized the importance of partnering with social and human service agencies to support their communities, including their staff and families. This practical awareness provided the healthcare delivery system opportunities to think about how to build back better by thinking about building more substantial and permanent ways to create an integrated system with both public health and human services providers.

Beyond hospital-based healthcare, there were two additional systems that he believed were impacted by COVID:

1. *Long-term care:* The lack of response from the main healthcare delivery system to support long-term care facilities underscored problems that existed prior to COVID; particularly the poor integration of long-term care with clinical care systems and public health systems. COVID revealed inadequate quality and safety infrastructures within LTC facilities. Finally, pre-existing understaffing and a lack of training for frontline workers worsened the COVID response and were in turn worsened by COVID.
2. *Primary care:* Primary care was ignored during the initial national response to COVID, and this he emphasized was a tragic missed opportunity. System resources were diverted away from primary care into acute care. Primary care practices were not used as distributed testing sites or later as vaccine administration sites. The local trusted relationships of primary care teams and their communities were not leveraged to build vaccine confidence. There will likely be long-term consequences of the unsupported strain of primary care due to lack of preventive care and chronic care management. Nevertheless, there were some small independent practices that were heroic, and there are bright spots like the CMS support of the [Maryland Primary Care Program](#). This joint state and federal program supported primary care practices through investments in expanding case management and integrated care to resolve unmet needs better.

Dr. Meyers then shared his ideas on how CMS can build our system back better:

Ideas for CMS-

1. It is important to think about whole person and value-based financing systems and accelerate the move away from FFS.

2. This is an opportune moment to create meaningful measures of equity to build into value-based financing.
3. New financing models for safety-net health systems are needed. The vulnerability of these systems was revealed during the pandemic and there needs to be a better way to support them and keep them whole.

Ideas for health systems-

1. There needs to be real-time information on supply side availability. It is critical for health systems to link their capacity, bed availability, staffing, financing, and clinical systems in ways that can drive them to become a learning system while providing high-quality care. This will prepare these systems for the next surge or crisis. If these internal systems are built well, it creates an opportunity to link them externally with local, state, and federal partners and have a better way as a country to plan and respond.
2. It is important to consider diversifying system revenue streams to create financial resilience in addition to moving away from FFS.
3. It is no longer a question about whether to continue integrating telehealth into care delivery. The new question is how to make telehealth drive quality, safety, equity, and value together; and we need research, innovation, and evaluation to figure this out.
4. Finally, it is important to continue and expand effort such as the [National Academy of Medicine's \(NAM\) health professional's wellbeing collaborative](#) to address healthcare personnel burnout and promote their well-being. We must care for those who provide care.

He closed with re-emphasizing the importance of rebuilding and strengthening our public healthcare system as we continue to focus on our clinical systems.

Mark McClellan, MD, Ph.D., Robert J. Margolis Professor of Business, Medicine, and Policy, and founding Director, Duke-Margolis Center for Health Policy, Duke University

Dr. McClellan reiterated several important themes:

1. There is no pathway to success without a strong level of provider commitment and culture that focuses on making communities better, and
2. It is much easier to change the culture and sustain a population health equity focus if our policies and payments are designed in a way that make it easy.

COVID-19 short-term impact on healthcare and health

From January 2020 to April 2021, COVID brought down hospital and outpatient utilization, which is good from a spending perspective, but unfortunately also produced reductions in primary care services and an increase in behavioral and mental health service needs. The overall life expectancy dropped by one year for people in the U.S. but three to four years for non-Hispanic Black and Hispanic populations in the U.S.

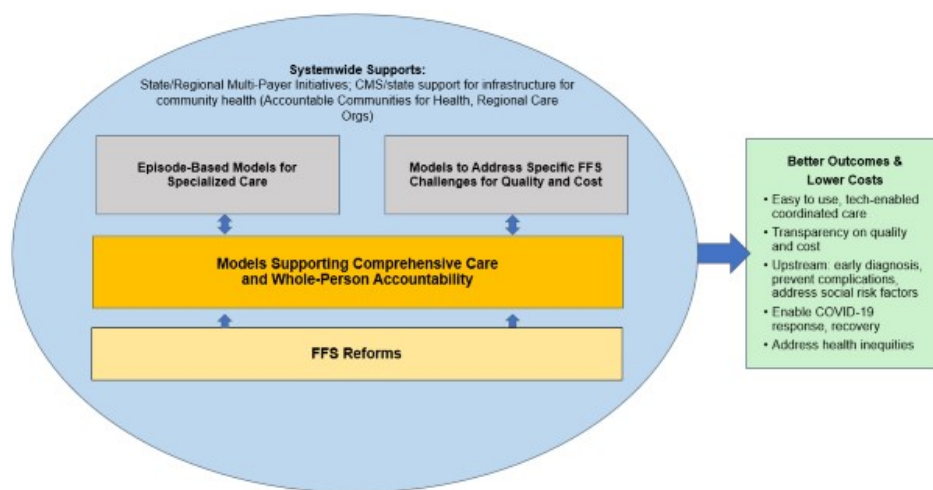
Over the past year Dr. McClellan worked with a range of health system collaborations to investigate differences for providers in value-based payment arrangements compared to FFS during COVID through a series of case studies. Evidence suggested organizations in non-FFS models were better able to focus on response through existing structures like telehealth visits. Non-FFS organizations already knew where

their beneficiaries were and how to reach them at home and get them COVID tests. So, value-based payment models had greater abilities to redesign effectively.

He emphasized that home based care models that used telehealth are much more than telephonic visits; they included remote monitoring, integrating digital self-care tools, robust longitudinal integrated data and analytics, care teams that consider caregivers, etc. Most healthcare systems that were FFS were not positioned to build up this kind of remote work to make effective models. Simply extending the telehealth and site of service flexibilities proved to not create the combination of supports and the accountability at the person level that built out these models effectively.

To sustain a shift to advance high value care models, all organizations need to shift to a non-FFS systematic approach. Some organizations like Blue Cross of North Carolina for example achieved this successfully. Dr. McClellan proposed a framework for comprehensive care, seen in the graphic below. It provides a foundation for making advanced alternative payment models, ACO type arrangements, or Medicare advantage approaches work better and to insure their wider available.

A Framework for Comprehensive Care Reform



Potential CMS and purchaser actions influencing long-term impact

The most important things CMMI should do next is get some clarity out about what should be after Next Generation ACOs and how to build out a version of direct contracting or other advanced primary care options. Additionally, CMMI needs to address FFS issues at the same time (i.e., some of the CMMI initiatives around home health payments did address FFS but were counterproductive to value and worked because these models were mandatory).

Additionally, to get to comprehensive care, primary care is the foundation. Parallely, it is still important to pay attention to decisions made by specialized providers. While there are some issues that can be addressed through episodic based care, it is much easier to make comprehensive changes in

coordination with primary care if done together. He hoped CMMI would prioritize models that address changes to both these provider types together.

Zooming out and thinking about the whole healthcare system, the Health Care Program Learning & Action Network (HCPLPN) which is a CMMI public-private collaboration to advance payment and care reform, is working to shift comprehensive care to be distributed equitably and affordably through targeted measures and goals at the state and market level. Ongoing work is and should be moving towards population care and outcome goals and less about full alignment with models.

Audience Discussion

Stuart Altman led the post-speaker discussion by identifying key thematic questions posed by the audience. The first question asked was why doesn't CMMI eliminate ACOs altogether based on dubious outcomes and what can we do to move forward?

Mechanic responded that there is a range of high and low performing ACOS, and we are looking at averages. Some of these organizations are providing much better clinical care, and some of the primary care models like lora health are saving money and improving outcomes through efficiency. The concern with these models is the revenue is still being generated through Medicare Advantage, so Medicare spending is not significantly less. So, we need to identify which of the models are successful and replicate them in a way that the taxpayer and individual get some of the savings.

Next the audience asked Dr. Thea James to make suggestions to convince Washington to prioritize achieving better equity and support safety net providers. Dr. James responded that one aspect of the President Biden's Build Back Better bill is a focus on addressing inequity and some of the social determinants of health. Most of the items created under this bill present opportunities for people to reset and enable those who are disadvantaged to achieve their fullest potential. The bill disrupts system structures that have created these inequities. She held hope this could be the right step for the future.

Finally, Altman asked Fowler to summarize themes she heard and asked what she would like to hear in the future to improve CMMI. Fowler highlighted the need for better coordination between primary and specialty care. CMMI is working to address this and looking into nested models or testing approaches within ACOs. They are also open to other ideas too. Second, Fowler highlighted there were questions about the Maryland total cost of care model, and should we go to a global approach to controlling costs or to regulating the health care system? The Maryland model is primarily a hospital-based model, and CMMI would love to see more primary care, Medicaid, and safety net providers in that model. Finally, she posited how do we make these new models easier for patients? We have focused so much attention on providers, we lost sight of better care for patients. We are working on shifting focus to person-centered care and being more responsive to patient needs.

Closing Remarks

Stuart thanked the speakers and audience for dynamic Q&A and participation in the chat.